

## Physician services payment system

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Physician services are billed to Part B. Medicare payments to physicians (about \$48 billion in 2003) account for about 18 percent of total spending.

The Medicare physician payment system was implemented in 1992. To make predetermined payments for physician services, Medicare uses a list of services and their payment rates, called the physician fee schedule, for more than 7,000 services. Many services have two payment rates: a higher rate for services provided in non-facility settings, such as physicians' offices, and a lower rate for those furnished in facilities, such as hospitals. Rates are lower for services furnished in facilities because physicians' practice costs are generally lower; the facilities furnish some of the services that physicians normally would supply in the office setting and are paid separately for them.

In determining payment rates for each service, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of

resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the final payment amount. However, rates may be adjusted further based on what role the physician has in providing the service, additional geographic designations, and other factors.

Payments are updated every year according to a formula called the sustainable growth rate (SGR) system, which is intended to keep spending growth consistent with growth in the national economy.

### Defining the services Medicare buys

Under the physician fee schedule, the unit of payment is the individual service, such as an office visit or a diagnostic procedure. These products, however, range from narrow services (an injection) to broader bundles of services associated with surgical procedures, which include the surgery and related pre-operative and post-operative visits. All services—surgical and non-surgical—are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for more than 7,000 distinct services.

### Setting the payment rates

Under the fee schedule, payment rates are based on relative weights, which account for

the relative costliness of the inputs used to provide physician services: physician work, practice expenses, and PLI expenses. The relative weights for physician work are based on physicians' assessments of the relative levels of time, effort, skill, and stress associated with each service. The relative weights for practice expense are based on the expenses physicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI relative weights are based on the premiums physicians pay for professional liability insurance.

In calculating payment rates, each of the three relative weights is adjusted to reflect the price level for related inputs in the local market where the service is furnished. Three geographic practice cost indexes are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor.

Payments under the physician fee schedule also may be adjusted to reflect other factors. First, payments are decreased if services are furnished by certain nonphysician practitioners. Services provided by physician assistants and nurse practitioners are paid at 85 percent of physicians' fees and nurse midwives' services are paid at 65 percent.

Second, payments are adjusted according to payment modifiers that appear on claims for payment to show whether the service provided was atypical. For example, physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the primary surgeon. Other modifiers apply to multiple surgical procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

Third, under the Medicare incentive payment program, physicians receive bonus payments when they provide services in health professional shortage areas (HPSAs). These payments are intended to attract more physicians to HPSAs. The bonus increases payments to these physicians by 10 percent (excluding beneficiary coinsurance).

Fourth, payments are adjusted downward when services are furnished by physicians who are not in Medicare's participating physician and supplier program. Payment rates for services provided by non-participating physicians are 95 percent of the fee schedule payment rate.

The fee schedule's relative weights are updated at least every five years; HCPCS codes and the conversion factor are updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group of physicians and other professionals sponsored by the American Medical Association and physician specialty societies.

The annual updates for the conversion factor are made according to the SGR system, a formula intended to keep spending consistent with a target based on growth in the national economy. If actual spending is less than the target, the update is greater than the change in input prices for physician services. If actual spending is greater than the target, the update is less than the change in input prices.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates increases to the physician fee schedule's conversion factor of at least 1.5 percent in 2004 and 2005, preventing a negative update of -4.5 percent projected for 2004 and another negative update projected for 2005. In addition to these increases in payments, the MMA includes provisions that

will raise payments for services furnished by many fee-for-service physicians:

- A floor is established for the physician work component of the fee schedule's geographic practice cost index (GPCI). This floor will raise payments for services furnished in areas with below average physician work GPCIs, and will be in place from 2004 to 2006;
- Geographically adjusted payments for services provided in Alaska will increase to become 67 percent higher than the national average. That is, the work, practice expense, and medical malpractice GPCIs will each be increased to 1.67. This increase will be in effect in 2004 and 2005;
- Services provided by physicians in newly established scarcity areas—determined separately for primary care physicians and specialists—will receive a 5 percent bonus payment in Medicare payments. This bonus will occur from 2005 to 2007; and
- For the pre-existing 10 percent bonus payment to physicians practicing in designated HPSAs, responsibility for identifying eligibility will shift from the individual physician to the Secretary of Health and Human Services. These automatic 10 percent bonus payments will start in 2005.

A service furnished in an area that qualifies for both the scarcity area bonus and the shortage area bonus can receive both incentive bonuses above.

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