Cite this article as:
G J Schieber and J C Langenbrunner
Physician payment research efforts at HCFA
Health Affairs 8, no.1 (1989):214-218
doi: 10.1377/hlthaff.8.1.214

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/8/1/214.citation

For Reprints, Links & Permissions:
http://content.healthaffairs.org/1340_reprints.php

Email Alertings:
http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe:
https://fulfillment.healthaffairs.org

Not for commercial use or unauthorized distribution
Physician Payment Research Efforts At HCFA
by George J. Schieber and John C. Langenbrunner

The Office of Research and Demonstrations (ORD), of the Health Care Financing Administration (HCFA) in the U.S. Department of Health and Human Services, conducts intramural research projects and funds extramural research and demonstrations relating to the Medicare and Medicaid programs. These studies and projects—numbering over 300 at any one time—are designed to develop, refine, and evaluate policy relating to the financing and efficient delivery of care under the Medicare and Medicaid programs. ORD sponsors research and demonstration projects in the areas of physician payment system reform/refinement, quality and effectiveness of care, the new catastrophic benefit program, alternative payment systems, hospital payment refinement, prevention and coverage policies, long-term care, and related health policy research issues, such as acquired immunodeficiency syndrome (AIDS).

ORD recently has increased its emphasis on physician payment issues. Over the past ten years, Medicare expenditures for physician services have increased at average annual rates of 15 percent. By 1990, Medicare physician payments will exceed $30 billion per year. About half of this growth is due to increases in the volume and intensity of services.

Volume and intensity of physician services. As Part B spending for physician services has grown, a substantial part of that growth has been associated with increasing volume and intensity of services provided by physicians to Medicare beneficiaries. This study examines several issues related to this growth. It first describes models of physician behavior; models are related to incentives surrounding current payment policies that affect the volume and intensity of services.

Second, it identifies current methods—in the public and private sectors—for control-
ling the volume of physician services. As part of this study, a private insurance carrier survey through the Health Insurance Association of America (HIAA) was undertaken in 1988 to examine and assess the effectiveness of existing carrier utilization review controls. Third, it considers the possible effects of an RBRVS on the volume and intensity of services. The study is being performed by the HCFA research center at the University of Minnesota, in collaboration with the University of Pennsylvania. The final report is expected in early 1989.

1988-1989 survey of physician practice costs and incomes. Over the past decade, HCFA has periodically sponsored comprehensive national surveys of physician practice costs, work patterns, and incomes in the United States. These surveys have been designed to be nationally representative of nonfederal patient care practitioners. These surveys allow examination of current and past trends relating to income and work patterns. Information on specialty, hours and weeks worked, location, practice size, and incorporation status is routinely collected. Information for policy development, such as sources of payer revenue, equipment costs, and malpractice premiums, is also collected.

The next survey, being undertaken by the National Opinion Research Center, will interview 6,000 U.S. physicians on the cost of practice, productivity, malpractice insurance, volume and intensity of certain procedures provided, and out-of-pocket costs to beneficiaries. The survey results—expected in early 1990—will come from all nine census regions, will focus on sixteen individual specialties, and will be stratified by three types of geographic areas: large urban, small urban, and rural.

Impact of Medicare fee freeze and participation agreements on physicians. The Deficit Reduction Act of 1984 (P.L. 98-369) established a freeze on physician fees effective July 1, 1984; the freeze subsequently lasted for thirty months. This legislation also established the Medicare physician participation program. This project examines the impact of these policies and, specifically, their effects on physician behavior. Did, for example, physicians increase the volume of services provided, or the levels and mix of services during the period when their fees and payments under Medicare were fixed?

The fee freeze study will use 100 percent of Part B claims files from the states of Alabama, Connecticut, Washington, and Wisconsin for the calendar years 1983–1986. Econometric analyses of the participation program also will use data from the HCFA 1984–1985 Physician Practice Cost and Income survey. Special analyses of the impact of the hospital prospective payment system (PPS) on physicians, and analyses of physician payment policy refinements, will be conducted as well. Results are expected in early 1989.

Under cooperative agreement with the Center for Health Economics Research in Needham, Massachusetts, this research already has generated a number of final reports, among them: "What Should Medicare Pay for Surgical Procedures?," "To Sign or Not to Sign: Physician Participation in Medicare, 1984," and "Learning by Doing: Productivity Gains for Surgeons Performing Coronary Artery Bypass Grafts." Each of these reports is available through the National Technical Information Service, access numbers PB86-215605/AS, PB87-210463/AS, and PB88-239926/AS, respectively. (See also Janet B. Mitchell et al., "The Medicare Physician Fee Freeze: What Really Happened," in this issue of Health Affairs.)

A national study of resource-based relative value scales for physician services. For several years, discussion and debate concerning reform of physician payment policy has focused on relative value scales as one approach for reforming the Medicare payment system. Under cooperative agreement to Harvard University (William Hsiao, principal investigator) since September 1985, HCFA has been funding a study to develop a national relative value scale—based on actual resource use—for physician services. The study is divided into two phases. Phase I developed values for over 1,400 services and procedures, and a scale across eighteen different medical and surgical spe-
cialties. The relative values were based on measures of time and "intensity," together comprising a level of total physician work or effort before, during, and after the service was rendered. In addition, specialty-specific measures of practice costs and training costs were included. The study included a national survey of physicians, over twenty individual physician technical and consensus panels conducted in conjunction with the American Medical Association (AMA), and statistical and extrapolation techniques to create and extend the values across services and specialties.

Results of Phase I (released in fall 1988) indicate a large variation of resource requirements both within and across specialties. The study results also indicate a large variation of relative values to current Medicare charge pattern ratios.

Phase II is in the developmental stage; it will refine the study's methods and extend the study to an additional fourteen specialties. The final report from Phase I is available in five volumes from the National Technical Information Service, accession numbers PB89-101836/AS, PB89-10136/AS, PB89-1011844/AS, PB89-101851/AS, and PB89-101810/AS.

Development of interim geographic practice cost indices. Medicare physician payments are based on individual and collective physician charges in some 240 reimbursement localities. Payments are not adjusted for differences in cost of practice among these areas. This project is designed to develop indices reflecting geographic differences in practice costs. To date, a set of interim indices has been developed.

This work addressed the technical structure of a geographic practice cost index, the definition of geographic areas for which such an index would be computed, and the applicability of available data sources needed to construct such an index. Given the numerous policy and data choices underlying construction of such an index, several alternative interim indices have been developed.

The initial set of indices share certain design features: a Laspeyres input price index was used, and a number of price input measures were included, such as physicians' own time, employee wages, office rents, malpractice insurance, medical supplies, medical equipment, and miscellaneous other expenses. With these indices, the cost of a market basket of goods (in this case, inputs) was compared across areas.

These indices form the basis for further refinements currently in progress. A 20 percent national sample of professional income data is being included; previous indices used only a 1 percent national sample. The choice of geographic areas also will be examined, with a focus on both current area definitions (states and localities), and proposed definitions (for example, metropolitan statistical areas—aggregations of adjacent counties with close social and economic ties). The impact of various choices, particularly as they could affect urban/rural physician supply patterns, will be analyzed. Refinement work is being carried out in conjunction with other projects related to Medicare physician payment policies (for example, the RBRVS).

The project is under cooperative agreement to the Urban Institute (Washington, D.C.) and Health Economics Research, Inc. of Needham, Massachusetts; the final report is expected in early 1990. An interim report is available from the National Technical Information Service, accession number PB88-220678.

Geographic and temporal variations in Medicare physician expenditures. This project is addressing a broad range of physician payment issues. The centerpiece of this research is the construction of an extremely rich and historically unique data file that will serve the policy research community for several years on a wide choice of policy topics. The data file will include 1985-1988 merged Part A and B claims from ten statewide carriers that represent all nine census regions and 18 percent of Medicare beneficiaries.

Examples of issues to be analyzed using these files include: overpriced surgical and anesthesia fees, decomposition of Part B expenditures and growth into factors relating
UPDATE

217

to price and quantity, variation in patterns of assignment and participation, inpatient and outpatient practice patterns and substitutions over time, and incentives provided by Medicare's capitation payment policies. The file currently includes claims data for 1985-1987. Simulations of selected payment policies are being undertaken as well. The project is being performed by the Center for Health Economics Research in Needham, Massachusetts and is expected to continue through the summer of 1990.

Global fees. The Medicare fee for a surgical procedure that currently includes all normal and uncomplicated follow-up care is termed a global fee. This fee includes the attending surgeon's visits to the patient while in the hospital and may include follow-up visits after the patient is discharged. The enactment of the Medicare PPS has resulted in significant decreases in length-of-stay. This project will examine implications for changes in clinical and any accompanying billing practices and charge patterns since PPS. This research will identify changes in practice patterns and develop an understanding of the changes taking place in the number of services and visits provided.

The HCFA research center at The RAND Corporation/University of California, Los Angeles is performing the project. Initial findings and results in early 1989 could yield appropriate budgetary savings in connection with payment policies for surgical procedures.

Diagnostic tests: technical components. Diagnostic test use in the Medicare program is growing and is developing into an important factor in the overall rise of Part B outlays. This project will, first, begin to describe the types of equipment typically used by physicians in office settings and how equipment purchase and use varies by specialty and practice size. Then it will examine the extent to which diagnostic tests currently are being billed as technical components or as global components. It will assess the variations in Medicare payments for the technical component of high-volume diagnostic tests.

Using this information, the project will analyze alternative methodologic approaches and criteria to understand if and to what extent Medicare payments are equitable. In particular, the research will explore the feasibility of using information on rates of return for these diagnostic test types of equipment. Approaches will be compared to private-sector policies and payment levels.

The study is being performed by the HCFA research center at the University of Minnesota, in collaboration with the University of Pennsylvania. Results in early 1989 might be useful for identifying over-priced lab and physician office tests under current Medicare practice.

Physician PPO demonstration. PPOs are one organizational innovation developed in the private sector to control costs associated with physician services. HCFA recently has initiated a demonstration pilot of this innovation in the Medicare program at five sites: HealthLink, St. Louis, Missouri; CareMark, Portland, Oregon; Family Health Plan, Minneapolis, Minnesota; Capp Care, Fountain Valley, California; and Blue Cross/Blue Shield of Arizona, Phoenix.

The PPO is designed to provide and test managed health care on a fee-for-service basis. Local beneficiaries in each of these sites will be given the option to use the PPO physicians. Physician and beneficiary incentives will vary by sites; incentives to use PPO physicians may include reduced out-of-pocket costs. Physicians who participate in the demonstration generally will have a history of providing services and performing procedures only as necessary and appropriate. In addition, participating physicians will agree to a more intensive level of utilization review than their peers. Project utilization review will measure the patterns and rates of services they provide.

Mathematica Policy Research, Inc., is providing technical support in the demonstration's design and implementation. The demonstration is expected to continue for three years.

Participating heart bypass center demonstrations. Prominent medical centers have begun offering private payers flat fees
that cover all inpatient and physician costs for certain "big-ticket" procedures. Medicare intends to begin testing the feasibility and cost-effectiveness of such a concept for its beneficiaries through "participating heart bypass centers" for the provision of coronary artery bypass graft (CABG) procedures. The demonstration will assess potential benefits of a negotiated package pricing arrangement with hospitals and physician groups.

High-quality provider groups will be selected to manage and coordinate the complex set of services associated with a CABG procedure for a fixed, prospective, all-inclusive rate. Hospitals and physicians participating in the demonstration will receive a global payment covering hospital and related physician services for CABG surgery (DRGs 106 and 107). Participating providers will accept the negotiated global rate as payment in full. Cost efficiencies might be realized through coordination of services and increased volume, in turn allowing the centers to provide a discount to Medicare. Participating centers will market services to physicians and beneficiaries and offer incentives to attract patients. Quality assurance and prior authorization will be carefully monitored.

Four to six sites are expected to begin operating as participating centers in mid-1989. The basic model developed in this demonstration may be expanded in the future to other hospitals and adapted for application to other procedures and provider types.