

FACTS Re: MEDICARE PHYSICIAN REIMBURSEMENT

Problems with using GPCIs:

- Variation in payment for the same medical service performed in different locations is vast, e.g., payment for a mid-level office visit (99213) varies up to 33%. However, as of 7/1/08, the variation will increase to 37% without congressional intervention to maintain the floor of 1.0 on the work GPCI.
- Low reimbursement rates have repeatedly had a negative impact upon physician recruitment.
- Patient access is being affected.

Physician payment reform

The move to a Resource-Based Relative Value Scale (RBRVS) physician payment schedule represents the most significant change in Part B since Medicare's inception in 1966.

For 25 years, Medicare physician payment was based on a system of customary, prevailing and reasonable (CPR) charges. Between the mid-1970s through the mid-1980s, government implemented a series of CPR cost controls. The major effect of the price controls was to make permanent the basic pattern of Medicare prevailing charges that existed in the early 1970s. In the mid-1980s, physician dissatisfaction with CPR grew, and government policymakers considered several payment reform proposals, including replacing CPR with a payment schedule based on a relative value scale (RVS).

An RVS is a list of physician services ranked according to "value," with the value defined with respect to the basis of the scale. An RVS can be either charge-based or resource-based. In a charge-based RVS, services are ranked according to the fee for the service. A resource-based RVS ranks services according to the relative costs of the resources required to provide them. An RVS must be multiplied by a dollar conversion factor to become an actual fee. A resource-based relative value scale was supported by surgical and nonprocedural specialty societies alike. With funding from the Health Care Financing Administration (HCFA) – now the Centers for Medicare & Medicaid Services (CMS) – the Harvard University School of Public Health began its RBRVS study in December 1985. The Harvard study produced what would become known as the physician work relative value units.

After external review and validation, it was generally agreed that the Harvard study was scientifically sound. However, there were passionate views on all sides. Many rural and primary care physicians called for immediate adoption; surgeons viewed the study more cautiously; and HCFA was concerned that a fee schedule, regardless of how carefully constructed, could not control the growth in the volume and intensity of services.

In 1989, Congress enacted Medicare physician payment reform. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) called for a payment schedule based on an RBRVS composed of three components: the relative physician work involved in providing the service, practice expense, and malpractice costs. OBRA 89 also defined other key features for physician payment reform:

- A 5-year transition to the new system beginning January 1, 1992;
- Adjusting each component of the three RBRVS components for each service for geographic differences in resource costs;
- Eliminating specialty differentials in payment for the same service;
- Calculating a “budget neutral” conversion factor for 1992 that would neither increase nor decrease Medicare expenditures from what they would have been under a continuation of CPR;
- A process for determining the annual update in the conversion factor;
- Tighter limits on balance billing beginning in 1991; and
- A Medicare Volume Performance Standard (MVPS) to help Congress understand and respond to increases in the volume and intensity of services provided to Medicare beneficiaries.

After a decade of legislation, study, and compromise, the Final Notice implementing physician payment reform appeared in the November 25, 1991 *Federal Register* effective for January 1, 1992 implementation.

RBRVS components

The Medicare RBRVS called for a payment schedule based on three components with each component adjusted for geographic differences in resource costs and a conversion factor (CF) used to transform relative value units (RVUs) into dollars.

Physician work. This refers to the physician’s individual effort in providing the service: the physician’s time, the technical skill and physical effort, mental effort and judgment, and psychological stress associated with the physician’s concern about iatrogenic risk to the patient. Physician work is geographically adjusted by the work GPCI, which represents the cost of living, but this index measures only one quarter of the geographic differences in cost of living.

Practice expense (PE). This refers to the cost of physician practice overhead, including rent, staff salaries and benefits, medical equipment and supplies. Practice expense is geographically adjusted by the PE GPCI.

Professional liability insurance (PLI). This refers to the cost of insurance to protect a physician against professional liability. This is geographically adjusted by the PLI GPCI, which measures differences in premiums across Medicare payment areas.

Conversion factor (CF). This is the factor that transforms the geographically adjusted relative value for a service into a dollar amount under the physician payment schedule. The 2008 CF for the period January 1 through June 30 is \$38.0870; it is scheduled to decrease to \$34.0682 on July 1. Without congressional intervention, Medicare will cut physician payments 10.6 percent on July 1 and another 5 percent or more on January 1, 2009. Payment rates will be cut about 40% over nine years beginning in July 2008, while practice costs increase 20%. These cuts come at a time when Medicare physician payment updates already lag far behind increases in the costs of caring for seniors. In 2011, the leading edge of the baby-boom generation will start enrolling in Medicare, with enrollment growing from 44 million in 2011 to 50 million by 2016.

GPCIs

Adjustments to each of the payment components are made using the Geographic Practice Cost Indices (GPCIs). There are three GPCIs, corresponding to the three components of the payment schedule – work, practice expense, and professional liability insurance (PLI). Three sets of GPCIs are defined for each of the 89 Medicare physician payment localities that currently exist. OBRA 90 requires that GPCIs be revised at least once every three years. CMS reviewed and proposed new GPCIs for 2008; the legislation stipulates that updated GPCIs be phased in over a 2-year period, with half of the overall adjustment occurring in 2008 and the other half in 2009. The Medicare Modernization Act of 2003 (MMA) established a floor of 1.0 for the work GPCI in 2004, 2005 and 2006. This provision was extended through December 31, 2007, by the Tax Relief and Health Care Act of 2006 and once again through June 30, 2008, by the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Physician work GPCI. The physician work, or cost of living, GPCI is not based on differences in physicians' earnings; rather, it measures geographic differences in the earnings of all college-educated workers, currently based on 2000 decennial U.S. census data.

Practice expense GPCI. The practice expense GPCI is designed to measure geographic variation in the prices of inputs to medical practice, e.g., office rent per square foot and hourly wages of staff. It is important to distinguish between the practice expense component of the RVS and the practice expense GPCI. The practice expense relative value reflects average direct and indirect expenses. The practice expense GPCI reflects only the differences in these costs across geographic areas relative to the national average.

The office rent portion of the practice expense GPCI is based on 2000 residential apartment rental data from the Department of Housing and Urban Development. As it did in calculating the original GPCIs, CMS continues to use proxy data to update this index, stating that no national data for physician office rents is available.

The employee wage portion comes from 2000 census data on wages of clerical workers, registered nurses and health technicians. The practice expense GPCI does not reflect geographic differences in medical equipment and supply costs. CMS believes a national market exists for these components and that input prices do not vary specifically across geographic areas.

PLI GPCI. The professional liability insurance GPCI reflects geographic differences in premiums for a mature claims-made policy providing \$1 million/\$3 million of coverage. Adjustments are made for mandatory patient compensation funds. The 2008 PLI GPCIs are based on a 3-year average of actual premium data from 2004, 2005, and 2006.

Geographic adjustment factor (GAF). The three GPCI components can be combined in a composite GPCI or GAF by weighting each by the share of Medicare payments accounted for by the work, practice expense and PLI components. On average, the work component comprises 52.466% of the total relative value for a service, the practice expense component comprises 43.669%, and the PLI component comprises 3.865%. The GAF indicates how Medicare payments in a locality differ from the national average (with the national average being 1.0).

Changes in the GPCIs do not affect total Medicare physician payments but, rather, redistribute payments among the localities.

Payment formula

As stated previously, the formula used to calculate Medicare physician payment includes work, practice expense and professional liability insurance geographic adjustors referred to as GPCIs. Medicare physician payment is the same for all 89 Medicare Part B payment localities until the GPCIs are applied. Under the 2008 Medicare Physician Fee Schedule, the highest PE GPCI is 1.494 (San Francisco, CA) and the lowest is 0.696 (Puerto Rico); Iowa's is 0.869. The highest PLI GPCI is 2.703 (Miami, FL) and the lowest is 0.254 (Puerto Rico); Iowa's is 0.506. For the first six months of 2008, the highest work GPCI is 1.083 (Santa Clara, CA) and, thanks to continuation of a floor, the lowest is 1.0; Iowa's is 1.0. However, without congressional intervention by June 30, 2008, the floor on the work GPCI will end, resulting in the lowest work GPCI decreasing to 0.905 (Puerto Rico); Iowa's would decrease to 0.966.

To better understand how the Medicare Physician Fee Schedule is developed, following is the formula used to calculate 2008 Medicare physician payments:

$$[(\text{Work RVU} \times \text{budget neutrality adjustor (0.8806)}^* \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{PLI RVU} \times \text{PLI GPCI})] \times \text{CF}$$

* Round the product of the two factors (i.e., the work RVU and budget neutrality adjustor) to two decimal places.

Work RVUs must be reviewed every five years. The CF, which is updated annually, is a dollar amount that is determined by the sustainable growth rate (SGR) formula. The flawed SGR formula ties physician payments to the gross domestic product, which bears no relationship to patients' health care needs or physicians' practice costs. Without Congress' intervention the past several years, physician payments would have been cut due to negative updates to the CF resulting from the SGR formula. Congress restricts annual Medicare Part B spending swings due to policy changes to no more than \$20 million. Because of changes in 2007 for work RVUs and other payment policies, including a new PE RVU methodology, a mandated budget neutrality adjustment was triggered. Not only was the BNA continued in 2008, it was increased (from 10.1% to 11.94%). Previously, CMS had applied a work RVU BNA in 1997 following the first work RVU review.

The Iowa Medical Society leads the Geographic Equity in Medicare (GEM) Coalition, which is comprised of 26 national medical associations. Both IMS and the GEM Coalition continue to lobby Congress to establish a floor of 1.0 on the practice expense GPCI and make permanent the floor of 1.0 on the work GPCI.