

PHYSICIAN AND OTHER HEALTH PROFESSIONAL PAYMENT SYSTEM

payment**basics**

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Physician and other health professional services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the 1 million clinicians in Medicare's registry, approximately half are physicians who actively bill Medicare. The remainder includes health professionals such as nurse practitioners, physician assistants, and physical therapists. These health professionals may bill Medicare independently (accounting for about 12 percent of physician fee schedule spending) or provide services under physician supervision.

Physician services are billed to Part B. Payments for these services (about \$69 billion in 2013) account for about 16 percent of Medicare fee-for-service (FFS) spending. In 2013, almost all (98 percent) beneficiaries enrolled in Medicare FFS received at least one physician or other health professional service.

Medicare pays for physician and other health professional services based on a list of services and their payment rates, called the physician fee schedule. In determining payment rates for each service on the fee schedule, the Centers for Medicare & Medicaid Services (CMS) considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor (\$35.93 from July through December 2015), to arrive at the payment amount. Medicare's payment

rates may be adjusted based on provider characteristics, additional geographic designations, and other factors. Medicare pays the provider the final amount, less any applicable beneficiary coinsurance. In 2013, the number of distinct services that Medicare paid for under the fee schedule totaled 1.1 billion.

Under prior law, a formula called the sustainable growth rate (SGR) system established the yearly adjustments to the conversion factor, based on the volume growth in physician and other health professional services. However, since 2003 Congress had overridden all of the negative updates called for by the SGR. The Medicare Access and CHIP Reauthorization Act (MACRA), enacted April 16, 2015, permanently repealed the SGR system and established a set of statutory updates to the conversion factor.

Defining the services Medicare buys

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

Setting the payment rates

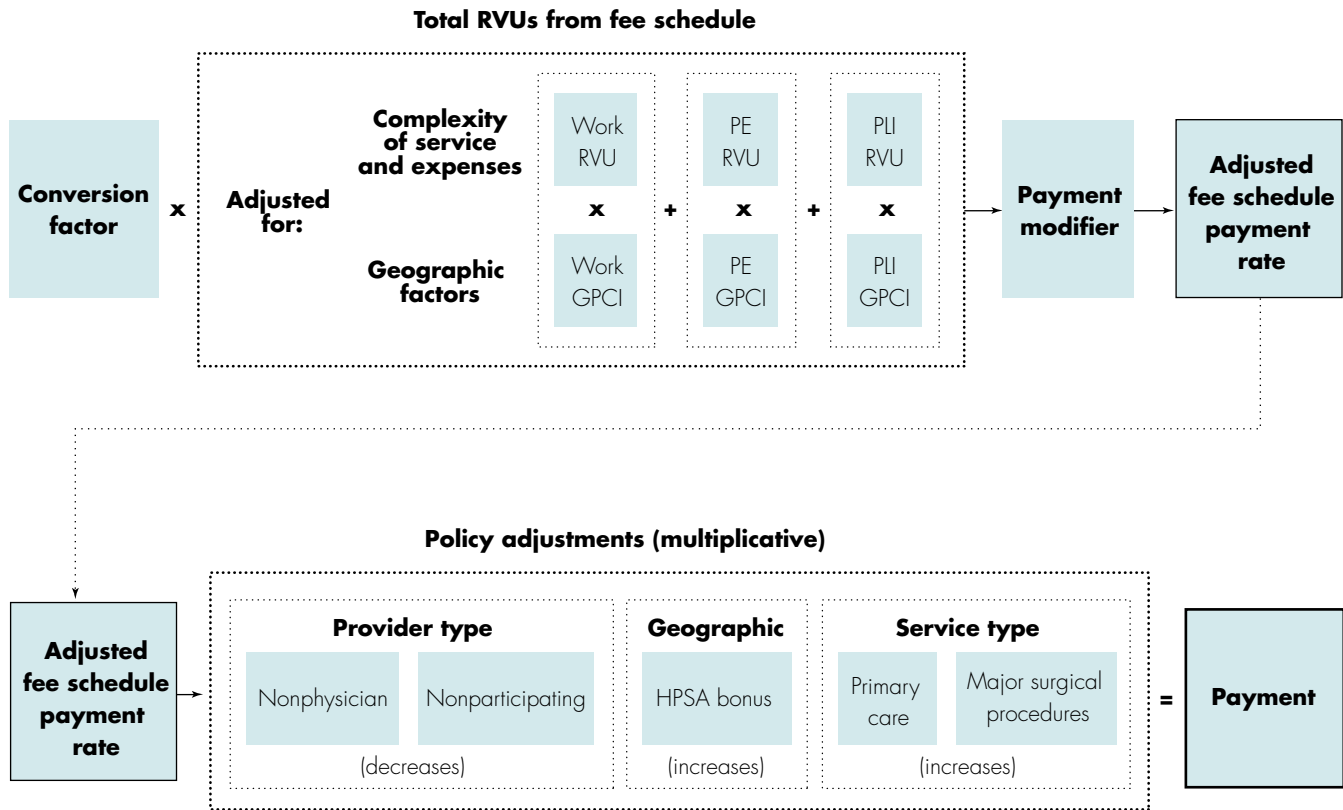
Under the fee schedule payment system, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide physician services: physician work,

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Figure 1 Physician and other health professional payment system



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare payments only. The fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are reduced when specified nonphysician practitioners bill Medicare separately, but not when services are provided "incident to" a physician.

practice expenses, and professional liability insurance (PLI). The RVUs for physician work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expense are based on the expenses physicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums physicians pay for professional liability insurance, also known as medical malpractice insurance.

In calculating payment rates, each of the three RVUs is adjusted to reflect the price level for related inputs in the local market where the service is furnished. Separate geographic practice cost indexes (GPCIs)

are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor (Figure 1). For most fee schedule services, Medicare pays the provider 80 percent of the fee schedule amount. The beneficiary is liable for the remaining 20 percent coinsurance.

Through payment modifiers, Medicare may adjust its payment for a service because of special circumstances. For example, physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the primary surgeon. Other modifiers apply to multiple surgical procedures performed

for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

Payments under the fee schedule also may be adjusted upward or downward to reflect other factors. The first potential downward adjustment occurs if services are furnished by certain nonphysician practitioners. For example, services billed separately and provided by advanced-practice nurses and physician assistants are paid at 85 percent of physicians' fees. When nonphysician practitioners perform services "incident to" or under direct physician supervision, they may not bill Medicare separately and Medicare pays for the fee schedule amount for the service as if the physician had personally furnished it.

Another instance in which Medicare can adjust fee schedule payments downward occurs when services are furnished by physicians who are not in Medicare's participating physician and supplier program. Payment rates for services provided by nonparticipating physicians are 95 percent of the fee schedule payment rate.

Physicians and other health professionals may receive increases for services they provide in underserved areas. Under the Medicare incentive payment program, physicians receive bonus payments when they provide services in health professional shortage areas (HPSAs). These payments are intended to attract more physicians to HPSAs. The bonus increases payments to these physicians by 10 percent (excluding beneficiary coinsurance).

The Patient Protection and Affordable Care Act (PPACA) established new incentive payments starting in 2011 for two types of services: primary care services and major surgical procedures. The primary

care incentive is a 10 percent increase in the payment for services defined in the law as primary care and furnished by an eligible practitioner. The incentive payment for major surgical procedures is also a 10 percent increase. It applies to qualifying services when furnished by an eligible surgeon and furnished in a HPSA. Both incentive payments—for primary care and for major surgical procedures—expire at the end of 2015.

Updating payments

While the statute requires a review of the relative values every five years, CMS, starting in 2012, is reviewing the fee schedule relative values annually. HCPCS codes and the conversion factor are updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group of physicians and other professionals sponsored by the American Medical Association and physician specialty societies.

The annual updates to the conversion factor are set in statute, as a result of the enactment of MACRA. All providers will receive a yearly update of 0.5 percent from 2016 through 2019. Starting in 2019, providers who have a specified share of revenue in a qualifying alternative payment model (APM) are eligible for additional payments of 5 percent per year through 2024. Providers who do not meet the APM criteria will receive no update in each year between 2020 and 2025 that they do not meet the criteria. In 2026 and thereafter, providers on the APM path will receive a yearly update of 0.75 percent, and other providers will receive an annual update of 0.25 percent. ■