MEDICARE PHYSICIAN PAYMENT, PARTICIPATION, AND REFORM

by Ira Burney, Peter Hickman, Julia Paradise, and George Schieber

Prologue: National expenditures for physicians’ services have been rising over the last twenty years at increasing rates, from 8.3 percent annually in the 1960-65 period to a 14.9 percent annual rate in 1980-82, despite a recession. Medicare program spending has reflected these trends. During the period 1978 to 1983, expenditures for physicians’ services increased at an annual average rate of growth of 20.5 percent. Between 1983 and 1984, the rate of increase for Medicare Part B outlays jell to 11.4 percent. In this essay, the authors, all of whom work for the Health care Financing Administration (HCFA), set out these physician spending trends, Medicare’s payment methods, existing problems with this system, and generic approaches to reform. The authors declare that “inefficiencies in the existing payment system, coupled with their impact on the federal budget deficit, make changes in Medicare a top priority for the administration and Congress.” The authors work for HCFA’s Office of Legislation and Policy. Ira Burney is a senior policy analyst who is steeped in the details of the complicated world of Medicare physician payment. Hickman has spent four years working as a budget and legislative analyst at the agency. Paradise is a presidential management intern, and George Schieber, who holds a Ph.D. in economics from Syracuse University, is a recognized specialist in physician payment. Schieber formerly taught at the University of Pittsburgh and conducted research at The Urban Institute. For the last decade, Schieber has specialized in physician payment issues at the Department of Health and Human Services. During this period, the department has been plagued with the lack of a consistent national physician data base and a dearth of information on how physicians would respond to payment reform proposals. These problems still dog the department’s policymakers. In January, Schieber took leave from HCFA for a time to conduct comparative international health policy studies at the Organization for Economic Cooperation and Development.
Medicare spending for physicians’ services has been the subject of increasing discussion and congressional interest in recent years. While there have been major changes in the Medicare program every year since 1981, the Deficit Reduction Act (P.L. 98-369; July 18, 1984) was the first to contain provisions that significantly affect all physicians. The Deficit Reduction Act established a participating physician program for Medicare; a fifteen-month freeze on Medicare’s payments for physicians’ services; a freeze on the actual billed charges of nonparticipating physicians; and a direct billing requirement for laboratory services. About one-quarter of the act’s $4.9 billion (three-year) Medicare savings derive from the provisions that affect physicians.

Congress has mandated three studies, due in 1985, on various aspects of physician payment: the advisability and feasibility of a physician diagnosis-related group (DRG) system; the response of physicians to the fee freeze measured by changes in the volume and mix of services they provide; and perceived inequities in the relative amounts paid to physicians with respect to type of service, locality and specialty, and between cognitive and medical procedures. Two blue-ribbon panels have also made recommendations recently concerning reform of Medicare physician reimbursement. Finally, several medical organizations have indicated their interest in developing relative value scales.

This article provides an overview of Medicare physician payment practices, problems, and potential reforms. First, the trends in and composition of Medicare physician spending are analyzed. Second, the current Medicare payment and participation systems are described in detail. Third, problems inherent in the current system are discussed. Fourth, generic approaches to reform are presented.

**Background**

**Physician spending trends.** In 1983, the nation spent $69 billion on physicians’ services. Of this total, Medicare payments accounted for 19.4 percent, Medicaid 4.3 percent, private insurance 43.6 percent, and other public programs (for example, VA and CHAMPUS) less than 5 percent. Direct out-of-pocket payments, exclusive of premium payments, represented the remaining 28.4 percent. This points to the fact that while third parties pay for 73 percent of all health spending, coverage is much less comprehensive for physicians’ services (72 percent) than for hospital services (92 percent).

In FY 1984, Medicare spending for physicians’ services was $14.9 billion or $511 per enrollee. This represented 1.3 percent of the federal budget.
and 0.42 percent of the GNP. Spending for physicians’ services is the second largest component (after hospitals) of total Medicare outlays, and in FY 1984 accounted for 24.5 percent of program expenditures. However, physicians’ impact on program spending extends beyond the reimbursements they receive themselves: as central decisionmakers in the health care system, they influence over 70 percent of all health care spending.

Medicare spending for physicians’ services has had a history of rapid growth. Exhibit 1 shows the dollar amounts and annual percent changes in this spending since the beginning of the program. In the eighteen years since the program’s inception, Medicare expenditures for physicians’ services have grown at double-digit rates, except during the years of the Economic Stabilization Program (1971-1974). During the period from FY 1978 to FY 1983, Medicare spending for physicians’ services increased by $8.2 billion, or at an average annual rate of 20.5 percent. Of this, 47 percent is attributable to price increases. (Inflation in the general economy accounts for 38 percentage points of the price increase, while physician fee inflation in excess of general inflation represents 9 percentage points.) Eleven percent is explained by growth in the Medicare beneficiary population. The remaining 42 percent of the growth in spending is

---

Exhibit 1

Medicare Physician Spending, 1967-1984

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Medicare physician spendinga (in millions)</th>
<th>Percent increase from previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>$629</td>
<td>--</td>
</tr>
<tr>
<td>1968</td>
<td>1,304</td>
<td>--</td>
</tr>
<tr>
<td>1969</td>
<td>1,516</td>
<td>16.3%</td>
</tr>
<tr>
<td>1970</td>
<td>1,814</td>
<td>19.7</td>
</tr>
<tr>
<td>1971</td>
<td>1,831</td>
<td>0.9b</td>
</tr>
<tr>
<td>1972</td>
<td>1,996</td>
<td>9.0b</td>
</tr>
<tr>
<td>1973</td>
<td>2,118</td>
<td>6.1b</td>
</tr>
<tr>
<td>1974</td>
<td>2,426</td>
<td>14.5</td>
</tr>
<tr>
<td>1975</td>
<td>3,065</td>
<td>26.3</td>
</tr>
<tr>
<td>1976</td>
<td>3,690</td>
<td>20.4</td>
</tr>
<tr>
<td>1977</td>
<td>4,599</td>
<td>24.6</td>
</tr>
<tr>
<td>1978</td>
<td>5,327</td>
<td>15.8</td>
</tr>
<tr>
<td>1979</td>
<td>6,397</td>
<td>20.1</td>
</tr>
<tr>
<td>1980</td>
<td>7,814</td>
<td>22.2</td>
</tr>
<tr>
<td>1981</td>
<td>9,512</td>
<td>21.7</td>
</tr>
<tr>
<td>1982</td>
<td>11,392</td>
<td>19.8</td>
</tr>
<tr>
<td>1983</td>
<td>13,498</td>
<td>18.5</td>
</tr>
<tr>
<td>1984</td>
<td>$14,936</td>
<td>10.6</td>
</tr>
</tbody>
</table>

*Medicare spending is for benefit payments and excludes administrative costs. Benefit payments include physicians services rendered and/or billed by physicians and nonphysician suppliers.

b The Economic Stabilization Program was in effect from 1971 to 1974.
due to increases in the utilization and intensity of services provided to the Medicare population. The fact that physician fee inflation in excess of overall inflation represents only 9 percent of the increase, while utilization and intensity represent 42 percent, suggests that policies and strategies designed to constrain the rate of growth in Medicare spending for physicians’ services must address themselves to the volume and mix of services as well as per unit prices.

Between FY 1983 and FY 1984, the rate of increase in outlays for physicians’ services fell to 10.6 percent. This drop in the rate of increase may be due to the lower rate of inflation, fewer hospital admissions, shorter lengths-of-stay, and/or competitive effects of the increased physician supply. The fifteen-month freeze on Medicare payments and other provisions of the Deficit Reduction Act are expected to reduce the rate of increase in Medicare physician spending for FY 1985 to 10 percent. However, Medicare spending for physicians’ services is still projected to grow at annual rates in excess of 11 percent between FY 1986 and FY 1990.

Price and utilization changes are also related to the supply of physicians. The per capita supply of physicians increased by 35 percent between 1965 and 1980 and is expected to increase by 38 percent between 1980 and 2000. This increase may spur competition, slowing the rate of growth in program spending. However, to the extent that physicians can generate demand for their services and receive payment through open-ended reimbursement systems, the supply increase may result in higher utilization of health care services.

**Composition of spending.** Medicare spending varies significantly according to type of service purchased, physician specialty, place of service, and patterns of beneficiary utilization. With respect to the types of services purchased, medical care (primarily physician visits) and surgery are, by far, the two most important types of physicians’ services for which Medicare pays. In 1981, they accounted for 40 and 32 percent, respectively, of Medicare reasonable charges for all physicians’ services. Four specialties—internal medicine, general surgery, ophthalmology, and general practice—accounted for 46 percent of reasonable charges for physicians’ services. Internal medicine alone accounted for 20 percent.

The importance of Medicare payment to physicians’ incomes varies substantially according to specialty. In 1981, physicians in eight specialties received at least 21 percent of their gross revenues from Medicare. These specialties—general surgery, internal medicine, radiology, thoracic surgery, anesthesiology, neurology, ophthalmology, and pathology—represented 56 percent of Medicare reasonable charges for physicians’ services and 41 percent of all physicians.

Medicare spending for physicians’ services is also highly concentrated in certain settings. In 1981, 64 percent of Medicare physician spending was for services delivered in hospital inpatient settings. Services rendered
in physicians’ offices accounted for another 29 percent. The remainder was for services rendered in hospital outpatient departments, nursing homes, and patients’ homes.

Finally, Medicare spending for physicians’ services is concentrated among a small number of beneficiaries who receive a large dollar volume of services. Beneficiaries currently face an annual $75 Part B deductible and coinsurance of 20 percent of the Medicare-determined reasonable charge. In 1981, the estimated 5 percent of beneficiaries who received physicians’ services whose submitted charges totaled $2,500 or more accounted for about 48 percent of total submitted charges. By contrast, the estimated 30 percent of beneficiaries who received physicians’ services whose submitted charges totaled less than $250 accounted for about 6 percent of total submitted charges. Moreover, approximately 38 percent of beneficiaries did not use enough physicians’ services to exceed the Part B deductible. These data suggest that the burden of cost-containment initiatives that emphasize higher coinsurance would fall most heavily on the relatively few high users of services. Some might question whether increased cost-sharing would curb unnecessary utilization by this subgroup.

Physician Payment And Participation Methods

**Medicare physician payment.** Medicare was designed to conform to the existing health care system and private market physician payment patterns. In the original statute, Congress adopted the fee-for-service method of paying physicians and specified that payment for physicians’ services would be determined based on customary, prevailing, and reasonable (CPR) charges. Under the CPR system, Medicare’s payment rate for a particular service, known as the reasonable charge, is calculated statistically from actual physicians’ billings. It is defined as the lowest of: the physician’s actual billed charge for the service; the physician’s customary charge for the service (defined as the physician’s median charge for the procedure during the previous year); and the prevailing charge for the service in that locality (defined as the seventy-fifth percentile of the customary charges of all physicians in the area, weighted by the number of times each physician performed that service). To restrain continued increases in Medicare physician spending, Congress, in 1972, enacted the “economic index” provision which limits the rate of increase in Medicare prevailing charges to an index based on inflation in the general economy and changes in office practice costs.

Nearly half of the state Medicaid programs, about half of the Blue Shield plans, and some commercial insurers also use a CPR system of payment. Another fee-for-service method by which insurers determine how much to pay physicians is fee schedules. Fee schedules specify, for each service, the maximum fee that will be recognized for payment purposes.
A CPR system can be viewed as a dual fee schedule— one customized to the individual physician and the other tailored to the charging patterns of most physicians in the area.

Medicare contracts with fiscal agents—private insurance companies called carriers— for the administration of physician payment, including calculation of CPR reimbursement rates and actual payment of claims. The thirty-nine Medicare carriers recognize over 225 distinct geographic reimbursement areas called localities based on local medical markets (fourteen carriers have statewide localities). In addition, for each service, carriers establish prevailing charges which generally vary by specialty (six carriers do not recognize interspeciality differences). The Medicare carriers use a variety of criteria to define specialty for reimbursement purposes, including board certification, board eligibility, and self-designation (the most common definition).

The Deficit Reduction Act imposed a fifteen-month freeze on the customary and prevailing charges for all physicians’ services provided to Medicare beneficiaries, and on the actual charges made to Medicare patients by nonparticipating physicians (defined below). Participating physicians may increase their actual charges. Although this provision does not affect physicians’ current reimbursements, increases in their actual charges will be reflected in higher customary charges following the freeze.

The act also moved the annual update in Medicare fee screens from July 1 to October 1 of each year (beginning on October 1, 1985) and prohibited physicians from billing for laboratory services that they do not perform themselves.

Medicare physician participation. Access to care and out-of-pocket costs, which determine the extent of Medicare financial protection for beneficiaries, are directly affected by physician participation in Medicare: the greater the participation of physicians, the greater the beneficiary access to care at predictable levels of out-of-pocket expenses. Thus, physician participation and its relationship to payment rates are key aspects of a physician payment system.

The Deficit Reduction Act modified the terms of physician participation in Medicare. Prior to the act, physicians could elect to participate in Medicare, that is, accept assignment, on a claim-by-claim basis. If the physician “accepted assignment” of the benefit, the physician submitted the bill directly to the Medicare carrier and agreed to accept the approved charge as full compensation for the service. The physician billed the beneficiary only for applicable deductible and coinsurance amounts. If the physician did not accept assignment, the physician billed the beneficiary directly. In turn, the beneficiary filed a claim with Medicare and received the reasonable charge, less applicable cost-sharing. The beneficiary paid the physician and was responsible for the entire difference between the approved charge and what the physician billed.
The Deficit Reduction Act instituted a Medicare participating physician program. A participating physician is one who signs an agreement to accept assignment on all claims for services provided to Medicare patients for a twelve-month period beginning on October 1 of a year. The claim-by-claim assignment option is retained for nonparticipating physicians. As incentives to participate, the statute provides for the publication of the names of participating doctors through directories and toll-free telephone numbers, improvements in electronic receipt of claims by carriers, and exemption from the freeze on actual charges to Medicare patients.

**Medicaid physician payment.** In FY 1984, Medicaid spending for physicians’ services reached $2.8 billion (federal and state shares combined). This represented 6.4 percent of total Medicaid spending. Unlike Medicare, which has a uniform national payment method, states have broad discretion in establishing Medicaid physician payment rates subject only to the general guideline that rates be high enough to attract sufficient participation of physicians. In 1983, twenty states used CPR methods (generally following Medicare principles) and thirty states used fee schedules. In 1979, state Medicaid fees for specialists ranged from 24 percent to 100 percent of Medicare prevailing charges. Medicaid is a “mandatory assignment” program. By statute, no billing of the beneficiary above the state payment amount is permitted. Claims for services provided to beneficiaries of both Medicare and Medicaid—the so-called “crossover claims” for “joint eligibles”—are generally required to be assigned.

**Problems In The Existing System**

The Medicare physician payment system has achieved the primary goal of the program—to provide beneficiaries with access to quality health care services. Today, over 29 million beneficiaries are covered by the program and most physicians treat some Medicare patients. Nonetheless, the Medicare physician reimbursement system has been criticized with regard to both payment and participation policies.

**Payment.** The existing Medicare payment system is confusing for both beneficiaries and physicians. Often, neither knows how much Medicare will pay until the carrier actually pays the bill. In addition, Medicare’s physician payment system is inflationary in terms of both the price and quantity of services. The open-ended nature of the reimbursement system (that is, the absence of an overall spending limit) permits increases in utilization and intensity to offset the impact of constraints on the price side.

The Medicare payment system maintains the relative price patterns that exist in the market for physicians’ services. These patterns represent what some believe to be payment imbalances, given actual resource costs. On a resource cost basis, they tend to favor specialists over generalists;
urban areas over rural areas; inpatient treatment over ambulatory care; and diagnostic, laboratory, radiology, and surgical procedures over primary care. For example, surgical procedures are generally compensated at rates two to three times higher than are cognitive services, such as primary care visits.10

However, relative to what physicians bill for these services to Medicare patients, Medicare payments do not discriminate against physicians who provide primary care. For example, in 1981, Medicare paid internists seventy-six cents on each dollar of their billed charges; general surgeons seventy-five cents; orthopedic surgeons seventy-three cents; general practitioners seventy-five cents; and the average physician seventy-five cents.11 While cognitive procedures may be underpaid relative to technological services in terms of resource costs, this is not the result of the Medicare reimbursement system per se, but a function of physicians’ actual charges to Medicare patients. One could argue that these market charge patterns are the result of imperfections in the market for physicians’ services.

Finally, the Medicare economic index has resulted in Medicare’s physician reimbursement system becoming a series of specialty-specific local fee schedules set at the economic index-constrained prevailing charge levels. This has occurred because physicians’ actual and customary charges are increasingly constrained by the more slowly rising economic index; consequently, the economic index-adjusted prevailing charges increasingly determine the Medicare payment amount. The resulting fee schedules lock into place all the relative price patterns in the Medicare CPR system.

Participation, The Medicare participating physician system reduces beneficiary confusion about which physicians always accept assignment. However, in the case of nonparticipating physicians, beneficiaries may still not understand why physicians accept assignment for some patients or services but not others. In addition, beneficiaries often do not know whether or not assignment will be accepted until the bill is received. The combined impact of Medicare’s payment and participation systems is to make beneficiary financial liability unpredictable and difficult to budget. The acceptance of assignment varies across several dimensions, resulting in variable Medicare financial protection for beneficiaries. In FY 1984, assignment was accepted on 56.7 percent of claims, but the rates varied across states from a low of 23 percent in South Dakota to a high of 86 percent in Rhode Island.12 In 1981, 54 percent of spending for inpatient physician care and 37 percent of spending for care provided in physicians’ offices was for services taken on assignment. In the same year, while some 23 percent of beneficiaries had all their Medicare services assigned, 37 percent had none assigned.13 An estimated 20 percent of physicians always accepted assignment, 30 percent never accepted assignment, and 50 percent accepted assignment some of the time.14

Although the national claims assignment rate has increased in the past
few years, the amount by which actual charges to Medicare have been reduced by the carriers has grown substantially due to the effect of the economic index on prevailing charges. Thus, beneficiary liability on unassigned claims has increased. In FY 1984, the Medicare reduction rate was 24 percent. Therefore, on unassigned claims, Medicare beneficiaries faced effective coinsurance of more than 40 percent—the 24-percent reduction rate plus the statutory 20-percent coinsurance.

Generic Approaches To Reform

Goals. Reforms of the existing system must be considered in the context of appropriate goals for Medicare physician payment and participation. Changes should encourage access to quality care at predictable levels of beneficiary out-of-pocket expenses, and at the same time establish the federal government as a prudent purchaser of services. Further, they should promote efficiency in the health delivery system.

To achieve an efficient and cost-effective reimbursement system, the following objectives should be accomplished. First, the right mix of services should be provided. Necessary medical care services should be rendered while unnecessary surgery or diagnostic tests should be eliminated. Second, care should be provided in the most appropriate setting. Patients who could be medically and cost-effectively treated on an ambulatory basis should not be treated in an inpatient setting. Third, a sufficient supply of physicians should be attracted into the profession and the right specialty mix should be achieved. Fourth, the geographic distribution of physicians should ensure the provision of care in all areas. Finally, payment rates should approximate both economically efficient production and consumption of services.

Proposed reforms of Medicare physician payment and participation include development of fee schedules, inpatient physician DRGs, and geographic capitation. All three approaches raise major issues which concern access, costs, and quality.

Fee schedules. For the majority of Medicare services, prevailing charges constrained by the economic index constitute a de facto fee schedule. Thus, the issue has become not whether or not to have a fee schedule, but rather what type of fee schedule Medicare should have.

Fee schedules could further such objectives as increasing physician participation and/or reducing existing reimbursement imbalances. Depending on how they were structured, fee schedules could result in minor to major changes in reimbursement rates. Fee schedules could be based on charges or payments under the current system, relative value scales, or negotiations. Fee schedules based on current charges or payments would be relatively easy to develop. While there is widespread interest in the medical community in a relative value scale approach,
there is little consensus on the specifics. Similarly, while there is much
discussion about negotiating with the medical community to develop a
system, major questions remain about who might represent physicians
and how to develop such a system. There may also be significant anti-
trust issues as evinced by the involvement of the Federal Trade Commis-
sion and the Justice Department.

Without effective utilization review and/or significant bundling of ser-
vices that are currently billed separately, the ability of a fee schedule to
restrain the growth in aggregate physician spending would be limited
because of the potential for unbundling and/or “upcoding” services. A
fee schedule approach would need to address three interrelated elements:
(1) establishment of the fee schedule itself, (2) physician participation,
and (3) utilization/aggregate spending.

1. Establishment of fee schedules. Issues in establishing fee schedules in-
clude the method by which rates will be set, rate differentials, and the
unit of payment. Methods for establishing fee schedules range from creat-
ing a formal fee schedule from the present one, to constructing an en-
tirely new system. Fee schedules could be based on current payments
under the CPR system. Since average Medicare-approved charges are
relatively close to prevailing charges, this would result in minimal
redistributions. Rates could be constrained so that program spending does
not increase beyond the expenditure level that would have resulted
under CPR.

Fee schedules could also be based on individual physician charge patterns.
A “family of fee schedules,” similar to CPR’s dual fee schedule, could be
based on individual physician charges and explicitly related to physician
participation. For example, subject to budget neutrality, carriers could
pay lower-priced physicians their charges in full (or, in large part), particu-
larly if they participated, and pay others a percent of their billed charges.

Fee schedules could be based on a relative value scale (RVS) which
ranks each procedure in order of its value, normalized to a standard pro-
cedure. The RVS can be converted into a fee schedule by using a dollar
multiplier or conversion factor (just as with DRGs). While a variety of
weighting factors have been suggested for developing an RVS, valuation
of several of them, such as complexity and risk of procedure, and the
value of physician time according to specialty, is highly subjective. Thus,
development of an RVS would not be as scientific or value-free a process
as some have indicated. Finally, a fee schedule based on a resource-cost
RVS might result in major redistributions of Medicare payments.

Fee schedules could be negotiated with representatives of the medical
community through a bargaining process. For example, a group repre-
senting a majority of physicians in a state could negotiate with Health
Care Financing Administration (HCFA) representatives for a fee sched-
ule for that state, subject to the constraint that it not result in spending in
excess of what would have occurred under CPR.

Alternatively, these approaches could be combined to create a fee schedule. For example, a fee schedule could be based on average approved charges and use a resource cost-based schedule to adjust payment for procedures which are substantially overpriced. Representatives from the medical profession could also provide advice about making such adjustments.

Having determined a method for establishing fee schedules, the issue of rate differentials remains. Should there be a uniform national fee schedule or should interstate and/or intrastate geographic reimbursement differentials be permitted? Should reimbursement differentials between generalists and specialists and/or among different types of specialists be permitted? If so, what criteria should be used to determine whether an individual doctor is a specialist—board-certification, board-eligibility, or self-designation? Other questions include: Should the same procedure be reimbursed differently depending on the setting in which treatment is rendered? What criteria should be used to define the “same” procedure and to determine when a procedure can be performed equally well in two different settings? For example, is an inpatient hospital visit the same procedure as an office visit? Also, should cognitive procedures or preventive services be explicitly encouraged through adjustments to the fee schedule? If so, how?

A fee schedule also requires that the unit of service be defined for reimbursement purposes. With the adoption of the HCFA Common Procedure Coding System (HCPCS), the Medicare carriers will be using a uniform procedure terminology and coding system comprised of about 10,000 codes (7,500 codes for physician services and 2,500 for nonphysician services). The transformation of a procedure terminology and coding system designed for medical reporting purposes into a system for reimbursement purposes involves two major issues—how to collapse procedure codes and how to package services.

Given that an estimated 500 codes account for more than 90 percent of expenditures, for how many codes should fees be established? Under what circumstances can procedure codes be collapsed for reimbursement purposes? For example, should three different codes for prostatectomy or draining a joint be paid the same amount or should separate fees be established for each code?

What services should be bundled in the fee for a specific procedure? For example, what services should be included in the package price for surgery? Likewise, what services should the payment for a medical visit include (for example, laboratory and diagnostic tests, specimen and handling fees, interpretation)? Under what circumstances would “out-of-package” services be separately reimbursable? All these issues have implications for the distribution of Medicare physician expenditures and could
have substantial impact on physician participation and beneficiary access.

2. Participation. In addition to the current participation options under Medicare, several alternative physician participation arrangements are possible. Under all-or-nothing assignment, nonparticipating physicians would no longer be able to accept assignment on any claim (except for those from joint Medicaid/Medicare eligibles). Beneficiaries receiving services from nonparticipating physicians would still be entitled to receive reimbursement from the Medicare carriers, but would be liable for the physician’s extra billing.

Under mandatory assignment, neither the physician nor the beneficiary would be eligible for Medicare reimbursement for services provided by a nonparticipating physician. In other words, services provided by nonparticipating physicians would not be covered. A less encompassing version of mandatory assignment could apply only to large bills (where beneficiaries most need financial protection) or to inpatient services. Alternatively, it could be applied to those cases in which the beneficiary has no opportunity to select a physician, or to choose a physician willing to accept assignment, (for example, assistants-at-surgery, consultants, or anesthesiologists selected by the attending physician, or pathologists or radiologists providing services to hospital inpatients, or emergency room physicians providing critical care).

Incentives for physicians to participate, in addition to those currently in effect, could include expanded informational activities, billing and paperwork simplifications, and benefit package changes to encourage the use of participating physicians. For example, Medicare coinsurance could be increased to 25 percent for services rendered by nonparticipating physicians and reduced to 10 percent for services furnished by participating physicians.

3. Utilization/expenditures. Aggregate spending is a key issue in a fee schedule approach because of the potential to unbundle services and because changes from present reimbursement rates could give physicians incentives to circumvent fee limitations or reductions by increasing the number, range, or complexity of services they provide. Utilization could be linked to aggregate spending in a manner similar to that employed in West Germany and Quebec: if utilization increased beyond the budget, the increase in the fee schedule could be reduced in the ensuing year.

In summary, since for the majority of services Medicare already has a fee schedule in place, the issue is whether a different fee schedule is desired. A revised fee schedule approach would deal with three related elements—the fee schedule itself, participation, and utilization/expenditures. How quickly these components might be adopted needs to be considered. A phase-in would ease the transition to the new system but make administration more difficult and add to confusion during the transition. A phase-in issue is whether to include a “hold-harmless” or “no-rollback”
provision for individual physicians.

Inpatient physician DRGs. An inpatient physician DRG system would set prospective payments for the package of physicians’ services associated with each of the 467 hospital DRGs. These amounts might vary across the eighteen geographic regions and urban and rural categories currently used under the hospital prospective payment system. However, since hospital resource use may not necessarily be a good proxy for physician resources associated with a given case, and because the existing DRG system does not adjust for severity of illness, it could result in significant payment inequities if applied to inpatient physicians’ services.\(^{15}\)

The purpose of an inpatient physician DRG system would be to give the physician (or the physician group) incentives to practice efficiently and to eliminate marginal procedures. If physicians could not bill for amounts in excess of the package price, they would be at risk for the costs of the services provided to treat a case and, therefore, would have direct financial incentives to coordinate the physician resources used within the patient stay. Some believe that aligning reimbursement incentives for physicians and hospitals would lead to efficiencies in the provision of services. However, others posit that this might adversely affect the quality of care because the physician’s role as the patient’s advocate for the provision of services may be jeopardized since both the physician and the hospital face strong financial incentives to limit services.

Inpatient physician DRGs could make Medicare spending for inpatient physicians’ services more predictable, and provide a way to achieve savings by limiting the rate of increase in package prices. However, the system might be circumvented and potential savings offset to the extent that admissions are induced or split, services are unbundled from the package price, costs are transferred to outpatient settings, and/or interns and residents are substituted for physicians. Moreover, beneficiary access to care could suffer if physicians change their practice patterns in response to the economic incentives inherent in the DRG system, that is, to treat patients in lucrative DRGs, or the less severe cases within a DRG.

By covering only inpatient services, physician DRGs leave unconstrained the 36 percent of Medicare spending for physicians’ services rendered outside the inpatient setting. However, extending physician DRGs to cover outpatient services may not be feasible for two reasons. First, since they are highly variable in duration and frequently involve multiple conditions, it is difficult to define unique ambulatory episodes. Second, it is difficult to determine which services to include in the package and which are separately reimbursable as “out-of-package” care.\(^{16}\) The design of an inpatient physician DRG system would need to address payment, physician participation, and utilization.

1. **Payment.** Three issues which concern payment in an inpatient physician DRG system are: who to pay, what services to include in the package,
and how to set package rates. Several alternatives for each issue are discussed below.

Since the inpatient physician DRG system provides a single payment for the services of all physicians associated with a case, a determination would need to be made about who should receive the case payment. This issue is related to who has legal responsibility for the case. Among the possibilities, payment could be made to the hospital, the attending physicians, or the hospital medical staff. Paying the hospital for the package of physician services would give the hospital powerful incentives to use efficient physicians and control utilization of services. This would effectively make physicians employees of the hospital. Physicians are unlikely to accept the vastly increased control hospitals would exercise over their practice of medicine.  

Alternatively, payment could be made to the attending physician who would assume responsibility for the case, obtain services from other physicians as needed, pay those physicians, and bear the financial risk for the costs of the case. This arrangement would impose administrative functions on individual physicians as well as expose them to risks of treating more severe cases. Since reimbursement is designed to cover resource use on average over a large number of cases, an individual physician who does not handle a large volume of cases within the same DRG could be exposed to more risk than he can bear.

Finally, the case payment could be made to the medical staff of the hospital which would be responsible for the care of the patient. This arrangement would put the hospital medical staff at collective risk for utilization of services in treatment of a case. This approach would require that medical staffs become more organized than they are presently and assume the necessary administrative functions and legal responsibilities. Payment to the medical staff would increase the risk pool and reduce the financial impact of cases that are more severe than average.

The second payment issue concerns which services to include in the package price and which would be separately reimbursable. Packaging of services will be successful in controlling costs only to the extent that fragmentation and unbundling of services are prevented.

Some services related to a hospital stay are performed before admission or after discharge. In order to encompass all the resources associated with the stay, these services might be included in the package price. The basic issues here include: Which pre- and post-operative care and pre- and post-hospitalization services should be included in the package? Under what circumstances, if any, should a separate fee be permitted for care rendered during the surgical aftercare period (for example, for illnesses unrelated to the DRG)? Should the fee be increased for complicated or more severe cases and reduced for simple cases? Under what circumstances, if any, should the fee for the package of services be reduced if the
full range of expected services is not provided (for instance, the patient dies)?

The third payment issue concerns how to set package rates. Historical allowable charges could be used or relative price patterns could be modified. Similarly, rates could be based either on existing physician practice patterns or on norms. Basing package prices on historical charge patterns would perpetuate the relative price patterns in the existing system. However, to create package prices that differ from those based on historical charge patterns might require use of an existing RVS or development of a new one. Resulting readjustments could significantly affect physicians’ incomes, their financial risk, and their ability to deliver all the care needed to treat a case.

Likewise, basing the package on historical practice patterns would maintain payments for inappropriate utilization in the existing system. Since these utilization patterns vary widely, basing packages on average patterns could have odd results. For example, in certain states, assistants-at-surgery are used in almost all cataract extractions, while in other states they are rarely used. Setting the package rate based on average utilization would result in payment for a fraction of an assistant-at-surgery. This would not reflect the pattern of practice in either state, nor would it necessarily represent an efficient method of practice. Such variations in practice style and, therefore, in cost were built into the hospital prospective payment system (PPS). Basing the package on normative standards of appropriate care—if they could be defined—might avoid the problems inherent in averaging current utilization patterns. However, such an approach has no precedent.

2. Participation. An inpatient physician DRG system could be structured either to allow or not allow physicians to bill patients for amounts in excess of the package price (except for cost-sharing). If assignment were made mandatory (that is, no extra billing permitted), physicians would have incentives to provide services efficiently and beneficiaries would have strong financial protection. This approach would parallel the mandatory assignment policy for hospitals under PPS. However, hospitals have always been prohibited from extra billing beneficiaries while physicians have always had that option. Mandatory assignment could result in a decrease in physician willingness to provide services to Medicare patients.

Allowing physicians to bill for amounts in addition to the package price would limit the federal liability for the bundle of services included in a package. However, this approach would not be consistent with the goal of making physicians financially responsible for all the services involved with a case and would expose beneficiaries to substantial financial liability. The payment system would be akin to an indemnity schedule for the bundle of physician services associated with the DRG.

3. Utilization. As with hospital PPS, the potential exists for the un-
bundling of services from a package, admission splitting, DRG creep, and the substitution of interns and residents for physicians. Each of these practices could reduce or conceivably offset the potential of physician DRGs to control Medicare expenditures. More rigorous utilization review might be required.

In sum, an inpatient physician DRG system requires policy decisions on payment, physician participation, and utilization. How quickly such a system should be implemented must also be decided; a phase-in period would ease transition to the new system, but would complicate administration. If a comprehensive inpatient physician DRG approach were determined to be infeasible and/or undesirable, two other forms of physician DRGs could be considered. Inpatient physician DRGs could be designed for certain types of cases, such as surgical ones, for which there is a history of paying global fees. Similarly, they could apply only to the services of selected specialists such as radiologists, pathologists, and anesthesiologists, and possibly, consultants and assistants-at-surgery.

**Geographic capitation.** Capitation refers to a per capita fee, or an all-inclusive prospective payment for all of the services provided to a beneficiary over a fixed period of time, regardless of the services actually provided. Capitation differs from a fee schedule which lists the payment allowable for each procedure, and from a physician DRG system which provides a prospectively set payment designed to cover the bundle of services associated with an inpatient stay, regardless of the services actually provided during that stay.

Crucial to a capitation system is the decision regarding who to pay. To date, capitation payments have most often been made to organizations such as health maintenance organizations (HMO) or individual practice associations (IPA) which bear the risk for and provide all necessary services to a patient over a fixed period. Recent regulations could lead to a major expansion of HMOs and competitive medical plans (CMP) by encouraging them to enroll Medicare patients on a capitation basis. However, even if substantial numbers of Medicare beneficiaries enroll in these organized delivery systems, the issue of physician payment reform remains for the population not enrolled.

Putting the individual physician rather than a larger organization at risk poses formidable problems. Individual physicians may be less suited to bear risk since they face adverse selection and a relatively low volume of patients over which to spread risk. Moreover, they may not have the administrative capacity to make necessary financial arrangements with other physicians who treat a patient. A geographic capitation system would put an organization such as an insurer at risk for physicians’ services provided to all Medicare beneficiaries living in a geographic area, like a state or carrier service area. In effect, the federal government would buy the Medicare benefit package on behalf of all Medicare beneficiaries in
an area at a fixed price from a single underwriting entity. A residual Medicare program would need to be available in the event that no entity were willing to take the area on a capitation basis.

A geographic capitation model differs from an area wide HMO in that physicians remain in private practice and would generally be paid on a fee-for-service basis. The model is more like a carrier-wide IPA or CMP in which both enrolled and unenrolled beneficiaries are covered. A capitation system could be designed to cover physicians’ services only, all Part B benefits, or a combined Part A and Part B benefit package. An entity underwriting a combined Part A and Part B benefit package could structure incentives which would reward physicians with the savings resulting from reduced hospital admissions.

Giving a single entity a “Medicare franchise” for an entire geographic area would give substantial market power to that entity, and if the entity were an insurer, the market power could have a “spillover effect” on the insurer’s private business. However, it is precisely that market leverage that could encourage competition both among organizations for a contract as an entity, and among providers for arrangements with entities. Allowing beneficiaries to continue to enroll in HMOs and CMPs in the same area would promote additional competition.

Implementation of a geographic capitation system would allow Medicare to determine prospectively its program outlays for a geographic area, and would cap federal financial liability. Unlike physician DRGs and fee schedules, capitation transfers from the federal government to the entity decisions regarding how much to pay for individual physicians’ services, how to define the unit of payment, how to bundle services, and under what circumstances services can be separately billed. Unless a uniform model were implemented in all states, one result of this approach could be the replacement of the national Medicare program with as many as fifty separate programs that could evolve very differently over time.

The incentive inherent in any capitation system is to reduce utilization to keep spending within the budget. Geographic capitation would redefine the federal role to one of awarding contracts, monitoring access to and quality of care, and evaluating performance of entities. The federal government would have to guarantee beneficiaries access to care and ensure that necessary covered services are not denied. Monitoring activities would need to be pursued aggressively to demonstrate that this approach does not represent an abdication of federal responsibility for the Medicare program.

Geographic capitation could be structured in a variety of ways. First, an at-risk entity could structure a preferred provider organization (PPO). To assure beneficiary access to care at predictable levels of out-of-pocket costs, Medicare could require, as a condition of eligibility for a contract, that an entity secure participation agreements from, for example, 35 per-
cent of physicians in the area, with similar standards for subareas and specialties. Nonparticipating physicians could continue to provide services as they do currently. Beneficiaries could choose participating or non-participating providers on a service-by-service basis. With the market power of the Medicare beneficiary population behind it, the entity might have the ability to structure the payment arrangement, discounts, and utilization controls necessary to establish a participating physician network and stay within its budget. However, unless the Medicare benefit package and cost-sharing were also redesigned to encourage beneficiaries to use the participating physician network, utilization controls in addition to those which currently exist might be needed for entities to keep their spending within the budget. Entities might offer beneficiaries the opportunity to purchase supplemental insurance policies to cover cost-sharing.

A different approach would require that the entity offer Medicare beneficiaries a choice of options, as employers often do for their employees. One of the options offered to beneficiaries would be traditional Medicare, that is, the Medicare program as it currently exists—including HMO and CMP options—without any changes in payment mechanisms or utilization controls. The entity would have to structure additional options attractive to Medicare beneficiaries (such as PPOs and managed care systems) which could cover cost-sharing liabilities and provide access to the entity's participating physician network, as well as incorporate utilization controls. Beneficiaries could enroll in these options by paying a supplemental premium. This approach would preserve Medicare "as is" for beneficiaries who choose not to enroll in any of the options, and expand beneficiary options by providing them with opportunities to "buy" access to private-sector systems. The entity would be at risk for all services provided to beneficiaries whether or not they purchased one of the options. As in all situations in which multiple options are available to beneficiaries, unless the enrollment process is well-managed and the rules clearly specified, the program could be confusing to beneficiaries or subject to marketing abuses. This approach as well as the one described above could be criticized because both allow a private entity to initiate program modifications that the federal government itself could potentially implement at lower cost.

A variety of methods could be used to calculate capitation rates. The method used to pay at-risk HMOs and CMPs could be employed, that is, 95 percent or less of the average adjusted per capita cost. Alternatively, the capitation rate could be based on last year's spending increased by a physician market basket or projected growth in the GNP. The capitation rate could also be set by a competitive bid, with the marketplace determining the level needed to provide the Medicare benefit package. In any case, in exchange for assuming from the federal government the risk of exceeding the capitation amount, an entity able to deliver the Medicare benefit package below the capitation rate could be allowed to make a
profit within defined limits. Entities could be required to carry reinsurance or to participate in a national reinsurance pool to assure beneficiary protection in the event of insolvency.

In summary, a geographic capitation approach would allow the federal government to operate like a large employer purchasing private health insurance on behalf of its employees at a fixed price from an underwriting entity. Assuring beneficiary access to care, monitoring the quality of care, and measuring the performance of entities would become major federal activities. Since geographic capitation has not been demonstrated for Medicare, how quickly such a system could be implemented must be considered. The risk-sharing aspect might be phased in with the capitation amount serving initially as a target rather than a cap. The types of organizations that would be permitted to act as entities must also be clearly specified.

Conclusion

The inefficiencies in the existing Medicare physician payment and participation systems coupled with their impact on the federal budget deficit make changes in Medicare a top priority for the Reagan administration and Congress. Any changes will require difficult tradeoffs among access, cost, and quality. Whether decisionmakers choose to extend the freeze for another year or to initiate genuine reform will depend on the political and operational feasibility of alternative reform measures as well as the macroeconomic debate over tax increases, defense cuts, and domestic spending reductions.


3. This percentage and the figures in the next three paragraphs which refer to physicians’ services also include other medical services rendered and/or billed by physicians and nonphysician suppliers.

4. These data come from special runs of the Part B Bill Summary Record, a sample of all claims for 5 percent of Medicare beneficiaries.


6. Part B Bill Summary Record.

7. The reasonable charge is now called the “approved” charge. The Medicare customary, prevailing, and approved terminology is analogous to the usual, customary, and reasonable (UCR) charge terminology used by Blue Shield plans and other private insurers.

8. During the freeze, nonparticipating physicians are not permitted to increase their actual charges to Medicare patients above the levels that they charged during the April 1, 1984 to June 30, 1984 period. Increases in actual charges will not be recognized when customary and prevailing charge screens are updated on October 1, 1985. Moreover, increases in actual charges can subject nonparticipating physicians to civil money penalties or exclusion from Medicare for up to five years.


11. Part B Bill Summary Record.

12. However, when crossover claims are excluded, the resulting assignment rate is estimated to be 35 to 40 percent.

13. Part B Bill Summary Record.


15. Janet B. Mitchell et al., Creating DRG-Based Physician Reimbursement Schemes: A Conceptual and Empirical Analysis, Year 1 Report, HCFA Grant No. 18-P-98387/1-01 (October 1984).


17. Payment of both the hospital and physician packages could also be made to the physician who would be responsible for selecting and paying the hospital as well as all necessary physicians’ services. This approach would grant substantial power to the physician and measurably change current hospital-physician relationships.

18. Mitchell et al., Creating DRG-Based Physician Reimbursement Schemes.

19. Payment to the hospital’s medical staff would have some similarities to an HMO, in that the medical staff would receive the payment and might need to impose administrative and utilization controls on physicians.