More Changes In Medicare Physician Payment Fee-For-Service Will Remain A Feature Of Major Payment Reforms, Requiring
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ABSTRACT Many health policy analysts envision provider payment reforms currently under development as replacements for the traditional fee-for-service payment system. Reforms include per episode bundled payment and elements of capitation, such as global payments or accountable care organizations. But even if these approaches succeed and are widely adopted, the core method of payment to many physicians for the services they provide is likely to remain fee-for-service. It is therefore critical to address the current shortcomings in the Medicare physician fee schedule, because it will affect physician incentives and will continue to play an important role in determining the payment amounts under payment reform. This article reviews how the current payment system developed and is applied, and it highlights areas that require careful review and modification to ensure the success of broader payment reform.

For many policy analysts, the term provider payment reform means abandoning the fee-for-service approach, which pays clinicians for each service rendered, in favor of broader units of payment—such as global payment or episode bundles—which either cover the whole person regardless of the number of services provided to that person, or cover the whole episode of care for a specific condition. These reforms are intended to replace the incentives inherent in fee-for-service medicine.

Fee-for-service payment typically has meant that a provider, usually a physician, receives a set fee for a particular service—such as performing a physical exam or administering an inoculation—either directly from the patient or from an insurer or other payer. Fee-for-service thus generates payments driven by the volume of services produced.

In payment reform models such as accountable care organizations, fee-for-service broadly will be replaced by new incentives that will reward appropriate, quality care—for example, a capitated payment made by the payer to the accountable care organization. However, when it comes to how the accountable care organization will pay individual physicians and other practitioners, most of the proposed payment reforms will still have a substantial role for fee-for-service payment. To be sure, physicians’ payments will be calculated not only according to volume, but also according to measures of physicians’ quality and efficiency. Both measurement and distribution of payment will be done by the organizations, or systems, such as the accountable care organization within which the provider delivers care.

As a result, for many physicians, these broad payment reforms, such as accountable care organizations, are more accurately seen as enhancements to fee-for-service, rather than as replacements. What’s more, in cases where fee-for-service is fully supplanted by a bundled payment for an episode of care, the structure of fee-for-service payment and the historical experience of payment within the fee-for-service approach will remain the basis for determining the bundled
payment amount.

Thus, efforts to improve how “relative value scales”—measures of physician inputs by time and intensity of effort—correspond to the efficient costs of providing different services should not be seen as a distraction from reforms, but as integral to their success.

This article, therefore, focuses on Medicare physician payment as well as on the broader provider payment reforms being undertaken in Medicare, most of which have been authorized under the Affordable Care Act. It first reviews efforts of the Medicare program to shape the payments for different services and to address the issue of rising volume of services, all reflected in the Medicare physician fee schedule. It then discusses current shortcomings in the fee schedule and recent policy changes to address them, including provisions in the Affordable Care Act.

Because Medicare physician payment approaches are followed closely by private insurers and Medicaid programs, the implications of the analysis go well beyond Medicare. Finally, then, the article describes in more detail how reformed fee-for-service payment of physicians fits into broader provider payment reform.

Aligning Physician Payment With Relative Costs In Medicare

When Medicare was implemented in 1966, it followed the practices of many Blue Shield health insurance plans in the way physicians were paid. Medicare sought to reflect existing fee patterns in its policies, so charges by physicians for each service were screened for “reasonableness,” a determination that was based on data on prevailing charges in the locality.

In the 1980s federal policy makers grew concerned about the structure of payment rates based on the reasonable charge approach. They had particular worries about the financial viability of primary care practices and many practices in rural areas, where the uneven distribution of physicians threatened access to care. There also were concerns that high payment rates for some procedures, such as the implantation of pacemakers, were driving growth in the volume of services.

Congress laid the groundwork for reforming the fee-for-service approach in the Consolidated Omnibus Budget Reconciliation Act of 1985 with the creation of the Physician Payment Review Commission (which later became the Medicare Payment Advisory Commission, or MedPAC). The commission was charged with making recommendations to Congress about the structure of payment for physician services in Medicare. At the same time, economist William Hsiao and his colleagues at Harvard University began to publish the results of their work on measuring physician services. This pathbreaking research on replacing the “reasonable charge” method with “relative value” scales for different physician services was based not on patterns of actual charges but on estimates of relative resources required to deliver the services.

Hsiao and colleagues devised a new metric to establish the value of physician work by using measurements of time and intensity of effort spent on performing specific services. The Physician Payment Review Commission endorsed Hsiao and colleagues’ approach to valuing physician time and effort. It added other components to the calculus of relative value—specifically practice expense, malpractice expense, and geographic adjusters to reflect local input prices faced by medical practices. A conversion factor takes these relative payments and translates them into a schedule of dollar amounts.

The commission also sought to address the issue of increasing volume of physician services through a process that based annual increases in Medicare physician payment rates on how growth in spending per enrollee compared to a target rate. It also called for limits on what physicians could charge beneficiaries for services.

The Omnibus Budget Reconciliation Act of 1989 included all of these elements: the fee schedule; an attempt to limit growth in service volume by a mechanism called volume performance standards, which tied annual changes in the conversion factor to how increases in service volume compared to a target; and limits on what physicians could charge Medicare beneficiaries. The legislation had profound effects on relative payments for categories of service and by specialty, which now differed from the structure of relative rates that physicians received from other payers.

Data from MedPAC and the Centers for Medicare and Medicaid Services (CMS) suggest that from 1991—the year before implementation of the fee schedule—to 2002, Medicare payment rates to family physicians increased by 45 percent relative to payment rates for all physicians. Payment rates for primary care services, mostly office and hospital visits, increased by more than 40 percent relative to payment rates for all services.

A development that surprised many economists was the degree to which private payers used the Medicare fee schedule’s relative value scale in negotiations with physicians over payment rates for in-network care. After all, Medicare’s relative values for different services under the fee schedule now diverged substantially...
from the existing pattern in “the market.”

Site-visit interviews conducted by the Center for Studying Health System Change over many years indicate that fee schedules in which payment amounts are expressed as “a percentage of Medicare” have been the norm for some time. Nevertheless, although a uniform percentage of Medicare is paid to small practices, which can either accept or decline the insurer’s offer, larger practices can negotiate higher percentages with insurers. With physicians in some specialties more likely to be in practices with negotiating clout, effective payment structures in private insurance do diverge from Medicare structures.9

Addressing Volume Trends

As part of the 1997 Balanced Budget Act, volume performance standards were replaced with a similar, but more stringent, mechanism to control rising costs—the sustainable growth rate formula—to reduce projected Medicare spending. The new formula was administered through the annual rule-making process until 2003, when congressional intervention started the pattern of numerous last-minute temporary “fixes,” which has been well covered in blogs and issue briefs in Health Affairs.10

In sum, every time a substantial reduction in fees is called for by the formula, Congress intervenes to defer most or all of the rate reduction. For policy makers, the key takeaway here is that a mandate lacking a mechanism for actually achieving the mandate’s goals will not be enforced. Slowing the rate of increase in spending requires changing the incentives of individual physicians or provider organizations that include physicians.

Problems With Current Medicare Fee-For Service Payment

Despite the large shifts in revenue by service type and by specialty documented through 2002, many analysts perceive that today’s Medicare relative value scale is highly distorted and no longer reflects relative costs.11 Today’s levels of reimbursement for primary care are perceived by many analysts as low and as evidence that the 1989 reform has failed, at least since 2002. But my perspective is that a combination of a flawed update process and shortcomings in implementing the element of practice expense in relative values scales has led to a gradual undoing of the intended changes in the structure of payment.

Much of the criticism of the update process has focused on the Relative Value Update Committee, established in 1991 to advise CMS on how to define physician work relative values.12 The committee is managed by the American Medical Association and composed of members representing specialty societies. The effort to include numerous specialties in the process has led to a very small presence of primary care physicians on the committee.

This structure and composition of the Relative Value Update Committee makes it very difficult to lower the assigned values for specific services, even when improved efficiencies might dictate such adjustments. Physician specialty societies cannot be expected to identify services their members perform for proposed reductions in relative values, and they can be counted on to resist such attempts by others.

For example, in 2002 the committee reviewed 807 codes and raised work values for 469 services, lowering the values for 27 services.13 Compared to procedures that involve new technologies, procedures that include evaluation and management services—such as taking a patient’s medical history, conducting a physical examination, and developing plans for therapy—are less likely to have substantial productivity increases per unit of physician time.

Thus, if the committee is spending most of its time valuing new procedures and little time revising the values of existing procedures, trends in productivity will lead to a gradual distortion of the relative value scale. This process will favor recently developed procedures at the expense of primary care services and long-established surgical procedures, such as appendectomies.

At the same time, updates of relative values for services involving new technology are also inadequate. Declining prices for medical equipment and supplies that are specific to particular procedures are not captured in a timely manner. Indeed, problems with the practice expense segment of the relative value scale also include the assumption of low rates of equipment usage.14

The assumption, in my analysis, reflected the attitude that providing services for Medicare is an entitlement (therefore, the price must be high enough for many practices to be able to provide services) as opposed to an attitude of prudent purchasing (which would involve setting a lower price so that beneficiaries would go only to efficient, high-volume facilities).

The poor quality of data used in the update process also leads to problems. To be consistent with the study by Hsiao and colleagues,5 which was based on large surveys of representative samples of physicians asking them to compare the relative time and intensity of performing different procedures, the Relative Value Update Committee has used survey methodologies. But the surveys tend to be conducted by specialty societies using inconsistent methods and small
samples that may not be representative. The time estimates incorporated in the relative value scale are often at odds with objectively measured times, such as from operating room logs.15

These issues have received increasing attention in recent years, and some important changes have been made. During the five-year review of codes conducted in 2007, the Relative Value Update Committee recommended an increase in the relative value of evaluation and management services, on the basis that delivering these services to an aging Medicare population now requires more time than it used to—a change accepted by CMS.16

For the 2010 relative value scale, CMS replaced a patchwork of surveys on practice expense conducted by some specialty societies with a national survey conducted by the American Medical Association.17 And CMS and the committee have devoted more effort to reviewing existing codes that might be overvalued, with CMS recently indicating that it is using objective data, such as operating room logs, to address some existing codes.18

The deterioration in the accuracy of the relative value scale has received extensive attention in Congress. Some steps toward a solution, beginning in the mid-2000s, have addressed practice expense relative values. For example, the Deficit Reduction Act of 2005 reduced payment for the technical component of some imaging procedures. In particular, the act reduced the payment for taking the image, rather than the one for interpreting it, when multiple images are taken at the same session. It also capped the payment for imaging services according to rates paid by Medicare in the area under the prospective payment system used for hospital outpatient services. A study by the Government Accountability Office documented very large savings from the latter change.19

In sections 3102 and 3134, the Affordable Care Act included an extensive agenda of refinements to the Medicare physician fee schedule for CMS to implement. These refinements include directives about targeting resources to revise the relative values for services whose volumes are rapidly increasing; services first valued three years earlier; services with a substantial increase in practice expense; multiple codes often billed in conjunction with furnishing a single service; services with low values, especially those billed multiple times during a single treatment; and services not reviewed since the implementation of the fee schedule. In section 3135, the act also specified the utilization assumption for expensive equipment (75 percent), which is higher than the 50 percent that had been established by regulation.

What is striking about these changes is that they reflect well the concerns expressed over many years by policy analysts about the shortcomings of the current relative value scale, many of them brought to the attention of Congress by MedPAC. Most, if not all, of these concerns could have been addressed by CMS under its longstanding authority. Presumably the congressional directives on these specific issues will raise the priority of the effort within CMS and embolden the agency to pursue the revisions more aggressively than it would have otherwise. But the speed and magnitude of changes in the fee-for-service payment structure that will be achieved remain uncertain.

Notwithstanding all of these reforms to increase the accuracy of relative values in the Medicare physician fee schedule, the Affordable Care Act included one change, in section 5501, that was clearly outside of the structure of the fee schedule. This change was a 10 percent bonus—effective in 2011–15—for primary care services (mostly visits) provided by primary care providers and for major surgical procedures provided by general surgeons, when delivered in federally designated health professional shortage areas.

The change reflected the use of additional federal resources for these services rather than a budget-neutral shift from payment for other services. One could characterize the inclusion of this section as an expression of Congress’s lack of confidence in the speed with which the changes discussed above would increase payment for primary care, especially given the concerns about the financial viability of and the expanded role for primary care envisioned in broader payment reforms.

Additional Changes Needed
The Affordable Care Act’s agenda for reform of the Medicare physician fee schedule is a strong one. However, some additional areas need work.

For example, procedures need to be developed to capture quickly any reductions in physician work and practice expense that occur as new technology evolves. One way to accomplish this may be by establishing a schedule of reductions in advance, subject to modification later if evidence shows that the reductions have been too large or too small.

CMS should be developing additional ways to bring more objective data into the process. More credible data could be obtained by the agency if it established relationships with selected large multispecialty medical groups. CMS could offer a stipend to practices for regular reports of cost accounting data for selected high-volume procedures. Even if the large groups had higher or
lower costs overall than other practices, the relative costs for different services could nonetheless be representative.

Additional issues are likely to arise around changes in the way physician care is delivered. The American Academy of Family Physicians has made the case that evaluation and management services provided by primary care physicians today are substantially different from services billed under the same codes by specialists and should receive distinct codes and relative values.20

**BROAD PROVIDER PAYMENT REFORM** Fee-for-service payment of physicians will be an important component of virtually all of the provider payment reforms being discussed today. For instance, in section 3007 the Affordable Care Act created one specific type of payment reform, a “value-based modifier” under the Medicare physician fee schedule. On a budget-neutral basis, the modifier will increase or decrease payment rates to each physician on the basis of CMS’s assessment of value, which will be based on various indicators of quality and of efficiency (costs).

CMS guidance issued in late 2011 in conjunction with publication of the 2012 Medicare physician fee schedule suggests that the measures of costs to be used during the early years of the program will also include total per capita costs for the following four chronic conditions: chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes.21 Costs for selected episodes of care might be used in the future, pending the development and testing of an episode grouper by CMS. (An episode grouper is a type of software that separates services received by a beneficiary that are related to an episode from services that are not.)

These cost measures would reflect not only spending by any specific physician, but also spending related to the episode from other providers. The measures will be dependent on methods that assign or attribute beneficiaries to specific physicians, methods now under development at CMS.

The upshot is that the strategies underlying accountable care organizations and episode bundles, which are being piloted as voluntary programs, will become a mandatory part of fee-for-service physician payment in Medicare (with a parallel program for hospitals called “value-based purchasing”).22 The risk borne by physicians will initially be very limited, but that may change later on through larger bonuses from a budget-neutral pool.

**PHYSICIAN PAYMENT IN ACCOUNTABLE CARE ORGANIZATIONS** Accountable care organizations are based on fee-for-service payment of physicians as noted above, but the potential rewards and penalties can be greater than under just the value-based modifier. In accountable care organizations, straightforward fee-for-service payment will continue, but physicians will become more accountable for the quality of care and costs of beneficiaries attributed to them.

Accountable care organizations must include primary care physicians. Indeed, the relationship between Medicare beneficiaries and their primary care providers is the basis of attribution—or assigning—beneficiaries to these organizations. The organizations can be selective about which primary care physicians to include and are likely to provide incentives or bonuses for the physicians that the organizations believe provide high-value care.

Accountable care organizations can also decide whether or not to include physicians in various specialties. They are likely to include specialties most integral to care coordination, such as cardiologists and endocrinologists. Other specialties in which coordination with primary care or other specialties is less important—such as dermatology or ophthalmology—may be less sought after by these organizations. But the organizations will nonetheless influence these specialties because physicians in the organizations will have incentives to refer patients to external specialists who are perceived to provide high value.

Thus, fee-for-service payment for physician services will continue in accountable care organizations. But assessments of value will influence invitations to join these organizations, bonuses or penalties for these physicians, and referrals to specialist physicians outside of the organizations.

Payment for episodes that include an inpatient admission will also retain large elements of fee-for-service payment of physicians. Note that for surgeries, physicians have long been paid a global fee that includes preoperative and postoperative care. What is different in pilots for episode payment is the broadening of incentives to include services by other providers involved in the episode, including other physicians, such as anesthesiologists and hospitalists, and facilities, such as imaging centers, hospitals, and rehabilitation facilities.

The risk sharing might come in the form of bonuses or penalties to the physician’s fee-for-service payment. This arrangement will provide surgeons with incentives to economize on services by other physicians and perhaps even direct patients toward higher-value facilities for post-acute care. Hospitals and physicians will have incentives to team up with more-efficient providers. For example, surgeons can ultimately
be more successful under episode payment by teaming up with higher-value hospitals.

**PATIENT-CENTERED MEDICAL HOMES** The type of provider payment reform most likely to depart from fee-for-service payment of physicians is the patient-centered medical home. Some private-sector pilot programs retain fee-for-service payment and simply offer higher rates for physicians practicing in medical homes that have received “recognition” or certification. However, the more promising model adds to fee-for-service a monthly payment to cover specific services not currently paid for by Medicare (and by many other insurers), such as telephone calls and e-mail, care coordination, and patient education and counseling.

The point of bundling these services is that the costs for billing, documentation, and auditing of such services is potentially very high, and resources would be better spent monitoring the overall effectiveness of the medical home. Another advantage of the use of an additional monthly payment is that it frees the physician (or advanced practice nurse) to delegate tasks to others. Not only might others be able to provide these services more effectively and at lower costs, but such delegation can also effectively expand the primary care provider supply and mitigate some of the projected shortage.

Even with a reform that departs from fee-for-service payment, such as the patient-centered medical home, the physician fee schedule will be critical in calibrating the additional payments. To prepare for Medicare pilots of medical homes, CMS asked the Relative Value Update Committee to propose a valuation of the services to be covered by the monthly payments. This calculation involved estimates of the frequencies with which the services covered by the additional payment will be performed and valuations of these services in reference to those that are paid on a fee-for-service basis.

Fee-for-service payment of physicians will be an integral part of virtually all of the provider payment reforms envisioned at this time. The implication is that the extensive work by CMS needed to better update and refine fee-for-service payment will not be superfluous or a sign that it is giving too little priority to broader reforms. Indeed, putting the Medicare physician fee schedule on a firmer foundation will be essential to the success of broader payment reform to improve quality and efficiency of care delivery. Policymakers would be wise to ensure that shoring up the foundation of fee-for-service payment to physicians receives adequate resources.

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**NOTES**

11. These issues have been discussed for many years in MedPAC reports to Congress. For example, see Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC): MedPAC; 2008 Mar.
16. Centers for Medicare and Medicaid Services. Medicare program; revisions to payment policies, five-year review of work relative value units, changes to the practice expense methodology under the physician fee schedule, and other changes to pay-
18 Centers for Medicare and Medicaid Services. Revisions to payment policies under the physician fee schedule and other revisions to Medicare Part B for CY 2013 (including DME face-to-face and non-random pre-payment review): proposed rules. Fed Regist. 2012;77(146):

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In this month’s Health Affairs, Paul Ginsburg notes that many payment reform experiments now under way in Medicare, including some forms of accountable care organizations, will still preserve fee-for-service payment to physicians. As a result, he observes, it will still be necessary to modify fee-for-service payment in areas such as correcting distortions in the relative value scale. Ginsburg recommends a number of steps that should be taken to make fee-for-service payment more workable as long as it persists.

Ginsburg is president of the Center for Studying Health System Change (HSC), an organization funded by the Robert Wood Johnson Foundation that advises policy makers on the human impact of local and national changes in health care delivery and finance. He is a nationally recognized scholar in health economics and health policy. His research interests include cost trends, consumer-driven care, provider payment, and the future of employer-based health insurance and competition in health care.

Before founding HSC, Ginsburg was the founding executive director of the Physician Payment Review Commission, precursor to the Medicare Payment Advisory Commission. During his tenure from 1986 to 1995, the commission developed the Medicare physician payment reform proposal that was enacted by Congress in 1989. Ginsburg was also a senior economist at the RAND Corporation and served as deputy assistant director of the Congressional Budget Office.

Ginsburg previously served on the faculties of economics and community medicine at Michigan State University and on the faculty of public policy studies at Duke University. He is a member of the Health Affairs editorial board and has written numerous Health Affairs articles. He earned a doctoral degree in economics from Harvard University.