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MEDICARE PHYSICIAN PAYMENT REFORM

Terry Coleman

Oncologists can expect major changes in Medicare payments as a result of new legislation that introduces a fee schedule based on a relative value system of payment for physician services. The author examines the critical issues: the development of relative values; the determination of geographic and conversion factor adjustments; the application of volume performance standards; and the effect of new restrictions on balance billing.

In November 1989, just before adjourning for the year, Congress passed historic legislation that radically altered the payment system for Medicare physician services and, in the process, created a payment method that is likely to be adopted by other payers. The new legislation requires Medicare payment to be based on a fee schedule derived from a relative value scale (RVS). It is generally believed that use of the RVS-based fee schedule will result in redistribution of significant amounts of Medicare payments from procedure-oriented physicians to those specialties, like medical oncology, that provide more cognitive services.

The fee schedule will be introduced through a phase-in period that begins in 1992 and becomes fully effective in 1996. In addition, the legislation creates new restrictions on balance billing that will greatly affect physicians whose fees significantly exceed Medicare's allowed charges, and who do not take assignment of Medicare claims.

Enactment of the physician payment reform legislation is the culmination of a long debate over the merits of Medicare's current payment system. The current system's use of payment ceilings based on the prevailing charge in each locality, and constrained since the mid-1970s by an inflation factor, has produced, in effect, a set of regional fee schedules based on local charging practices in the mid-1970s. As a result, Medicare payment for the same service varies greatly around the country. In addition, it is thought that the current system unfairly rewards the performance of certain procedures, such as surgery, and undercompensates cognitive services, such as office visits.

To remedy these perceived defects, Congress required the development of a relative value scale methodology to serve as the basis for the new fee schedule. This task was undertaken by William C. Hsaio and others at the Harvard School of Public Health under contract to the Health Care Financing Administration (HCFA).

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When the fee schedule is fully implemented, Medicare's payment for each service will be determined by multiplying the relative value for the service times a conversion factor times a geographic adjustment factor. The relative values and the conversion factor will be nationally uniform; the geographic adjustment factors will vary according to current Medicare localities. However, each element of the fee schedule methodology presents difficult implementation issues.

Relative Values

Relative values will be established for each physician service (i.e., for each code in *Current Procedure Terminology* [*CPT*]). As a "resource-based" RVS, the fee schedule will be based solely on the amount of resources used in providing each service and will not reflect factors such as the value of a service to the patient. Moreover, the law does not allow consideration of a physician's medical education expenses or of income foregone during training.

The relative value for each service will be determined by assigning relative value units to three components:

- A work component that reflects physician "time and intensity" in providing the service;
- A practice expense component that reflects practice overhead costs; and
- A malpractice component that reflects malpractice expenses associated with the service.

The work component is the most difficult to determine and the principal object of Hsaio's work.* Hsaio's methodology begins with a series of "vignettes" describing patient characteristics and physician services for about 20 to 25 CPT service codes in each physician specialty. These vignettes are intended to represent an average service covered by each of the codes involved. A sample of physicians in the relevant specialty estimates the time and intensity of physician work involved in each vignette. These survey results are then collated to form a relative value scale for the physician specialty involved. Dollar relationships among charges for

*W. C. Hsaio, and others. "Resource-Based Relative Values." *JAMA*, 260: 2347-2353, 1988, and the *N. Eng. J. Med.*, 319: 865-867, 1988.

various services are used to extrapolate relative values for the services that are not surveyed. Finally, the relative value scales for the various physician specialties are linked to each other by establishing the same values for services that are considered by an interspecialty panel of physicians to be the same or equivalent between two specialties.

Hsiao's group is currently in the process of ascertaining relative values for oncology services. A survey of selected physicians, related to both oncology and hematology services, was begun in August 1989, and the survey process is now in its final stages. Results of the work will be incorporated into a report to HCFA.

The relative values of the practice cost and malpractice components for each service will be determined in a more mechanical way, based on 1991 national average allowed charges for each service.

Geographic Adjustments

An important impact of the new system will be HCFA's rationalization of the sometimes extreme geographic variations in Medicare payments. HCFA is required to develop indexes that reflect geographic variations in practice expenses and in malpractice costs. This task may pose substantial technical difficulties, because data on such costs, to the extent that they are available at all, frequently do not correspond to Medicare's current locality boundaries. Because of these data problems, Congress has required HCFA to submit recommendations by July 1, 1991, on the desirability of using fee schedule areas based on statewide localities or metropolitan statistical areas, instead of the current Medicare localities.

A controversial issue that arose with regard to the geographic adjustment was whether or not there should be an adjustment for the non-overhead portion of the relative value (the portion representing the physician's work and, thus, professional net income). This adjustment, which is sometimes called a cost-of-living factor, would account for geographic differences in the expected level of professional income. The law adopted provides a compromise between those who favored full recognition of geographic differences in professional income and those who opposed it altogether, adjusting for only one-quarter of the relative variation. For

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example, if an area is determined to warrant professional income at 80 percent of the national average, the statute will assign the area an index value of 0.95—one-fourth of the difference between the indicated 0.8 and the average 1.0. The legislation does not specify a method for determining appropriate geographic variations in net professional income of physicians, but HCFA's research has focused on comparing geographic variations in the income of non-physician professionals and managers, such as lawyers and accountants.

The Conversion Factor

The last factor in the fee computation, in addition to the relative value and the geographic adjustment, is the conversion factor. While the first two factors determine the distribution of Medicare payments among various physician services, the conversion factor determines the amount of money paid by Medicare. As a result, adjustment of the conversion factor will be the primary instrument by which Medicare can control aggregate physician expenditures in the future.

For the first year, 1992, the conversion factor will be set at a budget-neutral amount intended to result in the same level of expenditures that would have resulted had the new system been in effect in 1991. For each subsequent year, the amount of the conversion factor will be set by Congress after considering recommendations from HCFA and the Physician Payment Review Commission (PPRC).

The statute allows for the possible use of different conversion factors for various categories of physician services. Surgical services are guaranteed separate treatment under the law; other classes of services are eligible to be treated separately if HCFA decides that it would be appropriate to do so. Separate treatment will undoubtedly become a major subject of contention in the coming years as physician specialty groups that restrain the growth of expenditures seek immunization from restrictions on fee increases that are likely to be imposed on groups that show substantial expenditure increases.

Volume Performance Standards

A principal factor expected to be considered in updating the conversion factor each year is whether expenditures have stayed within the new Medicare volume performance standard rates of increase. Due to increases in the volume and intensity of the services being provided, Medicare's expenditures for physician services have been increasing much faster than can be accounted for by inflation and population growth. The new standards are intended to address that concern by reducing the rate of increase.

The standard applied each year will be set at a level somewhat below the growth in volume and intensity during the previous five years. The reduction below the five-year trend will be one percentage point in 1991, one and one-half in 1992, and two percentage points in succeeding years. Subject to congressional approval of a HCFA plan, the law states that, beginning in October 1991, HCFA can apply the standard separately to particular physician specialties if requested to do so by an appropriate physician group.

Compliance with the volume standards will be taken into account during the annual updating of the conversion factor. Moreover, if the standards are applied separately to various specialties, year-to-year changes in the fee schedule could be tailored to each specialty's success in restraining the rate of growth in the volume and intensity of services. It is anticipated that Congress will act each year to determine the amount of the conversion factor update. However, if Congress does not act, failure to meet the standards will automatically reduce the amount of the update factor, subject to certain limitations.

Coding Issues

A major unresolved obstacle to smooth implementation of a nationally uniform fee schedule is the existing regional variation in interpretation of codes, particularly office visit and consultation codes. The PPRC has recommended differentiating among types of visits on the basis of the time involved, rather than the current, more subjective criteria. While the new law requires HCFA to develop a uniform coding system, it prohibits basing the visit and consultation codes on a time factor until at least 1993, after a study of the issue has been completed.

Transition

Beginning in 1992, the fee schedule will fully apply to those services for which the Medicare prevailing charge level (after certain adjustments) is within 15 percent of the fee schedule amount. For those services that are currently outside that range, there will be a transition period lasting through 1995 in which Medicare payment will gradually move toward the fee schedule amount.

HCFA is required to produce and distribute a model fee schedule by September 1, 1990, based on the relative values then available. This will enable Congress and the medical community to obtain a better understanding of what the final version will look like.

Balance Billing

The current Medicare limits on balance billing for unassigned claims (maximum allowable actual charges [MAACs]) are based on each individual physician's charges during a base period. Under the new legislation, maximum charges will be based on the fee schedule and will eventually be uniform for all physicians in the same locality. This change will dramatically reduce the permitted charges for some physicians.

Some physicians may start performing services that they do not currently provide to make up for lost income

Beginning in 1993, physicians can charge no more than 115 percent of the Medicare payment amount. During 1991, charges can be as high as 125 percent of the payment amount and, in 1992, as high as 120 percent.

The law also requires physicians to take assignment of claims in some cases—the first use of mandatory assignment. Physicians must take assignment of claims for Medicaid recipients beginning April 1, 1990, as well as for "qualified" Medicare beneficiaries. This latter group consists of Medicare beneficiaries whose income is below the poverty line and, therefore, qualify for state payment of their deductibles and coinsurance even though they are not Medicaid recipients.

Finally, even for unassigned claims, the law requires physicians to file the claims with Medicare on the patient's behalf without charge to the patient. This requirement applies to services rendered on or after September 1, 1990.

Summary

Many important issues will have to be resolved as the fee schedule is developed for implementation over the next two years. Relative values have to be developed for particular services, appropriate geographic adjustment factors have to be constructed, and criteria for determining a budget-neutral conversion factor must be adopted. Oncologists will be affected by the outcome of each of these decisions and, potentially, by reconfiguration of the locality system and the use of separate conversion factors and volume performance standards for oncology services.

A major, unknown factor is how physicians will change their practices in response to the combined effects of the fee schedule and the restrictions on balance billing. It is conceivable that some physicians may start performing services that they do not currently provide to make up for lost income. The effect of such changes on oncologists is difficult to predict at this time.

When the Medicare fee schedule is finally developed, there is a strong likelihood that it will be adopted by other payers, perhaps universally. Thus, the importance of HCFA's work in this area over the next two years may be of enormous importance to oncologists and other physicians. ■

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NEW PUBLICATION SCHEDULE FOR *ONCOLOGY ISSUES*

Beginning with this copy of *Oncology Issues*, a new publication schedule has been put into effect. Mailing dates have been advanced one month.

The journal will now be published on the following dates:

FEBRUARY 15

MAY 15

AUGUST 15

NOVEMBER 15.