Appendix C

Medicare and Medicaid Payment for Physicians' Services

Introduction

Third-party payment practices for physicians' services are complex and diverse, Third-party payers in the United States have traditionally paid a fee for each service* provided by physicians. Nonetheless, there are a variety of approaches in actual payment practices under fee-for-service among third-party payers, including public programs. Diversity is expected because fee-for-service is a generic term that includes multiple elements (e. g., payment basis, level determination, and payment updating schedule) that can be combined in numerous ways. Furthermore, public programs have broad policy discretion within Federal legislation, regulation, and guidelines in designing payments for physicians.

This appendix describes third-party payment for physicians' services in the public sector, focusing on the Medicare program. A general description of the Medicare program is followed by a summary of the origins of the fee-for-service method adopted by the program and a description of the current payment methods for physician services under Medicare. Although fee-for service by far is the most common method, the Medicare program has adapted it in numerous ways for special circumstances and has sometimes used other payment methods. This appendix also includes a section on physician payment under Medicaid, highlighting similarities to and differences from the Medicare program.

Medicare Payment for Physicians' Services

The 1965 legislation that established Medicare under Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act mandated eligibility for insurance benefits for most Americans 65 years and over.[2] On July 1, 1973, the Social Security Amendments of 1972 (Public Law 92-603) extended eligibility to persons under 65 who have been entitled for a period of 24 months to Social Security or Railroad Retirement benefits because they are disabled, and to most workers and their dependents with end-stage renal disease (ESRD).

Medicare covers hospital insurance benefits (Part A) and supplementary medical insurance benefits (Part B). Table C-l displays Medicare's current benefits and the financial responsibilities of the program and its beneficiaries under Parts A and B. Part A's primary purpose is to provide insurance against the costs of inpatient hospital care. Other benefits include payment for inpatient psychiatric services, skilled nursing facility services, home health services, hospice services, and comprehensive ambulatory rehabilitation facility services. Payment for most physician services is under Part B, which also includes payment for outpatient hospital services, ambulatory laboratory and X-ray services, ambulatory physical therapy and speech pathology services, and various other limited ambulatory services and supplies, such as prosthetic devices and durable medical equipment (see table C-l). part B also covers home health services for those Medicare beneficiaries who have Part B coverage only. The law excludes most preventive services and certain other services, such as dental and custodial care.

In order to pay for a new technology (service) that is not mandated or prohibited by law, a decision to cover the specific service, or technology, is required. (Coverage is distinguished from payment in that coverage refers to benefits available to eligible beneficiaries, and payment refers to the amount and methods of payment for covered services (585).) Impressive advances in the numbers and types of technologies available to the health care system in recent years has led to an increasing need for coverage decisions. Medicare decides whether or not to cover a service on the basis of Section 1862 of the Social Security Act, which prohibits payment for items and services that are "not reasonable and necessary for the diagnosis or treatment of illness and injury or to improve the functioning of a malformed body member. " The criteria Medicare uses to determine if a technology meets the broad statutory language of "reasonable and necessary" are: 1) general acceptance as safe and necessary, 2) not experimental, 3) medically necessary, and 4) provided according to standards of medical practice in an appropriate setting.[3]

I Throughout this appendix, the terms service and technology are used as synonyms.

'Although eligibility for Part A is tied to eligibility for Social Security, at the onset of the program, individuals who were age 65 and not ellgible for Social Security were given 3 years to establlsh eligibility (445)

[3]The OTA report Medical *Technology and Costs of the Medicare I'rogr~rn (486)* includes a comprehensive discussion of Medicare's coverage process

Table C-1.–Medicare Benefits and Limitations, as of January 1986

Kind of care	Medicare pays	Beneficial pays	Comments
Part A:			
Hospitalization	1-60 days 61-90 days 91-150 days (60 day lifetime reserve) After 150 days—no coverage	**Initial deductible ($492)** **Daily copayment ($123)** **Daily copayment ($246)**	**Deductible and copayments are adjusted annually** **Lifetime reserve can be used only once**
Psychiatric	Same as hospitalization	Same as hospitalization	Lifetime limitation of 190 days of coverage
Skilled nursing facility	1-20 days 21-100 days After 100 days—no coverage	Nothing Daily copayment ($61.50)	
Home health services	Unlimited visits Reasonable costs	Nothing	Beneficiary must be eligible for Part A
Hospice care	**Prospective payment rates,** per day to maximum of $6,500 average "cap" per beneficiary to each facility Routine home care: $53.17 Inpatient respite care: $55.33 General inpatient care: $271.00 Total continuous home care: $358.67	50/0 of cost to program for: —Drugs and biological (not to exceed $5 per prescription) —Inpatient respite a care (per day) (total not to exceed inpatient deductible)	Beneficiary may elect hospice care in lieu of other medical care services (with its attendant deductibles and copayments), for two periods of 90 days and one of 30 days, to be taken in that order, upon determination of a terminal illness. Benefit provision expires Sept. 30, 1986.
Part B:		SMI basic premium—$15.50/mo.	
Home health services	Unlimited visits Reasonable costs	Nothing	Beneficiary eligible for Part B only
Physician and other medical services	80% of approved charges after deductible is met **1000/.** of approved charges for services provided in approved ambulatory surgical center or hospital outpatient department if the physician accepts assignment	Initial deductible ($75) 20% of approved charms Excess of physician charges above approved charges if physician does not accept assignment of benefits	
Immunizations	Pneumococcal vaccine Hepatitis B vaccine (for ESRD patients and others at high risk of hepatitis)	Nothing for covered vaccines, deductible does not apply All costs for all other vaccines	
Chiropractors' services	Manual spinal manipulation	All other charges	
Most routine foot care	Nothing	All charges	
Dentists' services	Jaw surgery, setting of facial fractures, treatment of oral infections	All other charges	**May cover other dental services** when incident to the provision of covered medical services
Dentures	Nothing	All costs	
Routine hearing and eye exams	Nothing	All costs	Examinations may be covered as incident to other diagnostic and therapeutic procedures, e.g., prior to surgery to correct hearing and vision disorders
Eyeglasses and hearing aids	Nothing	All costs	
Routine physical examinations	Nothing	All costs	Examinations covered as incident to diagnosis and treatment
Prosthetic devices	Those needed to substitute for an internal body organ, or for artificial limbs and eyes, and arm, leg, back, and neck braces	All costs	
Durable medical equipment	If rented, approved charges If purchased, monthly payments until Medicare's share is paid or equipment is no longer necessary For long-term use, payment may be made in a lump sum	200/0 coinsurance	Equipment furnished by provider is paid by Part A intermediary on a reasonable cost basis
Medical supplies	Dressings, splints, and casts	All other costs (e.g., common first aid supplies purchased by patient)	Physicians may bill for supplies provided at cost to them

Table C-1 .—Medicare Benefits and Limitations, as of January 1986—Continued

Kind of care	Medicare pays	Beneficiary pays	Comments
Blood	For all but first 3 pints	First three pints or replace	
Outpatient mental illness	62.5°/0 of reasonable charges up to $500 (i.e., $312.50)	37.5°/0 of reasonable charges up to $500, and 100°/0 of charges above $500	
Outpatient physical therapy	In doctor's office, 800/0 of approved charges after deductible is met From physical therapist, $400/yr. maximum From clinic, home health agency, or other agencies, 800/0 of approved charges after deductible	$75 deductible and 20°/0 coinsurance All costs above $400/yr. $75 deductible and 200/0 coinsurance	
End-stage renal disease treatments	80% of prospectively determined, per treatment regionally adjusted rates Physicians' services incident to maintenance dialysis, 800/0 of monthly cavitation rates	$75 deductible and 200/. coinsurance	Coverage ends 12 months after the month maintenance dialysis stops or 36 months after month of kidney transplant
Comprehensive outpatient rehabilitation facilities (CORF)	Lesser of 800/0 of reasonable cost or the reasonable cost minus 20°/0 of reasonable charges	$75 deductible and 20°/0 of customary charges	In order for the beneficiary to receive reimbursement for CORF services, a physician must submit a plan of treatment which must be reviewed every 60 days, Coverage ends when no further progress is being made with respect to the goals specified in the plan
Rural health services	800/0 of prospectively determined all-inclusive per visit rate	$75 deductible and 20°/0 coinsurance	

aRespite care is defined as short-term (limited to 5 days) inpatient care provided to the individual only when necessary to relieve the familY members or other Persons caring for the Individual during period of hospice election.

SOURCE" Commerce Clearing House, Inc., *Medicare and Medicaid Guide* (Chicago, IL: Commerce Clearing House, Inc , 1985),

Part A is an entitlement program and is available without payment of a premium to those eligible.[4] Individuals who are not automatically entitled may voluntarily obtain insurance by paying the full actuarial cost of such coverage ($174 per month in 1985) (471). Individuals eligible for Part A are automatically enrolled in Part B unless they indicate they do not wish to be enrolled. Any citizen or legal alien for 5 years who is age 65 and older, even individuals who are not eligible for Part A, may enroll in Part B, a distinct program under Medicare. Participation in Part B is voluntary and requires payment of a monthly premiums The Part B, premium is deducted automatically from monthly Social Security checks, except in cases where States pay the premium or when work or some other event precludes payment of the monthly benefit check. Participation in Part B is high. In 1982, 99 percent of the eligible elderly and 92 percent of eligible disabled people in Part A were also enrolled in Part B (467). Medicare is administered through private contractors (intermediaries for Part A and carriers for Part B), all of whom maintain a private business as well as the Government contract business. In fiscal year 1984, Medicare had 60 carrier jurisdictions that were serviced by 39 carriers: 28 Blue Cross/Blue Shield Plans and 11 others (514).

'Thirty percent, or 4 mllllon, of State and local employees are the ma]or group of ind]wduals currently not el]gible for Part A (27)

'The I'art B premium was $15.50 month as of Jan 1, 1985.

Fee-for-Service Payment

Background.—By the early 1950s, the movement for a national health insurance program for the entire population that began in the 1930s had become a proposal to assist Social Security beneficiaries with the costs of hospitalization. However, despite the limited nature of proposed health insurance legislation, successive attempts at passage failed until 1965, when President Johnson's active interest in a health insurance program during and after his successful bid for reelection and striking changes in the political composition of Congress overcame the resistance of opponents (27). The knowledge that some form of Medicare would pass caused some opponents to facilitate enactment of Government health insurance for the elderly and other opponents to sponsor health insurance bills for the elderly for the first time (287)

In early 1965, revised versions of bills sponsored by the Administration (H.R. 1 introduced by Rep. Cecil R. King and S. 1 introduced by Sen. Clinton Anderson) were reintroduced, and Rep. James Burns, a former opponent, sponsored H.R. 4351—a Government health insurance bill. The King-Anderson bill called for compulsory contributions and was closely associated with the Social Security system. It limited benefits to hospital care, nursing home care, and home health care. The Burns bill included physician and other medical services as well as inpatient services. It

provided for voluntary participation and a Government subsidy, and was separated from the Social Security system (445). The Burns bill was modeled on a high-option Aetna policy available to members of the Federal Employees Health Benefits Program **(27,580).**

In a strategic move, Rep. Wilbur Mills, chairman of the House Ways and Means Committee, proposed incorporating elements of both the King-Anderson bill and the Burns bill into Title XVIII of the Social Security Act. [b]Title XVIII retains the basic philosophy of both bills. Although insurance for hospital services, Part A of Title XVIII, is financed by compulsory contributions of employers and employees through the Social Security system, insurance for physician services, Part B of Title XVIII, is voluntary and is financed from premiums paid by the insured and general revenues.

The nonregulatory approach of H.R. 4351 was incorporated into the following statutory language **(580):**

> . . . where payment . . . is on a charge basis, such charge will be reasonable and not higher than the charge applicable for a comparable service and under comparable circumstances to the policy holders and subscribers of the carrier . . . In determining the reasonable charge . . . there shall be taken into consideration the customary charges for similar services as well as the prevailing charges in the locality for similar services.

Although longstanding advocates of Medicare legislation had recognized that basing physician payment on physician charges was potentially inflationary,[7] they also knew that it was impractical to contest the method. If Medicare was to be passed, Rep. Mills' support was necessary, and tampering with his package in this major way would jeopardize his approval **(27).** Furthermore, the logical alternative, i.e., paying physicians on the basis of prospectively determined fees, exercised more control over physicians than a charge-based method and might have adversely affected physicians' cooperation with the program **(287).**

Fee schedules were a traditional payment method for physician services in the United States that had the advantages of uniformity and ease of understanding by both patients and physicians. On the other hand, the charge-based method that Congress adopted was relatively new—it had first been used by a Blue Shield plan in Wisconsin in **1954.** Blue Shield had also initiated a "prevailing fee program" for national accounts, which was designed to permit physicians to establish charges for their services without being limited by fee schedules or income levels (312). Furthermore, the method afforded physicians considerable latitude in establishing payment levels and was considered less intrusive than fee schedules in a physician's financial decisions.

Specific definition of the terminology used in the legislation was lacking, but " . . . fears of a physicians' boycott and the absence of an obviously attractive alternative, persuaded Senate reformers not to raise further questions about the sensitive issue of what constituted reasonable charges" (287). The congressional intent to make health care for aged citizens available without regard to income level was evident in the report of the Committee on Ways and Means to accompany H.R. 6675. The report states, "where payment is on the basis of assignment, the reasonable charge would have to be accepted as the full payment" (478). In the late 1960s and 1970s, the original statutory language was clarified by a series of regulations and administrative guidelines. In attempts to strengthen Government control over physician payment and to restrain the rising costs of the Part B program, tighter controls on the operations of the carriers were developed by increasing the frequency of updating physician charges and by freezing charge limits for various periods of time (27,565).

The payment method and its administration described below have perpetuated a loosely administered, decentralized system with differences in payment levels among physicians. The implications of the Medicare payment system for current Part B costs and other effects of the payment system are discussed in chapter 2 of this report. Significant refinements to the current system are considered in chapters 4, 5, 6, and 7.

Current Status.—As noted earlier, Title XVIII of the Social Security Act specifies that payment for physician services under Part B of Medicare are to be made on the basis of *reasonable charges* that are computed from usual, customary, and prevailing (CPR) charges.[8] The Part B program generally pays 80 percent of reasonable charges in excess of the beneficiaries' annual Part B deductible, $75 in 1985.

Medicare carriers, private contractors that receive, process, and pay claims for Part B services, have the primary responsibility for determining the reasonable charge for each service provided. Their determinations are to be consistent with the law, regulations, and general principles and guidelines issued by the Health Care Financing Administration (HCFA) (509). Although the basic formula is applied uniformly nationwide, carriers exhibit great variation in executing the method-

[b]The "Eldercare" bills, H.R. **3727** and H. R. 3728, became Title XIX of the Social Security Act.

[7]In the 1965 Senate debate, the leading Senate proponent of Medicare, Sen. Clinton Anderson noted that paying physicians their "usual and customary fees (the Burns suggestion) would significantly and unnecessarily inflate the cost of the program to the taxpayer and the aged" (287).

[8]Both usual, customary, and reasonable and CPR refer to a general system of computing a payment level based on historical and comparative profiles of physicians' charges. Since CPR is Medicare terminology, it will be used in this report. The terms reasonable, allowed, and approved are used as synonyms in this appendix.

ology in such areas as locality designation and specialty recognition because of the autonomy offered by the law and implementing instructions.

Based on claims information, Medicare carriers maintain records of the services provided and the charges billed by physicians in their charge area. The carriers then develop individual statistical profiles and areawide statistical profiles of physician charges, which are updated annually and are in effect for a "fee screen" year.' The standards per fee screen year have been based on charges submitted during the calendar year preceding the fee screen year, creating a lag period in updating (509). For example, the charge limits for the fee screen year July 1, 1982 to June 30, 1983, were based on charges received during the preceding calendar year January 1, 1981 to December 31, 1981 (509).

The *reasonable charge* is the lowest of a physician's ***actual charge,*** a physician's ***customary charge*** (Level 1 fee screen), or the area's ***prevailing charge*** (Level 2 fee screen). There are special circumstances when the reasonable charge may not be the lowest of the above three charges. If there are unusual circumstances or medical complications causing essentially different services to be provided, the actual charge for the service may be specified as the reasonable charge even though the actual charge is higher than the customary charge and prevailing charge. The Social Security Act requires that the reasonable charge for a service may not be higher than the charge for a comparable service provided under comparable circumstances to a carrier's non-Medicare subscribers.

The actual charge is the charge the physician has billed for the service provided. The customary charge is the physician's median submitted charge during the data collection period preceding the fee screen year. 10 The customary charge is fluid. If a physician revises his or her fees, the carrier will recognize the change when processing claims with the new charges.

Until 1976, the prevailing charge for a service was the lowest charge for the service that was greater than or equal to a percentile of the distribution of physicians' customary charges weighted by the number of times each physician billed for the service in a locality (designated as a "charge area") the previous calendar year. The prevailing charge limits were originally paid by some individual carriers at the 90th percentile. Medicare later set prevailing change limits at the 83rd percentile in 1969, and they have remained at the 75th percentile since 1971 (496).

The Social Security Amendments of 1972 (Public Law 92-603) placed further limits on the yearly increases in prevailing charge levels—because of subsequent congressional action to prevent a rollback in approved charges, these limits were not fully implemented until 1976. The amendments established a Medicare Economic Index (MEI) that relates the rate of increase in physicians' fees to increases in general earning levels and increases in physician practice costs. The index, which is updated annually for a 12-month period beginning July 1, sets an annual capon prevailing. Prevailing charges are now either the lesser of the prevailing charge ("unadjusted" prevailing) or the product of the 1973 fee screen year prevailing charge multiplied by the value of the current MEI ("adjusted " prevailing) (116). The MEI for 1983 was 2.063. If a prevailing charge for a certain service was $10.00 in 1973, and if the "unadjusted" prevailing was no less than $20.63, the prevailing charge for fiscal year 1983 would be $20,63 (the "adjusted" prevailing). However, if a prevailing charge for a certain service was $10.00 in 1973, and if the "unadjusted" prevailing in 1983 was less than $20.63, the prevailing would be set at the charge that is less than the $20.63 (the "unadjusted" prevailing).

In implementing the CPR approach, each carrier is allowed considerable latitude in delineating a charge area. Carriers are expected to delineate localities based on their knowledge of local charging practices, service patterns, and differences in population density, economic levels, and other factors that affect charges for services. Charge areas are usually a subdivision of a State that includes a cross-section of the population (509). Thus, there is no uniform geographic configuration for a charge area. Four types of locality configurations are: 1) statewide localities, 2) regional localities (contiguous counties) without specific regard to urban/rural distinctions, 3) urban and rural localities comprised of noncontiguous areas, and 4) separate localities for major metropolitan areas with nonmetropolitan areas consolidated into one or more localities. Currently there are 240 geographic charge localities (514).

Charge areas may also differ according to types and levels of services. For example, a carrier may decide in determining a prevailing fee screen that a State has seven localities for general practitioners, but only one locality (the entire State) for members of a particular specialty.

'As a result of provisions of the Deficit Reduction Act of 1984 discussed later, the fee screen year as of October 1, 1984, was changed from July 1-June 30th to October l-September 30th and charge limits for the tee screen year will be based on charges submitted from April I-March 30th of the previous year.

[10]The customary charge for a service provided by physicians beginning a new practice is based on the 50th percentile of the customary charges in a charge area weighted by how often physicians billed for the service (509)

In calculating the customary charge, the earner not only corwders charges made by physicians to Medicare benef]c~aries, but also cons]ders charges made by the physicians to their pat]ents]n general The amount of non-Medicare data included m the computatmn varies among carriers according to the wze of their non-Medicare business (509).

Furthermore, carrier practice concerning specialty recognition for the purpose of determining prevailing charges is also extremely variable as it is meant to reflect the existing patterns of charges within a locality. The variation in carrier practice ranges from carriers that use a single prevailing charge screen for services of all physicians[11] to those carriers that calculate separate prevailing charge screens for individual specialties. Blue Shield of Pennsylvania, for example, has individual charge screens for more than 50 distinct specialties (458). Some carriers calculate a prevailing charge screen for general practitioners and a prevailing charge screen for all other physicians. Other carriers group specialties into other categories, so that there may be one prevailing charge for all surgical specialties and another prevailing charge for medical specialties. Massachusetts constructs prevailing charge screens by type of service and recognizes 25 specialties in constructing prevailing screens for visits and consultative procedures, but only two groups (general and family practitioners, and other physicians) for other procedures (475).[12]

The recognition of specialties is a complex issue, confounded by the lack of a clear definition of a specialist within the medical community.[13] Eighty-two specific physician specialties and subspecialties are reported by physicians and included in the Masterfile of the American Medical Association (124). At this time, some carriers define a specialist as one who is board-eligible in a particular specialty, and others limit the designation only to board-certified physicians. Still other carriers define specialists as physicians who classify themselves as such and who limit their practice to a particular specialty (30).

Medicare carriers frequently rely on relative value studies if there are insufficient charge data about a particular physician's use of a specific service to determine a customary charge screen or if there are insufficient data about the use of a service in a charge area to determine a prevailing charge.[14] Physicians also rely on such studies when determining a fee for a new service.

Relative value studies express the relationship between services in unit values and not dollar amounts.[15] In determining a physician's customary charge for a service, the carrier multiplies the relative value of the service and a monetary conversion factor that is derived from a physician's known customary charges for similar services in the same category of service (e. g., medicine, surgery, and radiology), In determining the prevailing charge for a service, the carrier multiplies the relative value of the service and a monetary conversion factor derived from the fully adjusted prevailing charges for other services in the same category (509). Thus, an important factor in price determination is the monetary conversion factor which, when used as a multiplier, establishes the price (or payment level) for a service, The conversion factor can be changed to decrease or increase the price of services, and different conversion factors can be used to develop different prices for the same service depending on locality, medical specialty, or other factors.

Relative value studies are also procedural terminology documents that health professionals use in describing (coding) services when claiming insurance payment and for other purposes. The number of terms in the various studies has increased dramatically over the years. For example, the number of terms in the Current Procedural Terminology of the American Medical Association increased from 2,084 in 1966 to 6,132 by 1977 and to 7,040 by 1985. The increase in coding terms is intended to provide physicians with more accurate descriptors of the services provided. It also provides physicians with flexibility in describing services.

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[11]Carriers for the States of Florida, North Dakota, and South Dakota, the State of Kansas excluding Kansas City, western New York, and the combined territories of the Puerto Rico and the Virgin Islands use a prevailing charge screen for the services of all physicians. The American Society of Internal Medicine has brought suit against Florida Blue Cross Blue Shield to force recognition of specialists. The court suit also concerns differentiating between physicians and nonphysicians who use the same codes for a service, and discriminating between specialists and levels of expertise. The suit was withdrawn in 198s.

[12]The variation in carrier practice can be explained by the lack of the specificity of the regulations concerning specialty practice and the wide latitude allowed carriers in implementing instructions. The regulations stipulate that: 1) carriers should be responsive to differentials in levels of charges among different kinds of services in establishing prevailing charge levels; 2) where general practitioners and specialists in a locality have established different levels of fees for their services, the carriers should recognize such differences in establishing prevailing charge screens; and 3) when the physicians have not themselves established fee differentials based on specialty practice, the carrier should not establish artificial ones (42 CFR 405.504).

[13]An important step on the part of the medical community in defining a medical specialist was taken on Mar. 20, 1984, when the Ad Hoc Committee on Designation of a Specialist of the Council of Medical Specialty Societies released guidelines for the designation of a physician as a specialist. The guidelines do not accept self-designation alone, but list four objective criteria to be used in verifying specialty designation.

[14]In order for a carrier to have a sufficient statistical base on which to calculate a physician's customary charge for a specific service, the physician must submit three claims for that service. And, a minimum of four customary charges for a particular service are required for calculating the prevailing charge for the service in a locality (88).

[15]The antitrust implications of relative value studies have been under examination by the Federal Trade Commission (FTC) and the Justice Department in the past. Continued publication and revision of a number of relative value studies, including the California Relative Value Study, were halted after the settlement of a series of lawsuits in the mid and late 1970s. The antitrust implications of relative value studies depend on the extent to which the members of the groups and output involved in their construction attempt or wish to influence prices and output; thus, the use of relative value studies by the medical professions can be questioned if the intent of the physicians is to fix fees. However, their use by health insurers when determining payment levels for physician services appears to "serve a valid function" (266). Recently, a few medical societies have approached the FTC for advisory opinions concerning the development or updating of new relative value guides and a reexamination of the previous orders. The current standing of the issue is discussed in ch. 5.

Recently the Deficit Reduction Act of 1984 (Public Law 98-369) mandated a fee freeze, which started on July 1, 1984, of Medicare customary and prevailing charges for physicians' services. Although the freeze is scheduled to continue only until September 30, 1985, the administration has recommended extending the freeze for another year (552). The conditions of the freeze are dependent on assignment arrangements and are discussed in a section below.

Special Provisions. —There are special provisions for hospital-based physicians, teaching physicians, and physician services in intermediate care facilities.

Hospital-Based Physicians, —Hospital-based physicians are defined as physicians who provide ancillary medical services in a hospital setting. The three "traditional" hospital-based specialties are radiology, pathology, and anesthesiology, although a number of other types of practices, including emergency medicine, rehabilitation medicine, and cardiology, sometimes meet this definition.

Since the beginning of the Medicare program, the Federal Government has made special provisions for paying hospital-based providers, because the program requires the separation of charges for professional and hospital services and because the services hospital-based physicians provide are so closely allied with hospital services. A physician's professional service—a service that contributes to the diagnosis or treatment of the patient—is paid on a charge basis under Part B. Other services performed by physicians, such as administrative or quality control activities, are considered hospital services and are reimbursed under Part A.

In order to simplify reimbursement and claims processing, the 1967 Amendments to the Social Security Act (Public Law 90-248) allowed "combined billing" to be used by hospitals for radiology and pathology services furnished to inpatients, and all physicians' services furnished in hospital outpatient departments. Under combined billing, the hospital uses a single billing form for both the professional and hospital components of inpatient radiology and pathology services. The professional component was identified as a fixed proportion of the total bill for services. Combined billing could be used only if all the physicians in the radiology or pathology departments had a salary or percentage arrangement with the hospital. [16]

[16] Hospital-based physicians are compensated for their services primarily by salary, percentage of departmental revenue, or fee-for service, with fee-for-service becoming the predominant important method Many variations and combinations of methods have been developed to meet specific needs of physicians and hospitals.

The 1967 amendments also specified that radiology and pathology professional services rendered to hospital inpatients were to be reimbursed at 100 percent of reasonable charges. Beneficiaries bore no liability for copayment of those services. Because the charges that radiologists and pathologists billed to their carriers continued to be reimbursed at the 80 percent level, this provision was justified as eliminating coinsurance payments by beneficiaries to physicians whose services were not the choice of the beneficiary. It was also intended to reduce hospital-based physicians' incentives for separate billing and thereby reduce processing costs to providers and to the Social Security Administration, even though it made more Federal dollars available for financing hospital-based services (451). The intermediaries paid the combined billing charges, ***and*** adjustments were made on an actuarial basis between the two Medicare revenue sources to account for Part B charges being paid by Part A intermediaries. The hospital was paid on the basis of cost, using the charges to compute the cost. The allocation between the Part A and Part B trust fund was based on the physician's allocative agreement.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248) modified the way Medicare pays hospital-based physicians. Section 112 eliminated the provision that Medicare pay 100 percent of the reasonable charges for pathology and radiology services delivered to hospital inpatients. These professional services became subject to the same deductible and coinsurance requirements as other Part B services, Moreover, HCFA determined that the special processing routines required for combined billing were not justified since the option was never widely used, and in implementing regulations eliminated combined billing as of October 1, 1983 (48 FR 39740).

More importantly, TEFRA mandated a clearer distinction between Part A hospital services and Part B physician services, regardless of the doctor-hospital relationship. The regulations implementing Section 108 of the legislation restated and clarified the criteria that must be met for a physician's service to be paid on a reasonable charge basis under Part B. In addition to the existing requirements that the service be personally furnished by the physician and contribute to the diagnosis or treatment of an individual patient, a requirement was added that the service ordinarily require performance by a physician (48 FR 8902). If the physician is salaried by the hospital or is on a percentage arrangement, the carrier is required to develop customary charges based on the compensation that the physician receives for the services.

TEFRA also mandated that all physician services that do not meet the conditions for charge payment, but benefit a hospital or the patient population as a

whole, are considered hospital services and are to be reimbursed under Part A. Physicians who receive any compensation from the hospital must have formal agreements that specify time and reimbursement for any Part A services or that provide the basis of allocation of payment between Part A and Part B services. The regulations implementing TEFRA provided that the reasonable cost reimbursement for physicians' services paid under Part A could not exceed "reasonable compensation equivalent" limits that HCFA developed based on physicians' average net income adjusted for specialty, location, and hours worked. The reasonble compensation equivalent limits never became an important factor except for hospital outpatient services, since the implementation of TEFRA and the Social Security Amendments of 1983, which replaced cost-based reimbursement for inpatient services with a prospective payment system based on rates determined by diagnosis; both started October 1, 1983. Part A inpatient physician services are covered by prospective payment just like any other Part A inpatient service.

TEFRA also mandated specific provisions governing reimbursement for radiologists, pathologists, and anesthesiologists. The hospital-based radiologist became subject to a limit of 40 percent of the prevailing fee services generally available in radiologists' offices in the community. TEFRA regulations permit payment on a reasonable charge basis to anesthesiologists for up to four concurrent procedures if the anesthesiologist also meets specific guidelines defining appropriate patient care. If an assisting nurse anesthetist is employed by the anesthesiologist, the physician can bill his or her full customary charge as an anesthesiologist. If a nurse anesthetist is employed by the hospital or is self-employed, computation of the anesthesiologist's customary charge is based on one-half time units. (Anesthesiologists bill using a "relative value guide" that combines time units with the relative difficulty and skill involved in procedures,)

The greatest changes in TEFRA regarding physicians apply to pathologists. The legislation defined almost all clinical laboratory tests as Part A services, and thus, not reimbursable on a charge basis. Under TEFRA's regulations, only clinical laboratory services meeting very specific criteria can be considered consultative services and reimbursable under Part B; all other clinical laboratory services are reimbursed by Part A. On the other hand, all anatomical pathology services are considered professional services and must be paid on a reasonable charge basis under Part B, Anatomical pathology generally requires examination of body tissue, fluid, or cells by the pathologist. Because anatomical pathology services and some clinical laboratory services, which had previously been combined billed to Part A, are now required to be billed to Part B, carriers have had to quickly establish customary charges using charges for similar services.

Teaching Physicians. —Like hospital-based physicians, teaching physicians provide services for the hospital itself (educational and supervisory services) in addition to supplying professional medical services to individual patients. Teaching physicians also tend to be salaried for at least part of their total compensation.

Since 1969, with the issuance of Intermediary Letter (IL) #372, Medicare has targeted teaching physicians for special treatment. IL #372 established criteria for identifying the personal, identifiable services that a teaching physician must perform for an individual patient to qualify for fee-for-service payment (6). In 1972, Section 227 of Public Law 92-603 mandated a legislative solution to paying teaching physicians, but was never implemented by regulation. Section 948 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) repealed Section 227 and essentially codified the requirements in IL #372 that define when a teaching physician may bill for professional services.

Section 948 also set forth the manner in which fee-for-service payments should be determined for physicians practicing primarily in teaching hospitals. It required that Medicare use the greater of the mean or modal charge collected from non-Medicare patients to determine payment for an individual service. In order to ensure a reasonable minimum for Medicare fees, the Deficit Reduction Act of 1984 amended the 1980 Onmibus Reconciliation Act and set the floor for Medicare fees in a teaching setting at 85 percent of the Medicare prevailing fee in the area.

HCFA has not yet published regulations to implement Section 948 of the Omnibus Reconciliation Act of 1980, although they are expected some time in 1985 (252). The Medicare program's only policy that is in effect is its administrative directive, IL #372, which stipulates the conditions for charge payment. There are no promulgated regulations on the level of payment for teaching physicians, and as a result, teaching physicians are today reimbursed by Medicare just like any other physicians.

Physician Services in Intermediate Care Facilities, — Under fee-for-service, Medicare limits physician payment for visits to beneficiaries in intermediate care facilities (nursing homes) with respect to multiple visits. This restriction was initiated in response to reported abuses early in the program (99). Except when more intensive care can be substantiated, Medicare pays only for one physician visit a month to the same patient in a nursing home, and there is a difference in payment level if more than one patient is visited. If the visit is a routine followup visit, it is paid at the level of a routine followup house call. If the physician

visits more than one patient ("multiple visits") for routine followup visits, the payment level is lowered to that for a routine followup office visit. If the visit is brief, the Medicare payment may not exceed the payment for brief house calls for single patients and brief office visits for multiple patients (514). Multiple visit rates are 25 percent lower on average than single patient visits (318). Attempts by the Office of the Inspector General in the Department of Health and Human Services to extend the multiple visit limitation to physician visits in skilled nursing facilities[17] and hospitals (254) have been unsuccessful to date (99).

In addition to limiting payment, Medicare and Medicaid rules also require that patients in skilled nursing facilities be visited at least once every **30** days for the first **90** days following admission, after which the requirement is lowered to once every **60** days (**42** CFR 405 l123(b)). Patients in intermediate care facilities must be visited every 60 days (42 CFR 442.346 (b)).

Other Payment Methods

Although fee-for-service is by far the method used to pay for the great majority of physicians' professional services under Medicare, the program has veered from traditional fee-for-service payment and used alternative payment methods for physicians' professional services to accommodate to special conditions. In certain circumstances, the program has paid an institution, either on a cost or cavitation basis, and the institution subsequently has paid the physician a salary or negotiated a fee with the physician for the service or paid the physician per capita. The Medicare program has also paid the physician directly on a non-fee-for-service basis for some services and uses a statewide fee schedule to pay for certain physician provided clinical laboratory services.

Physician Services for Kidney Dialysis Patients.—Medicare uses alternative methods of fee-for-service in paying for some physician services provided to beneficiaries in the Medicare's ESRD program. Until August 1, 1983, physicians could choose from two methods of payment for maintenance dialysis, the principal service provided in the ESRD program. Under the "initial method, " payment for physician services to patients undergoing maintenance dialysis was to the facility, and physicians negotiated a fee with the facility for their supervision or for routine services provided during a dialysis session (nonroutine services were paid according to reasonable charge criteria). Or, under the "alternative method, " Medicare could pay a comprehensive monthly fee per patient. For patients dialyzed in facilities, the physician's fee was based on a calculation of the customary or prevailing charges for a followup visit, multiplied by 20, For supervision of home patients, the weighting factor was set at 14, to reflect the presumed lower requirements of home patients for physician supervision (405). The payment would be made by the carrier to the physician, if the physician accepted assignment, or to the patient, if the physician did not accept assignment (see discussion of assignment below).

In order to provide incentives to the use of home dialysis, the Omnibus Reconciliation Act of 1981 (Public Law 97-35) and subsequent regulations (48 FR 21254) eliminated the "initial method" and require that on and after August 1, 1983, physician services furnished to ambulatory maintenance dialysis patients in a free-standing facility or hospital-based facility or to patients undergoing dialysis at home be paid only under the alternative method. The calculation of the physicians' monthly payments is based on the number of typical dialysis sessions per month, prevailing charges for a medical specialist's brief followup visit for an established patient, and prevailing charges for an intermediate followup visit, weighted by the national averages of patients dialyzed in facilities and at home.[18] Upper and lower limits on the physicians' monthly capitation payments were established after adjustments for extreme ranges in prevailing charges. The minimum is set at $144 per month and the maximum at $220 per month for both physician services in the home and in facilities. HCFA's intention is not to automatically change the payment levels according to changes in prevailing charges but to review program data and change payment levels if warranted (48 FR 21254).

Physician Services for Clinical Laboratory Services.—Prior to July 1984, Medicare payments for clinical laboratory services furnished by a physician or an independent laboratory were made on a reasonable charge basis subject to the Part B deductible and coinsurance.[19] The method varied somewhat from Medicare's traditional CPR method of computing reasonable charges. The reasonable charge for ambulatory laboratory services was the lowest of the actual charge, the customary charge, the prevailing charge in the locality, and the lowest charge at which the test is widely and consistently available (which was established for 12 common laboratory tests).

[17] A skilled nursing facility is a specially qualified facility which has the staff and equipment to provided skilled nursing care or rehabilitation services and other related health services Medicare pays for care in skilled nursing facilities and for physician services provided in such facilities Medicare, however, does not pay for care provided in nursing homes that are not specially qualified.

[18] Specifics of the calculation are in 48 FR 21269.

[19] A later section discusses Medicare's deductible and coinsurance under part B.

Assignment was permitted on a case-by-case basis, and physicians could bill for laboratory services whether or not they performed or supervised the test.[20] When the physician's claim indicated that the test was performed in the office, Medicare would pay the physician as indicated above; when the physician's claim indicated that the test was performed by an outside laboratory, Medicare would pay the physician the laboratory's reasonable charge plus a $3 handling fee.

Before July 1984, Medicare payment for laboratory services ordered during hospital outpatient visits was on the basis of reasonable cost. Hospitals providing these services to their outpatients were required to accept assignment; hospitals providing these services to nonhospital patients receiving laboratory services from a hospital serving as an independent laboratory were not required to accept assignment and were paid on a reasonable charge basis.

The Deficit Reduction Act of 1984 established a different payment method–a carrier-based fee schedule—for clinical laboratory services conducted in physicians' offices, in independent laboratories, and in hospital laboratories acting as independent laboratories, i.e., furnishing tests to nonhospital patients. The fee schedule was established at 60 percent of the prevailing charge levels for the fee screen year beginning July 1,1984. After 3 years, a national fee schedule will be formulated with methodology as yet undefined, to serve as the basis of payment.

The 1984 law also established a fee schedule for clinical laboratory services conducted by hospital laboratories serving hospital outpatients—the payment level to be set at 62 percent of prevailing charges. After 3 years payment will be on the basis of cost reimbursement unless Congress decides otherwise.

Other relevant provisions in the Deficit Reduction Act of 1984 include an annual adjustment of fee schedules to reflect changes in the consumer price index for all urban consumers (U.S. city average) and permission for the Secretary of Health and Human Services to adjust the fee schedules to reflect technological change, emergency services, and other special services.

Furthermore, the act also modifies current billing and assignment options. Physicians may bill for services only if the physician personally performs or supervises the test. Anyone who furnishes laboratory services may bill a nominal amount, currently $3 for the collection of the patient specimen; however, only one collection fee per patient encounter will be permitted, Physicians may continue to accept assignment on a bill-by-bill basis, but independent and hospital laboratories must accept assignment. For assigned claims, Medicare will reimburse at 100 percent of the fee schedule and waive coinsurance and the deductible for all assigned tests. Physicians can accept assignment on the laboratory portion of a claim only and not accept assignment for other services.

Physician Services and Health Maintenance Organizations (HMOs).—Medicare does not pay physicians directly for their services provided in HMO settings, but contracts with HMOs for physician and other services. The original Medicare legislation authorized payment on the basis of the costs to the organization for providing the specific services to beneficiaries. The Social Security Amendments of 1972 added the option of paying HMOs on a risk-sharing basis for services covered under both Part A and Part B to the existing method of reimbursement on a reasonable cost basis. Under the risk-sharing method, a per capita reimbursement rate that reflects the estimated costs to an HMO for its enrolled Medicare population is compared at the end of the year to the actuarial measure of the costs that would have been incurred by Medicare to serve comparable beneficiaries within the HMO's service area on a fee-for-service basis (the average adjusted per capita cost or AAPCC). If the HMO's costs are less than the AAPCC, the HMO is reimbursed for costs and receives one-half of the excess of the AAPCC over its costs, up to a maximum of 10 percent of the AAPCC. If the HMO's costs are greater than the AAPCC, the HMO has to absorb the entire loss.

Both the risk and reasonable cost reimbursement methods required retrospective determination of costs, which is an awkward arrangement for HMOs, which are designed to operate under prospective budgets without extensive reporting requirements to third-party payers. Furthermore under the risk-sharing method, although the HMO might have to absorb all losses, it can share in only half of any surpluses. This lack of a strong incentive resulted in only one HMO's entering into a risk-sharing contract with Medicare. As of June 1984, 62 HMOs were reimbursed on a cost basis and an additional 26 were reimbursed on a risk basis under various HCFA demonstration projects. Forty-four other health care prepayment plans had contracts with HCFA on a cost basis for Part B services only (50 FR 1341).

In 1982, the Tax Equity and Fiscal Responsibility Act or TEFRA changed the way organizations are reimbursed on a risk basis to permit prepaid cavitation payment without retroactive adjustments. The regulations, which became effective February 1, 1985, provide for monthly per capita payments equal to 95 percent of the AAPCC, as adjusted for geographic area and variations within the enrolled Medicare population—age, sex, disability status, welfare status, institutional status, and other relevant factors (50 FR 1369). The orga-

[20] A detailed description of assignment under Medicare is in a subsequent section of this appendix.

nization is also required to compute an "adjusted community rate"—a rate equal to the premium the organization would charge its non-Medicare enrollees for the Medicare covered services adjusted to reflect the utilization characteristics of the organization's Medicare enrollees. If the organization's adjusted community rate is less than the cavitation payment rate, the HMO may keep the entire surplus, but must use it either for providing beneficiaries with additional benefits beyond those required by Parts A and B of Medicare or for reducing premium rates. The HMO may also put some of the surplus into a benefit stabilization fund or return it to HCFA (see ch. 7). If the adjusted community rate exceeds 95 percent of the AAPCC, the organization may elect to be reimbursed on a reasonable cost basis as in the past,

TEFRA also expands the definition of organizations eligible to contract with HCFA for Medicare payment to other medical delivery systems, termed competitive medical plans, that do not meet the restrictive definition of federally qualified HMOs in the Public Health Service Act. Like HMOs, competitive medical plans are required to enroll members on a prepaid capitation basis and assume full financial risk for the full scope of Part A and Part B Medicare benefits. HMOs that have federally qualified must meet other structural regulations and are required to community rate, rather than experience rate, their premiums for their private lines of business (see ch. 7).

Physicians' Acceptance of Medicare Payment

Physicians receive Medicare payment for each claim for their services ***on*** an assigned or nonassigned basis. When a physician accepts assignment, the physician agrees to accept Medicare's reasonable charge determination as full payment. The physician bills the program directly and, after the deductible is satisfied, is paid an amount equal to Medicare's reasonable charge less the 20-percent coinsurance, which is the patient's share of the bill. If the patient has not had bills sufficient to meet the annual deductible, the patient is also obligated to pay the physician the deductible amount not met.[21]

When a physician does not accept assignment, the physician bills the beneficiary and the beneficiary requests reimbursement from Medicare. If Medicare's reasonable charge is lower than the physician's actual charge, the beneficiary is responsible for paying the difference between the two charges ***in*** addition to the amount of the coinsurance after the beneficiary has satisfied the deductible. The physician's actual charge is included in the calculation of the customary charge and the prevailing charge for the next fee screen period irrespective of his or her assignment status.

The nationwide net assignment rate of claims declined from a high of 61.5 percent in 1969 to a low of 50.5 percent in 1976 and 1977, and rose to 59 percent of claims and 59.6 percent of charges in 1984 (518). Voluntary assignment is lower than the above rates indicate, since joint Medicare-Medicaid claims are factored into the calculations and assignment is mandatory for Medicaid beneficiaries. The number of the noninstitutionalized dually entitled people, i.e., those eligible for both Medicare and for Medicaid, is estimated at over 3 million or about 15 percent of persons over age 65 (295). However, the exact number of Medicaid beneficiaries who are enrolled in Part B of Medicare is unknown due to insufficient data about the institutionalized elderly and "buy -ins," i.e., beneficiaries for whom States pay the Part B premium. Based on estimates of the dually entitled, voluntary assignment rates appear to average about 11 percent less than indicated by the aggregate statistics (496). Specific estimates of the voluntary assignment rate ranged from 35 (1) to 40 percent in 1982 (486) to 42 to 43 percent in 1982 (174a).

The assignment rate varies according to a number of factors, including the following:

1. Physician.—Selected physician reimbursement data from Medicare and Medicaid programs in the 1970s indicate that 28 to 30 percent of physicians never accept assignment, 18 to 19 percent always accept assignment, and 52 to 53 percent make their decisions on a case-by-case basis (71,315). Later data from the American Medical Association show that in 198483.9 percent of all non-Federal patient care physicians who treated some Medicare patients sometimes accepted assignment. Slightly over 16 percent did not accept assignment for any patient and 32.1 percent accepted assignment for all of their patients (15).
2. ***Beneficiary.*** —Physicians are more likely to accept assignment for disabled Medicare beneficiaries than for elderly beneficiaries and for the older Medicare population than for the younger elderly (494).
3. ***Geography,—The*** region and, even more so, the State are factors in accepting assignment. In calendar year 1982 assignment rates ranged from 82.9 percent in Rhode Island to 19.4 percent in Wyoming (494). i-he geographical variation has been ascribed to historical precedent, physician preference, and administrative practices of individual carriers (496).

[21] The following section on beneficiary financial liability discusses deductibles and coinsurance in detail.

4. *Medical* specialty .—The highest assignment rates (about 60 percent) are in the hospital-based specialties of pathology and radiology (297). Among office-based physicians, general surgeons had the highest and otolaryngologists and ophthalmologists had the lowest assignment rates (138).
5. ***Size of*** bill.—Physicians tend to accept assignment more often on bills of $100 to $200 than on bills lower than $100 or higher than $200 (297,494).
6. ***Payment*** level.—Assignment rates increase with an increase in Medicare reimbursement rates, and decrease with a decrease in reimbursement rates (188,315,357,394).

A recent, fundamental addition to the assignment process is the establishment of a participating physician program on July 18, 1984, as mandated by the Deficit Reduction Act of 1984. The acceptance of assignment on a bill-by-bill basis still pertains for those physicians who decide not to become participating physicians. However, those physicians who have become participating physicians have voluntarily entered into an agreement to accept assignment for all services provided to Medicare patients for 12-month periods beginning on October 1st of each year (516).

There are a number of incentives in the legislation to encourage participation; the major incentive is that participating physicians are exempt from a limitation on future physician charge increases. The statute, as noted earlier, freezes Medicare customary and prevailing charge levels for the services of physicians from July 1, 1984, through September 30, 1985. The law prohibits nonparticipating physicians from raising their actual charges to Medicare patients during the 15-month freeze period and stipulates that Medicare will not recognize any increases in charges during the fee freeze period in calculating customary charges on October 1, 1985, and October 1, 1986. In addition, if nonparticipating physicians increase their actual charges billed to Medicare beneficiaries, they can be excluded from the Medicare program for up to 5 years or be subject to civil monetary penalties.

Participating physicians are exempt from some of these limitations. Although no increases in Medicare payment are permitted from July 1, 1984, to September 30, 1985, participating physicians who increase billed charges during the 15-month freeze were to have the increase recognized in the customary charge updates on October 1, 1985, and October 1, 1986.[22] Other incentives for participating physicians include listings in directories made available to beneficiaries, toll-free carrier telephone services, and electronic transmission of claims.

January 1985 data show that almost one-third (29.8 percent) of all physicians billing Medicare have chosen to become participating physicians (516). The level of participation varies by specialty and State. As can be seen in table C-2, "other" surgical specialists, anesthesiologists and otolaryngologists have the lowest percentage of participation; and nephrologists, radiologists, and pathologists have the highest percentage of participation. Among the States, physicians and suppliers who practice in South Dakota, Alaska, and North Dakota have the lowest percentage of participation; and physicians who practice in Alabama, Kansas, and the District of Columbia have the highest percentage of participation (516).

More recent data indicates that 30.4 percent of all physicians billing Medicare were participating physicians in fiscal year 1985 and 28.4 percent are expected to participate in fiscal year 1986.

The assignment rate for all physicians, participating and nonparticipating, in January 1985 had increased to 66.5 percent, a considerable increase over the fiscal year 1984 rate of 56.4 percent (352). The 66.5 percent assignment rate includes mandatory assigned claims by clinical laboratories, as indicated earlier, as well as physicians who have accepted assignment on a claim-by-claim basis, and physicians who have accepted assignment for all services to Medicare beneficiaries. The assignment rate for fiscal year 1985 for all physicians has increased to 67.7 percent (521a).

Beneficiary Payment Liability

Eligible individuals must pay monthly premiums for coverage of physician and other services under Part B and are subject to a deductible and coinsurance for covered services used. If a physician does not accept assignment, the Medicare patient is also liable for the difference between the amount the physician bills and the amount Medicare allows for the service. Services that are not covered for payment by Medicare are the complete financial responsibility of the beneficiary.

Beneficiaries' participation in Part B of the Medicare program begins with a fixed monthly premium, which has been rising gradually from $9.60 in fiscal year 1980 to $15.50 on January 1, 1985, a 60-percent increase (see table C-3) (523). The annual out-of-pocket premium payment by the elderly for Part B coverage increased 138 percent from 1977 ($78) to 1985 ($186).

At the outset of the program, premiums contributed half of Part B revenues, while general revenues subsidized the other half. Subsequent amendments limited Part B premium increases to no more than the percent-

[22] As noted earlier, the Administration's budget proposal for 1986 includes extending the phyician fee freeze for an additional 12 months and delay updating of participating physicians payments by 1 year,

Table C-2.—Medicare Participating Physicians and Suppliers

Specialty	Number of participants	Percentage of all physicians/ suppliers	Specialty	Number of participants	Percentage of all physicians/ suppliers
Physicians (M.D.s and D. O. S):			*Limited license practitioners:*		
General practice	**13,743**	27.30/a	Chiropractor	6,217	25.40/a
General surgery	**9,491**	33.9	Podiatry-surgical chiropody	**4,541**	38,2
Otology, laryngology, rhinology	**1,741**	24.6	Optometrist	**4,541**	38.2
Anesthesiology	**3,269**	21,1	Other limited license practitioners (audiologists, psychologists, physical therapists)	2,845	36.8
Cardiovascular disease	**3,820**	35.6	Independent laboratory	1,698	28.4
Dermatology	**2,089**	34.0	Durable medical equipment suppliers	5,018	22.7
Family practice	**8,820**	25.5	Ambulance service suppliers	2,551	28.6
Internal medicine	**21,067**	32.5	Miscellaneous suppliers (orthotists, prosthetists, portable X-ray suppliers)	8,555	22.5
Neurology	**2,543**	34.8	Grand total	**156.001**	**29.4%**
Obstetrics-gynecology	**4,220**	27.3	Total physicians	118.428	29.8
Ophthalmology	**4,220**	27.3	Total limited license practitioners	19,751	**34.0**
Orthopedic surgery	**4,096**	29.0	Total suppliers	17,822	**23.8**
Pathology	**2,263**	39.6			
Psychiatry	**6,871**	30.0			
Radiology	**6,658**	41,3			
Urology	**2,381**	27.8			
Nephrology	**944**	50,8			
Clinic or other group practice—not GPPP	6,795	33.8			
Other medical specialties	6,515	32.4			
Other surgical specialties	4,398	18.2			

SOURCE: US Department of Health and Human Services, Health Care Financing Administration, HCFA Fact Sheet January 1985

Table C-3.—Monthly Beneficiary Premium for Medicare Part B Coverage

Period	Premium	Inflation adjusted premium (1980=100) [a]	Annual increase above inflation (percent change)
Fiscal year 1980	$ 9.60	$ 9.60	NA
Fiscal year 1981	11.00	9.98	3.96
Fiscal year 1982	12.20	10.44	4.61
Fiscal year 1983	13.50	11.22	7.47
Calendar year 1984	14.60	11.72	4.46
Calendar year 1985	15.50	—	—

[a]Premlum deflated by Consumer Price Index forUrban Wage Earners and Clerical Workers forthecalendar year, aspubllshed in US Department of Labor, Bureau of Labo Statistics, *Monthly Labor Review*, September 1985

SOURCES US Department of Health and Human Services, Health Care Financing Administration, *Medicare Program Stat/stics 1981* (Washington, DC U.S Government Printing Office, 19&3); and 49 FR 38511

age increase in Social Security cash benefits. As a result by **1978,** the percentage contribution of premiums to Part B costs had dropped below **25** percent (164).

The Tax Equity and Fiscal Responsibility Act of **1982** and the Social Security Amendments of **1983** (Public Law 98-21) temporarily suspended the limitation and increased Part B basic premiums as of calendar year **1984** to a level that results in premium revenues equal to **25** percent of program costs. The Deficit Reduction Act of 1984 extended the requirement that the Part B premium produce income equal to 25 percent of program costs through 1987, with the constraint that the increase in the Part B premium may not exceed the dollar amount of the Social Security cost-of-living adjustment (49 FR 38510).

Almost **80** percent of Medicare enrollees 65 years of age and over used physician services in 1982 and **60** percent of Medicare enrollees met the initial deductible **(495),** In any year, the beneficiary has to incur an initial expense—a deductible—before Medicare will pay for Part B services. In 1982, the deductible was raised from the first **$60** to the first $75 of approved charges in a calendar year. Coinsurance is applied each time physician and other Part B services are used and is **20** percent of the remainder of approved charges after the deductible is satisfied. The deductible and coinsurance per enrollee for 1984 was estimated to average at $236, which is an increase of 143 percent from 1977, when they were $97 (see table C-4).

Beneficiaries also incur costs when physicians do not accept assignment, since the beneficiary is liable for any difference between the physician's billed charge and Medicare's payment for the service (reasonable charge reduction on unassigned claims). HCFA esti-

Table C-4.—Medicare Supplementary Insurance: Estimated Total and Per Enrollee Cost-Sharing for the Aged, 1977-84[a]

Year	Total in millions					Per enrollee[b]					
	Deductible	Coinsurance	Total copayments	Potential liability from unassigned claims[c]	Total cost-sharing	Deductible	Coinsurance	Total copayments	Annual SMI premium	Total cost-sharing	Potential liability from unassigned claims[c]
1977, ...	$ 969	$1,244	$2,213	$ 804	$3,017	$42	$54	$97	$89.40	$186.40	$32
1978	1,011	1,454	2,465	912	3,377	43	62	105	95.40	200.40	35
1979	1,055	1,736	2,791	1,158	3,949	44	72	116	96.65	212.65	43
1980	1,103	2,112	3,215	1,538	4,753	45	86	131	101.40	232.40	56
1981	1,148	2,576	3,724	1,873	5,597	46	103	148	123.60	271.60	67
1982	1,525	3,235	4,760	2,281	7,041		126	186	139.20	325.20	80
1983	1,571	3,967	5,538	NA	NA	60	152	212	146.40	358.40	NA
1984[d]	1,616	4,678	6,294	NA	NA	61	175	236	175.20	411.20	NA

NA = Data not available.
[a]January 1984 current law estimates of copayment amounts based on incurred charges. Data are subject to revision.
[b]Average annual enrollment is used to calculate these items.
[c]Includes both aged and disabled beneficiaries, "Potential liability" refers to the fact that physicians who do not accept assignment are free to pursue payment Of their billed charges in excess Of the Medicare approved charges from the beneficiary, but it is not known how many actually do so.
‘Projected.

SOURCE: D.R. Waldo, and H.C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-64," *Health Care Financing Review* 6(1):1-29, Fall 1964. U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin,* Annual Statistical Supplement, 1962, Table 145 (Washington, DC: 1964).

mates that the reasonable charge reduction on unassigned claims has increased from $31 per enrollee in 1977 to $85 per enrollee in 1983 (a 214-percent increase) (563).

Of the per capita expenditures on physician services by the aged projected for 1984, the Medicare program is expected to spend 58 percent. The beneficiary out-of-pocket component, when defined as the deductible, coinsurance, and reasonable charge reduction, was estimated to be 26.1 percent of the per capita expenditure in 1984 (563). When the Medicare premium and the payments to the deductible made by Medicare beneficiaries who do not meet the deductible are included, Medicare beneficiaries are estimated as paying 60 percent of the cost of physician services under Part B (8).

Most of the elderly participants in Part B have some form of supplemental "Medigap" private insurance.[23] By 1977, approximately 66 percent of the elderly population had some type of private health insurance to supplement their Medicare benefits (558). Private insurers annually paid $117 in 1984 ($48 in 1977) for physician services for elderly Medicare beneficiaries (563). Most policies are supplementary to Medicare coverage and limited to paying for deductibles and coinsurance ("Medigap"), although there are other forms of "Medigap" insurance that are more comprehensive. To the extent that beneficiary unassigned liability is actually collected, the payment of deductibles and coinsurance by Medigap tends to dilute control of beneficiary use of Part B services through cost-sharing,

Medicaid Payment for Physicians' Services

The Medicaid program was authorized in 1966 under Title XIX of the Social Security Act as a social welfare program to provide medical assistance to certain categories of low-income people, including the elderly, the blind, the disabled, and members of families with dependent children (the categorically needy). Medicaid is a joint Federal-State program that is administered by individual States under general Federal guidelines that include minimum benefits that must be available to eligible recipients and optional benefits that individual States may elect for their recipients.

Both the individual States and the Federal Government provide program funds; the Federal Government contributes "matching funds" for the categorically needy, and, if the State chooses, for the medically indigent.[24] The Federal Government's current contribution to Medicaid payment is estimated at an average of 53 percent with a range from 50 to 78 percent among the States (236,563).

State Medicaid programs have considerable discretion in the method to determine payment levels and can use adaptations of either the maximum fee screen method (CPR) or fee schedules. In early 1982, 25 Medicaid programs used various adaptations of the CPR method, 12 of which reimbursed at below Medicare's 75th percentile of prevailing charges (255). The States vary in how often they update prevailing charges, the data sources they use to establish physician profiles, and the percentile at which they set the prevailing charge (214). For example, Medi-Cal (the California Medicaid program) at one time defined the prevailing charge as the 60th percentile in contrast with the 75th percentile then used in the Medicare program (430). State Medicaid programs are required to use the MEI as a screen to limit the rate of increase in prevailing charges (214).

In 1982, 24 States reported using a fee schedule (255). Some States derive their fee schedule from Medicare or private insurance payment levels and adjust the schedule over time. Others base the fee schedule on a relative value scale and a conversion factor of their choosing (214). Two States reported using this methodology in 1982 (255).

Although in 1979, almost an equal number of States based payment levels on fee schedules as those that used the CPR methodology, 7 of the Nation's 10 largest Medicaid programs used fee schedules, and States with fee schedules accounted for 68 percent of all Medicaid expenditures. States that employed fee schedules increased their fees much less frequently than States that used the CPR methodology to establish payment levels (214).

The fee levels in the Medicaid program average only 72 percent of Medicare levels and areas low as 49 percent in some States (204). The State Medicaid programs **vary** widely in payment levels. When an adjusted weighted average fee for each State adjusted for the cost of living is used, statewide fee indices that aggregated fees across 41 procedures varied from $108.04 for Nevada to $21.68 for Pennsylvania (214). The Medicaid programs also vary according to medical specialty and geographic area (214). For example, payment for an appendectomy performed by a general practitioner ranged from a low of $100 in Pennsylvania to $512.89 in Nevada (255).

[23]For a comprehensive discussion of supplementary medical insurance, see app. F of the October 1982 OTA report *Medical Technology Under Proposals To increase Competition in Health Care (483).*

[24]The medically indigent are individuals who meet categorical requirements for Aid to Families with Dependent Children and Aid to the Aged, Blind, and Disabled, but have incomes that a State considers too high to be eligible for cash assistance, but not sufficiently high to pay medical bills

Physicians who provide medical care to Medicaid recipients cannot bill recipients, but must accept Medicaid payment as payment in full (236). Medicaid recipients in States with low Medicaid payment levels and low rates of physician participation are more likely to receive care in hospital outpatient departments and clinics, which are usually more expensive than physician's offices (170).

Physician fee freezes are utilized by many State Medicaid programs to control program costs. As of July 1984, 17 States had frozen physician fees for 1985 at the allowable rates established for 1984 or an earlier year (214). Some State programs have frozen fees for many years. For example, except for certain procedures, Florida has not increased physician fees since 1983, Michigan since 1977, and Ohio since 1972. Louisiana has frozen fees for 2 years and intends to initiate a flat fee system. Although New York State has frozen physician fees, there is legislation pending to increase physician fees for primary care services (214).

In addition to fee-for-service physician payment, State Medicaid programs also have the authority to contract with federally qualified HMOs and with comprehensive medical plans. However, the influence of HMOs has been small; as of September 30, 1984, there were only 65 HMO Medicaid contracts in 21 States (229). Until recently, payment to the HMOs was on a cavitation basis only[25] and no more than 50 percent of the enrollees in a contracting HMO could be Medicaid or Medicare beneficiaries.[26] The Omnibus Reconciliation Act of 1981 increased the maximum proportion of Medicare and Medicaid beneficiaries to 75 percent, with provisions for a waiver in special circumstances. Furthermore, regulatory reform efforts have relaxed regulations governing Medicaid reimbursement to HMOs and established procedures for States to contract with HMOs for services provided to Medicaid beneficiaries on a cost[27] as well as on a cavitation basis.

Until October 1, 1982, when the Arizona Health Care Cost Containment System (AHCCCS) became operational, Arizona was the only State without a Medicaid program. The purpose of AHCCCS is to develop and test an alternative payment and delivery system that is based on cavitation, competition among providers, and a network concept of primary care. AHCCCS contracts with both the public sector (county government) and with the private sector (including individual practice associations (IPAs) and other HMOs) to provide basic health services to individuals in the Aid to Families with Dependent Children program, individuals on Supplementary Security Income, and single individuals with less than $3,200 annual income (238). The program appears to be encountering problems with respect to costs, the providers' financial performance, and quality of care, and HCFA is imposing tighter controls on its operation (198).

The Arizona experiment illustrates some of the changes taking place in the payment and delivery philosophy of the Medicaid program. As described above, the Medicaid program historically has paid physicians on a fee-for-service basis with care delivered by the private delivery system. Beneficiaries have had little or no cost-sharing requirements and were allowed free choice of providers. In the last few years, States, with support from the Federal Government, have turned to systems of case management combined with payment on a cavitation basis, restrictions on physician choice, and beneficiary cost-sharing in attempts to contain costs (235).

The Omnibus Reconciliation Act of 1981 wrought a major change in State Medicaid programs by modifying Medicaid's long-standing provisions that gave recipients the freedom to obtain services from any provider. As of June 1984, 24 States had restricted recipients' access to all providers by limiting freedom of choice, by requiring recipients to obtain services from a primary care provider or "gatekeeper," or by requiring recipients to receive care only from providers with whom the State had contracts (214). Six of the State programs are in the demonstration or pilot stage. Of the 14 States that will reimburse only those providers with whom the State has a contract, 3 States have limited the provision to selected services, and 1 State has applied the provision only to 6,000 Medicaid recipients enrolled in HMOs (214).

Other changes from traditional Medicaid payment procedures include cavitation programs and recipient cost-sharing.[28] Twelve States now have provisions for paying physicians on a cavitation basis rather than traditional fee-for-service; four of the States have demonstration cavitation programs. And, as of July 1984, 25 States collected a copayment or deductible from Medicaid recipients for selected services that vary from State to State. States have also provided medical care for some recipients by enrolling them in HMOs; 23

[25] Although th, Social Securit, Act did not expressly forbid reimbursement arrangements from being on a cost basis, regulations governing Medicaid payment to HMOs (42 CFR 431.524) required that all such contracts be on a risk basis.

[26] Social Security Act, Section 1903(m).

[27] 48 FR 54013, final ru]e establishing new Section 42 CFR 434.

[28] ZeThe Tax Equity and Fiscal Responsibilit, Act of 1982 (TEFRA) altered Medicaid cost-sharing requirements so that States now have the option to require copayment, coinsurance, or deductibles for almost all services to both the categorically needy and the medically needy with certain exceptions, such as categorically needy who are enrolled in an HMO. The regulations also state that no provider participating in the Medicaid program may deny care or services to individuals because of their inability to pay the cost-sharing charges.

States had exercised this option for some of their recipients as of July 1984 (214).

Conclusion

Medicare's payment method for physician services can be characterized as a predominantly fee-for-service system, which, in comparison with Medicaid and private health insurance, has remained relatively unaltered in the past 20 years. Until July of 1984, when a temporary freeze on physician fees went into effect, Medicare's major efforts to control physician payment were to reduce the level of prevailing, to delay the updating of physician fees, and to apply the MEI (which became effective in 1976).

The prescribed method for computing physician payment based on reasonable charges as determined by the CPR method is extremely variable among Medicare carriers because of the decentralized mechanism established in law and regulations. The variation extends to the delineation of charge areas and the specification of prevailing charges depending on medical specialty.

The Medicare program has been flexible in its payment method on a national level. The program has adapted CPR for special conditions, e.g., paying hospital-based physicians. Morever, Medicare has veered from the traditional fee-for-service method, and for some special services (maintenance kidney dialysis and ambulatory laboratory services) has paid physicians on other bases. Medicare has also contracted with HMOs on a cost or cavitation basis for physician and other services.

Physician financial involvement in Medicare is influenced by payment practices. The data on physician participation indicate that the number of physicians accepting assignment on a claim-by-claim basis is rising slowly, with extreme variation among medical specialists and among States. Similar variation exists among physicians who have become "participating physicians" in Medicare, i.e., they have agreed to accept assignment for all services provided to Medicare beneficiaries.

Over the years beneficiaries' financial liability for physician charges has increased. As a result many elderly Medicare beneficiaries have purchased supplemental medical insurance (Medigap).

The other major Federal third-party payment system, Medicaid, differs from Medicare with respect to physician payment historically in having used two ways of setting payment levels, CPR and fee schedules. Almost an equal number of States use each method. Typically, Medicaid pays physicians at a lower rate than Medicare. Another difference is that in the past few years, States, with support from the Federal Government, have used innovative ways of paying physicians and organizing the delivery of medical care. Many States are using systems of case management and restrictions on physician choice as cost-control methods.