

policy points

Medicare Payment Cuts As Medicare reimbursement rates drop, some physicians are not willing to serve Medicare patients. Although the service shortage does not seem widespread, a careful look at how rates are established is due.

BY JEFF ATKINSON



Mariana Halsan of Olympia, Washington stood with members of

her Congressional delegation and told the story of her 82-year-old friend who lost her doctor and was turned down by 15 other physicians. The friend then became more creative in her quest for a primary care physician, drafting a resume and cover letter to “apply” to physicians in her community to be accepted as a patient. The woman finally did find a new physician. As recounted by the

editorial page of Washington State’s *The Olympian*, Ms. Halsan said in a wealthy society, senior citizens should not have to beg for medical care.

Meanwhile, the [American College of Physicians and the American Society of Internal Medicine](#) have issued projections that the recent cuts in reimbursement rates for physicians who treat Medicare patients will cost the typical solo

general internist \$7,884 per year and will cost a typical solo geriatrics practitioner \$30,630 per year. In addition to loss of compensation for physicians, the physicians’ associations said that the cuts in Medicare reimbursements would force physicians to lay off nurses, billers, and clerical workers.

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rates for physicians were cut by 5.4 percent in 2002 and are projected to be cut again by 4.4 percent in 2003.

Refusing new patients

Physicians’ organizations are saying that the reduction in rates is leading to fewer physicians being willing to care for Medicare patients. The scope of the problem is uncertain, but it seems to be particularly pronounced in Washington State and Colorado. In Colorado, a study of 900 physicians indicated that more than 40 percent of family physicians will not accept new Medicare patients. Nationwide, the [American](#)

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Reimbursement rates in different parts of the country

The rates Medicare pays physicians vary from region to region, depending on the cost of practicing medicine in the 89 regions established by the Centers for Medicare and Medicaid Services (CMS). Here are examples of reimbursement rates in 2002 for three different areas and the national average.

CPT Code	SERVICE	NORTH DAKOTA	CHICAGO	MANHATTAN	NAT'L AVG.
99203	Office visit new patient	\$83.66	\$99.34	\$112.67	\$91.95
99213	Office visit moderate level	\$45.73	\$54.16	\$62.09	\$50.32
76092	Mammogram (global)	\$73.04	\$90.01	\$105.05	\$81.81
45378	Colonoscopy (diag)	\$412.00	\$498.16	\$588.48	\$459.37
66984	Cataract removal	\$611.62	\$717.66	\$813.79	\$669.32
27130	Hip replacement	\$1,306.25	\$1,611.28	\$1,807.25	\$1,452.31

Sources: Physician Billing Solutions, LLC, Skokie, IL, and Centers for Medicare and Medicaid Services (CMS)

Association of Family Physicians said that the number of physicians not accepting new Medicare patients was 17 percent in 2000.

Officials at the **Centers for Medicare and Medicaid Services** (CMS) caution that one should not read too much into those studies. Although physicians in Colorado and elsewhere may not be taking new Medicare patients, many of those physicians also are not taking any new patients because their practices are full. They also note that the percentage of physicians willing to accept assignment for treating Medicare patients has risen every year from 1993 (62.1 percent) to 2002 (89.8 percent).

Federal officials acknowledge that there is some degree of access problem, particularly in Denver and Seattle. CMS said it is studying the issue by reviewing billing records in different parts of the country, surveying Medicare beneficiaries, and monitoring complaints made to 1-800-Medicare. CMS also is working with medical societies, physicians' practices, and individual physicians

to reduce the administrative burden on physicians. The federal government, however, has not yet changed reimbursement rates as a result of the reported access problems.

Attempt at a quick-fix

In May of this year, Washington Senators Patty Murray and Maria Cantwell tried to obtain a quick-fix

An RVU is the sum of three components: physician work, practice expenses, and malpractice insurance.

(or at least attention) for their state by introducing the "**MediFair Act of 2002**" (S. 2568). The bill took a Robin Hood approach by directing the Secretary of Health and Human Services to, in effect, take money away from the states with high reimbursement rates and give it to the states with low reimbursement rates.

Under the proposal, the govern-

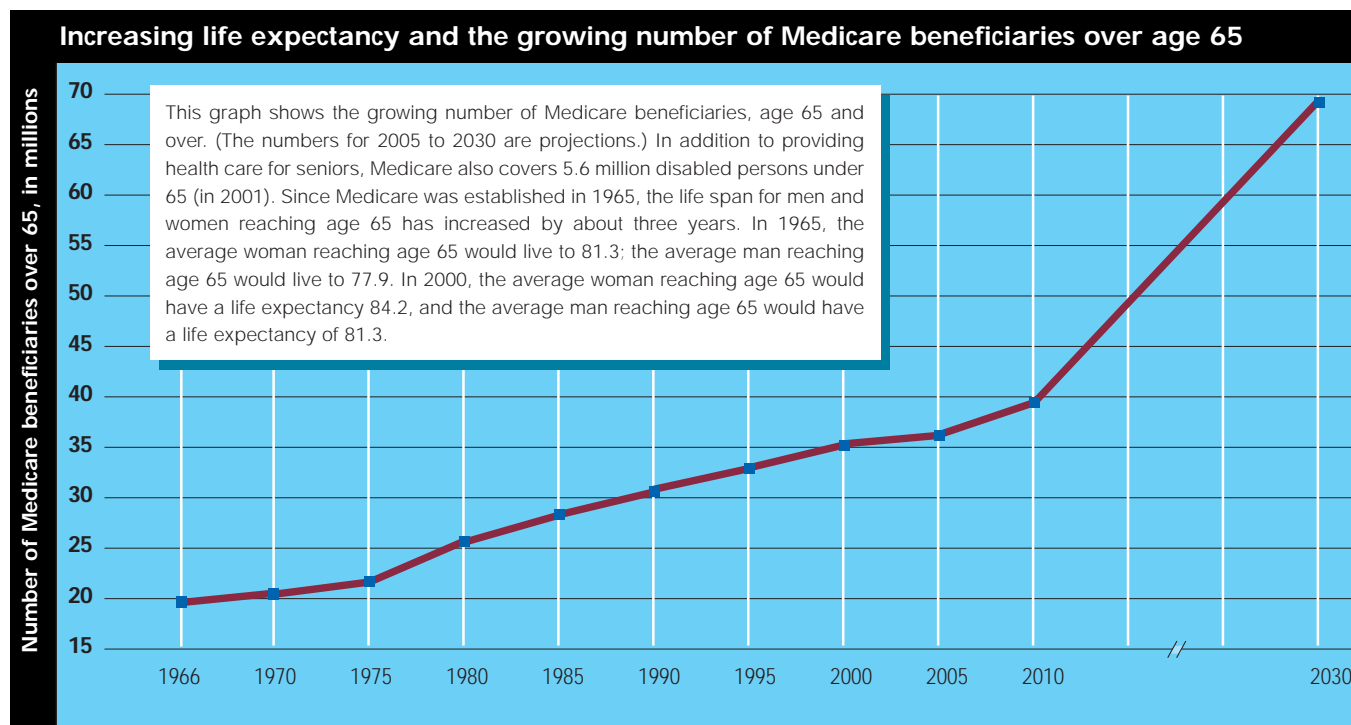
ment would shift payments so that no state would receive less than the national average, which would make all states equal, regardless of the varying cost of delivering health care in the different states. A state could obtain above-average payments if it could show that "quality care measurements . . . are being used to improve access of beneficiaries to quality care." The bill's chances of passage are nil, for among other reasons, congressmen from states with above-average reimbursement rates will not be inclined to take money from their states for the benefit of other states.

Complicated formula

Medicare reimbursement rates are set by use of a complicated formula that takes into account the cost of practicing medicine in different parts of the country. The amount that Medicare will pay for an individual service can vary by as much as 38 percent depending on where the service is performed. (See "**Reimbursement Rates**".) For example, a surgeon performing hip

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Sources: Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics, Congressional Budget Office, and Government Accounting Office.

replacement surgery in North Dakota will be paid \$1,306, while a surgeon performing hip replacement in New York will be paid \$1,807.

The process of setting fees for physicians under Medicare involves an alphabet soup of acronyms, the first of which is RVUs (Relative Value Units). Each of the more than 7,000 services paid under the physicians' fee schedule has an RVU, and each service also has a CPT (Current Procedural Terminology) code.

An RVU is the sum of three components: physician work, practice expenses, and malpractice insurance. (For more details about RVUs, see ["The Making of an RVU."](#))

The second step to the determination of fees is multiplication of RVUs by the Geographic Practice Cost Index (GPCI) an index used to measure different costs of the three components in 89 geographic regions of

the country. For example, the government surveys rental rates, employee wages, and malpractice insurance rates in different localities to determine the GPCI. The indexes are reviewed and then adjusted as needed every three years. If a physician is serving in a locality designated as a Health Professional Shortage Area (HPSA), typically a rural area or inner-city area, the physician will receive a 10 percent bonus.

The third step to determining fees for a particular service is the National Dollar Conversion Factor. The product of the RVU and GPCI is multiplied by the conversion factor. The conversion factor is determined by the Centers for Medicare and Medicaid Services with reference to what it calls a Sustainable Growth Rate (SGR), which in turn encompasses several factors including, the growth of the economy, the rate of

inflation for medical goods and services, the growth in the number of fee-for-service Medicare beneficiaries, and changes in laws and regulations. (For a chart showing the growth of the Medicare population, see ["Increasing life expectancy and the growing number of Medicare beneficiaries over 65."](#))

Checks and balances

Federal regulators are aware of the possibility of what might be called "RVU-creep." Just as the average of academic grades tended to creep up in recent years, so too have RVUs crept up as physicians argue that the value of a particular service is more than what is reflected by the service's current RVU. If adjustments to payment schedules were not made, reimbursement rates would climb indefinitely with the increases in the numerical value of RVUs. To

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solve that budgetary problem, Congress directed that if changes in RVUs will result in an increase or decrease in Medicare spending by more than \$20 million in one year, CMS must apply the conversion factor so that changes in RVUs will be budget-neutral.

With the condition of the economy uncertain and the return of budget deficits, Congress is understandably wary about spending more money on existing programs, including Medicare. At the same time, Congress may be even more concerned if it hears from more constituents like the 82-year-old from Washington State who are having trouble obtaining medical care because doctors are unwilling to work for the rates offered by Medicare. Congress is likely to allocate more funds for Medicare, but it also will need to make some hard choices about how to pay for increased rates such as through increased Medicare taxes or raising the age of eligibility for Medicare. ■

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The making of an RVU

Federal law requires that each of the more than 7,000 services for which physicians are reimbursed have its own Relative Value Unit (RVU). The RVU is a key component in determining how much a physician will be paid for a particular service. The calculation of the amount of fee also includes adjustments for the cost of practicing medicine in different geographic areas. The following are the three components and the main sub-indices for determining RVUs, as well as for determining the Geographic Practice Cost Index (GPCI). The percentages in parenthesis indicate the proportion of the total practice cost for each item. ■

- 1. Physician work**
(54.5 percent)
 - time of physician's effort
 - intensity of physician's effort
- 2. Practice expense**
(42.3 percent)
 - employees' wages (16.8 percent)
 - rent (11.6 percent)
 - office equipment, supplies, and miscellaneous (13.9 percent)
- 3. Malpractice**
(3.2 percent)
 - medical malpractice premiums