Development of the Resource-Based Relative Value Scale

The resource-based relative value scale (RBRVS) payment schedule was fully phased in on January 1, 1996. The system's most significant changes to Medicare physician payment occurred during 1992, the first year of implementation; however, numerous legislative and regulatory provisions have been adopted since then that have had a major effect on the Medicare RBRVS. In addition, relative payment levels have continued to shift throughout the transition to the full-payment schedule. As a result, many physician practices have had to make major readjustments.

The transition to Medicare's RBRVS-based physician payment system began on January 1, 1992, culminating nearly a decade of effort by the medical profession and the government to change the way Medicare pays for physicians' services. Interest in changing the payment system for Part B of Medicare, which covers physicians' services, was initially motivated by steep annual increases in Medicare expenditures. Pressure to change the Part B payment system increased following the 1983 im-plementation of "prospective pricing" for the hospital portion of Part A, which covers inpatient hospital and nursing home services.

Three factors combined to heighten interest in physician payment reform between 1983 and the adoption of the 1989 payment reform legislation: rising dissatisfaction with Medicare's original payment system; continued escalation in Part B costs; and the promise of a credible basis for a new payment schedule-RBRVS. This overview describes these three factors, including the rationale for organized medicine's involvement in RBRVS development, the alternative payment reform approaches considered by physicians and the federal government, Phase I of the Harvard University RBRVS study, and the events that followed pub-lication of the Phase I Final Report in the autumn of 1988.

The Profession's Interest in an RBRVS

In 1992, payments for physicians' services comprised about 81% of expenditures for Medicare Part B, with the remainder divided among clinical laboratory services, durable medical equipment, hospital outpatient services, drugs, managed care services, and several other Medicare benefits.[1] The move to an RBRVS physician payment schedule (MFS*) represented the most significant change in Part B since Medicare's inception in 1966. (*Note: From the American Medical Association's [AMA's] perspective, the distinction between a "payment schedule" and a "fee schedule" is extremely important: a ***payment*** is what physicians establish as the fair price for the services they provide; a ***fee*** is what Medicare approves as the payment level for the service. Therefore, the AMA has opted to use the term "payment" where appropriate, instead of "fee" in reference to the Medicare physician fee schedule [PFS] and has abbreviated the acronym to "MFS.") For 25 years, Medicare physician payment was based on a system of "customary, prevailing, and reasonable" (CPR) charges.

The CPR system (which will be referred to as the CPR henceforth) was designed to pay for physicians' services according to their actual payments, with some adjustments to keep government outlays predictable. It was based on the "usual, customary, and reasonable" (UCR) system used by many private health insurers. Medicare defined *customary charges* as the median of an individual physician's charges for a particular service for a defined period of time. The *prevailing charge* for this service was set at the 90th percentile of the customary charges of all peer physicians in a defined Medicare payment area. (The CPR was specialty specific.) The *reasonable charge* was defined as the lowest of the physician's actual payment for the service, that physician's customary charge, or the prevailing charge in the area.

Problems with CPR

Due to the diversity in physicians' payments for the same service, the CPR system allowed for wide variation in the amount

Medicare paid for the same service. The insurance companies that process Medicare Part B claims, known as Medicare carriers, added to this diversity through their own policies. For example, some carriers paid only one prevailing charge per service, while others paid a different prevailing rate for each physician specialty providing the service. As a result, wide variations in Medicare payment levels developed among geographic areas and physician specialties.

Although these variations initially caused some dissatisfaction within the medical profession, the dissatisfaction reached a crescendo between the mid-1970s and the mid-1980s when Medicare placed a series of controls on the CPR payment levels. Designed to stem the growth in program costs, the first of these controls progressively reduced prevailing charges from the 90th to the 75th percentile. It was followed by an extension of the federal government's wage and price freeze on payments for physicians' services.

After lifting the freeze, the government implemented a new control in 1976, when it tied increases in prevailing charges to increases in the Medicare economic index (MEI). The MEI is intended to measure annual growth in physicians' practice costs since 1973 (prevailing charges in 1973 were in turn based on 1971 actual charges) as well as general earnings trends in the economy.

The major effect of the price controls and the MEI limit was to make permanent the basic pattern of Medicare prevailing charges that existed in the early 1970s. This pattern remained virtually unchanged until 1992. Payments per service were, therefore, unresponsive to changes in clinical practice and technology. Although compensation levels for new, high-technology procedures were generally commensurate with their high initial cost and limited availability, many physicians believed that payment increases for visits and consultations lagged far behind increases in the complexity and cost to diagnose and manage Medicare patients. Because compensation for new procedures remained relatively high even when their relative costs declined over time and compensation for visits remained relatively low while their relative costs increased, relative payment levels were thought to have become distorted.

Payment levels also remained stable across geographic areas. Consequently, as innovations in clinical practice and technology spread to rural and suburban areas, compensation did not increase. As a result, payment differences among Medicare localities, states, and regions remained, generally reflecting charge patterns that prevailed during the 1970s, despite changes in practice or demographics. Thus, Medicare often paid physicians in neighboring regions and states with similar costs of practice at very different levels for the same service.

As the prevailing charges became increasingly outdated, physicians in primary care specialties and rural areas, in particular, began to call for change. A new set of the CPR changes occurred in the 1980s. These included a second freeze on payment levels accompanied by limits on physicians' actual charges and reduced payments for surgical procedures deemed to be "overpriced." The CPR changes brought more calls for payment change to physicians in other specialties and geographic areas and accelerated interest in long-term, comprehensive physician payment reform. Because of the many constraints on the CPR, Medicare's physician payment system had become complex, confusing, unpredictable, and unrelated to physicians' actual payments, producing exactly the opposite result from what the CPR's architects had intended.

Options for Change

In the mid-1980s, as physician dissatisfaction with the CPR continued to grow and government policymakers produced several payment reform proposals, the medical profession faced several options for change:

- Modifying the CPR
- Extending the new approach introduced for hospitals under Part A of Medicare, diagnosis-related groups (DRGs), to physicians' services
- Mandating Medicare's health maintenance organization (HMO) program or other capitation approaches to be the dominant means of payment under Part B
- Replacing the CPR with a payment schedule based on a relative value scale (RVS)

Each option had its supporters and critics. Support was generally divided between physicians who wished to maintain the status quo by modifying the CPR and those seeking to develop a payment schedule based on an RVS. Under such a schedule, Medicare would pay a standardized "approved amount" for each service regardless of the physician's payment for the service, rather

than basing payments on individual physician's payment as they originally had been under the CPR. (The Medicare "approved amount" includes both the 80% that Medicare pays and the 20% patient coinsurance.) Although Medicare would pay a standardized approved amount, physicians would still be able to charge patients their full payment. The difference between the Medicare-approved amount and the physician's payment is called the *balance bill*.

In an HMO-based system, HMOs receive a monthly Medicare payment for each beneficiary enrolled in the organization. The HMO pays physician and hospital services but usually limits patients' choices of physicians and hospitals.

Under the hospital DRG system, the hospital receives a standardized amount for each patient admitted with a particular diagnosis. The standardized amount represents the average hospital's cost to provide the average bundle of services required to treat patients with that diagnosis. Although a physician DRG system would vary from the hospital DRG system, the basic concept of bundling or packaging services covered by a single payment would be the same.

Of the four major payment reform options, only the CPR and a payment schedule are payment-for-service systems. Many medical professionals felt that preserving payment-for-service under Medicare was critical to protecting physicians' clinical and professional autonomy. Although the AMA supported a pluralistic payment system, it believed that adopting physician DRGs or mandatory capitation for Medicare, given the program's size, would severely threaten physicians' ability to use their own professional judgment in patient care decisions.

Historically, the AMA had also opposed policies to restrict or eliminate physicians' ability to charge patients the difference between their payment and the Medicare-approved amount. A DRG- or capitation-based system for physicians' services would, by definition, impose mandatory assignment, a policy requiring physicians to accept the Medicare-approved amount as payment in full, thereby prohibiting balance billing.

To preserve payment-for-service as a viable option under Medicare, the AMA pursued two parallel tracks. First, using lobbying efforts to influence legislation and litigation challenging the legality of various statutory provisions, the AMA tried to eliminate or mitigate the most onerous aspects of the CPR, including the payment limits, the Physician Participation Program, and the payment reductions. Second, it sought to develop a new RVS and the policy basis for its implementation, if appropriate. The first track achieved only limited success because Congress was reluctant to enact changes that would increase beneficiary expenses, and the courts upheld congressional authority to limit physicians' payments.[2]

The basis for the RVS. An RVS is a list of physicians' services ranked according to "value," with the value defined with respect to the basis for the scale. Using an RVS as a basis for determining payments and payments is a familiar concept for physicians and insurers. The California Medical Association (CMA) developed the first RVS in 1956 and updated it regularly until 1974. Beginning in 1969, the California relative value studies (CRVS) were based on median charges reported by California Blue Shield. Physicians used the CRVS to set payment schedules, and several state Medicaid programs, Blue Cross/Blue Shield plans, and commercial insurers used it to establish physician payment rates. In the late 1970s, however, Federal Trade Commission (FTC) actions raised concern that the CRVS might violate antitrust law, leading the CMA to suspend updating and distributing the CRVS.

Although many possible options existed for constructing a new RVS in the mid-1980s, the medical profession favored either a charge-based or a resource-based RVS. In a charge-based RVS, services are ranked according to the average payment for the service, the average Medicare prevailing charge, or some other charge basis. For example, if the average charges for service A is twice the charge for service B, the relative value for service A would be twice that of service B.

In a resource-based RVS, services are ranked according to the relative costs of the resources required to provide them. For example, suppose service A generally takes twice as long to provide, is twice as difficult, and requires twice as much overhead expense (such as nonphysician personnel, office space, and equipment) as service B. Then the relative value of service A in an RBRVS is twice that of service B.

An RVS must be multiplied by a dollar conversion factor (CF) to become a payment schedule. For example, if the relative value for service A is 200 and for service B is 100, a CF of $2 yields a payment of $400 for service A and $200 for service B. Likewise, a CF of $0.50 yields payments of $100 for A, $50 for B, and so on.

Most surgical specialty societies supported development of a charge-based RVS. These groups believed that physicians' payments provided the best basis for determining relative worth because payments reflected both the physician's cost of providing the service and the value of the service to patients. In addition, with readily available data, a charge-based RVS could easily become the basis for a payment schedule, thereby improving the degree of national standardization and eliminating the wide payment variations. However, experience with portions of the Harvard-RBRVS study that used charge data demonstrated

that such data contained errors and often produced anomalous and unreasonable results.

Most nonprocedural specialty societies also considered these factors but reached a different conclusion, which the AMA shared. These groups believed that in a well-functioning market, physicians' relative charges would reflect their relative costs. In their view, however, Medicare payment levels did not reflect the prices that would emerge from a well-functioning market. They believed that the wide gap between payments for visits and payments for procedures, as well as the wide variations in payments for the same service between geographic areas and specialties, failed to reflect differences in the costs of the resources necessary to provide them. They also believed that the constraints on Medicare payments, including the freezes, reductions in prevailing charges, and tying annual updates to the MEI, had further distorted charges, so that Medicare charges would not provide an appropriate basis for a new RVS.

After weighing all of these factors, the AMA decided to drop a charge-based RVS, concluding that it was likely to preserve the same historical charge pattern that generated the dissatisfaction with the CPR. The AMA believed that an RVS based on relative resource costs was more likely to equitably cover physicians' costs of caring for -Medicare -patients. In choosing to pursue the development of an RBRVS, the AMA also emphasized the following:

- Any RVS-based payment system must reflect the often-substantial variations in practice costs between geographic areas.
- Based on its long-standing policy, the AMA would strongly oppose any newly developed payment system that required physicians to accept the Medicare-approved amount as payment in full.

The AMA proposal to develop an RBRVS. The AMA believed that organized medicine's participation in the development of an RBRVS was a key factor in physician acceptance of such a system. In January 1985, after discussing the issue with the national medical specialty societies, the AMA submitted a proposal to the Centers for Medicare & Medicaid Services (CMS, formerly known as the Health Care Financing Administration [HCFA]—the government agency responsible for administering the Medicare program) to develop a new RVS based on resource costs with extensive involvement of organized medicine and practicing physicians. Responding two months later, CMS said that despite its desire to involve organized medicine in developing an RBRVS, antitrust considerations raised by the FTC precluded a direct contract between CMS and a physicians' organization.

Because CMS had stated its intention to contract with a university or independent research center instead of a medical organization, the AMA discussed the possibility of jointly developing an RBRVS with several major universities. After careful consideration, the AMA accepted a Harvard University School of Public Health proposal for a "National Study of Resource-Based Relative Value Scales for Physician Services." It was similar to the AMA's earlier proposal and outlined an extensive role for the medical profession. With funding by CMS, Harvard began its study in December 1985.

The Government's Interest in an RBRVS

Through 1983, efforts to curtail the growth in Medicare spending focused principally on reducing expenditures for inpatient hospital care. Although Part B expenditures had been rising steeply each year, physicians' services accounted for only about 22% of Medicare spending, while hospital services accounted for about 70%. Hospital cost containment efforts, which curbed construction, admissions, length of stay, and intensity of services, had greater potential to reduce total Medicare spending than efforts to reduce spending on physicians' services.

The prospective payment system (PPS), introduced in 1983 to pay for Medicare patients' hospital costs, provides a standardized payment for each hospital admission, with variations to reflect geographic differences in wage rates and hospital location (urban or rural). The PPS authorized additional payment for "outlier" cases requiring exceptionally long stays or high costs. Admissions are categorized according to approximately 850 DRGs with payment based on the national average cost of hospital care for patients with a particular diagnosis.

The PPS assumes that hospitals care for patients whose severity levels range from mild to high within each DRG. While it is recognized that some patients' care will cost more than others, in the long run the cost of caring for all patients within a DRG is expected to equal the average approximate payment for the DRG. Because the DRG payment is the same regardless of the hospital's actual cost to provide care for a particular patient, prospective pricing provides an incentive for hospitals to improve their cost-efficiency.

Government policymakers view PPS as a success because the average annual growth rate in Medicare expenditures for inpatient hospital care decreased from 18% between 1975 and 1982 to 7% between 1983 and 1990. However, the extent to which PPS is solely responsible for this trend is unclear. In addition, those who believe that DRGs may adversely affect quality of care have been critical of PPS.

Governmental Options for Change

After the introduction of prospective payment, Congress and the Reagan administration turned their attention to reducing growth in Medicare spending for physicians' services, and the CPR system came under increasing attack. However, many physicians believed that CPR payments for primary care services and services provided in rural areas were inequitable. Although many members of Congress shared that view, other government and health policy officials criticized CPR as being inflationary. They argued that payment-for-service medicine encouraged overuse of services and that CPR encouraged overpricing of services, especially invasive and high-technology services.

Buoyed by the successful implementation of DRGs for hospitals, the government began exploring the feasibility of DRGs for physicians. In 1983, as part of the same law that created the prospective payment system for hospitals, Congress mandated that CMS study physician DRGs for Medicare and submit its report with recommendations by 1985.

In 1985, Congress also gave CMS authority to enroll Medicare beneficiaries in HMOs on a "risk-sharing" capitation basis. Previously, CMS could only enroll Medicare patients in HMOs using cost-based contracts, meaning that the HMO's capitation payment would rise or fall at year end depending on the actual cost of the services provided to Medicare enrollees. Under risk-sharing, if costs incurred by the HMO were less than the capitation payment, the HMO could retain up to 50% of the savings, but it would have to absorb 100% of any losses. By 1988, about 3% of Medicare beneficiaries had enrolled in HMOs and by 1999 that number had increased to more than 15% of Medicare beneficiaries. By 2005, this number had decreased to almost 12% enrolled in HMOs.

Expansion of HMOs for Medicare was partially a response to papers by health economists, published in the early 1980s, stating that the regulatory efforts of the 1970s had failed to control rising health care costs and calling instead for more competition in health care. The HMOs were viewed as the foundation of a more competitive system, in which employees and individuals enrolled in government entitlement programs could choose from a variety of HMO-type plans. Competition between these plans for enrollees would provide incentives for the plans to maintain low costs and premiums while providing high quality of care and amenities not offered by the Medicare payment-for-service program. CMS developed a strategy for increasing Medicare enrollment in HMOs and HMO-type plans, which it called the Private Health Plan Option. Despite strong support in Congress and the administration for mandating either DRG or HMO options for Medicare, the potential problems these options presented were also well known. For example, DRGs for physicians would be administratively complex and could produce serious inequities. In contrast to the approximately 579 DRGs for 5756 hospitals, more than 8000 codes describe the services that more than 800,000 physicians provide. Even if a DRG system could be developed for physicians' services, averaging DRG payments over the patient mix of a physician practice would be more difficult than it is for hospitals.

Recognizing these problems and responding to strong pressure from the AMA and organized medicine, Congress continued to explore payment-for-service options for Medicare physician payment reform. In the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272), Congress mandated that the secretary of Health and Human Services (HHS) develop an RBRVS and report on it to Congress by July 1, 1987. Simultaneously, however, legislation had been introduced in Congress to establish a DRG payment system for the major hospital-based physician specialties: radiologists, anesthesiologists, and pathologists.

Establishing the Physician Payment Review Commission

To evaluate the various physician payment reform options and to advise Congress, COBRA also created the Physician Payment Review Commission (PPRC). Composed of physicians, health policy researchers, and patient representatives, the PPRC's 13 members were nominated by the congressional Office of Technology Assessment. The PPRC's first meeting took place in November 1986.

The PPRC reviewed the options for Medicare payment reform, including changes in the CPR, physician DRGs, and expansion of capitation plans. It also studied international experience with physician payment, including the payment systems of Germany and Canada. The Commission's First Annual Report to Congress, submitted March 1, 1987, endorsed the concept of a payment

schedule for Medicare. One year later, the PPRC recommended that the payment schedule be based on an RBRVS. A minority opinion signed by three commissioners endorsed the concept of a Medicare payment schedule but opposed the decision to base the schedule on relative resource costs because the RBRVS study had not yet been completed.

Harvard RBRVS Study

With Congress considering proposals for physician DRGs and the Reagan administration advocating its Private Health Plan Option for Medicare, the PPRC's 1987 endorsement of an RBRVS-based payment schedule gave a much-needed boost to the medical profession's efforts to preserve payment-for-service payment under Medicare. The other major factor that bolstered support for this payment reform alternative was the Harvard University RBRVS study. In addition to its intense lobbying and grassroots efforts, the AMA's argument that Congress should wait for results of the study before undertaking any major reform of Medicare's payment system was a crucial element in defeating proposals for physician DRGs.

The principal investigators in the Harvard study, William C. Hsiao, PhD, and Peter Braun, MD, had conducted previous studies that provided the foundation for the CMS-funded RBRVS study. In a 1979 exploratory study, Hsiao and William Stason, MD, attempted to rank 27 physicians' services provided by five specialties according to the time each service required and the complexity of each unit of time. Study results suggested that physicians had difficulty distinguishing between duration and complexity in ranking services. Consequently, the study results were considered unreliable. In a second study conducted by Hsiao and Braun in 1984, physicians directly ranked the overall work involved in their services without distinguishing between time and complexity. Although this study produced more consistent rankings, problems developed with the scale that was used (ie, the closed numeric scale, from 1 to 100, led to unreasonably low values for lengthy procedures).

In the national study, which began in 1985, CMS initially funded the Harvard team to develop an RBRVS for the following 12 physician specialties:

- Anesthesiology
- Family practice
- General surgery
- Internal medicine
- Obstetrics and gynecology
- Ophthalmology
- Orthopedic surgery
- Otolaryngology
- Pathology
- Radiology
- Thoracic and cardiovascular surgery
- Urology

The following six additional specialties were independently funded and included in the study at the request of the relevant national medical specialty societies:

- Allergy and immunology
- Dermatology
- Oral and maxillofacial surgery

- Pediatrics
- Psychiatry
- Rheumatology

The scope of what came to be known as Phase I of the study was considerably broader than previous studies. Its objectives were to develop an RBRVS for each of the 18 specialties included in the study and to combine the specialty-specific scales into a single cross-specialty RBRVS. Although COBRA required the secretary of HHS to report to Congress on the development of this cross-specialty RBRVS by July 1, 1987, the Omnibus Budget Reconciliation Act of 1986 (OBRA 86, PL 99-509) extended the report's submission date until July 1, 1989. The following year, Congress expanded the study mandate to include an additional 15 specialties, which became Phase II of the Harvard study. Phase III refined estimates from the earlier phases and expanded the RBRVS to include the remaining services coded by the Current Procedural Terminology (CPT®) system. Because Phase III was not completed by the January 1, 1992, implementation date, CMS established a process involving carrier medical directors (CMDs) to assign work relative value units (RVUs) to about 800 services for which Phase I and II data were not available. Phase III data were also used as part of CMS' refinement process for work RVUs first published in the 1992 Final Notice as part of the November 25, 1992, *Federal Register*.

The AMA's Role in the RBRVS Study

Under the terms of its subcontract from Harvard, the AMA's major role in the RBRVS study was to serve as a liaison between the Harvard researchers, organized medicine, and practicing physicians. The AMA worked with the national medical specialty societies representing the studied specialties to secure physician nominations to the project's Technical Consulting Groups. These groups studied specialty-provided advice to the researchers, helped to design the study's survey of practicing physicians, and reviewed and commented on its results.

Drawing on its Physician Masterfile, the AMA also supplied representative national samples of practicing physicians in each of the studied specialties. Throughout Phases I and II, the AMA advised the Harvard researchers, and an AMA representative attended every meeting of the Technical Consulting Groups.

The AMA's liaison role ensured that the RBRVS was based on the experience of a representative national sample of practicing physicians and that the specialty societies, through representation on the Technical Consulting Groups, were involved in important aspects of the development of relative values for their specialties. Involvement of both the AMA and the specialty societies also enhanced the study's credibility with practicing physicians and helped to increase its acceptance among physicians after results became available.

One additional benefit of organized medicine's involvement in the study was the high level of communication about the study, its results, and its policy implications. From 1985 to 1991, the front page of *American Medical News* covered this subject at least six times each year. Articles also appeared regularly in the *Journal of the American Medical Association (JAMA);* specialty journals such as the *Internist* and the *Bulletin of the American College of Surgeons;* state journals such as *Ohio Medicine;* and major newspapers, including *The New York Times*.

Reaction to the Completion of Phase I

On September 29, 1988, nearly three years after the study's inception, Harvard submitted its final report of Phase I of the RBRVS study to CMS. An overview of the study ran simultaneously in the *New England Journal of Medicine*. The entire October 28, 1988, issue of *JAMA* was devoted to the study. In addition to a series of articles on the study's methods and results, as well as simulations of the impact of a payment schedule based on the Phase I results, the *JAMA* issue included editorials by AMA, CMS, and PPRC leaders.

With completion of Phase I, the debate over whether Medicare should adopt an RBRVS-based payment schedule for Part B reached a pivotal moment. There were passionate views on all sides. Many rural and primary care physicians called for immediate adoption of a new Medicare payment system; surgeons viewed the study more cautiously. Even though CMS had funded the study, CMS' then-Administrator, William R. Roper, MD, expressed several reservations about continuing payment-for-service payment under Medicare:

. . . we face substantial problems in controlling the overall growth in expenditures for physicians. A payment schedule based on a relative value scale, no matter how carefully constructed, cannot be expected to address the growth in the volume and intensity of services. Whatever their merits, payment-for-service systems do not provide physicians with incentives to control this growth.[3]

The AMA's reaction to the study affirmed its belief that Medicare should adopt a payment schedule based on an appropriate RBRVS, but it reserved judgment about whether the Harvard study should serve that purpose. In his *JAMA* editorial on the subject, James S. Todd, MD, the AMA's then-Senior Deputy Executive Vice President, stated:

We went into this study with our eyes open. We have not wavered in our support for completing this study, or in our insistence that the AMA has no prior commitment to support its results or implementation.

. . . there must be external review and validation of the study's credibility, reliability, and validity. No less important will be the consideration of whether and how this academic research should be translated into the cold, hard realities of Medicare policy. The medical profession must and will assume a leading role in both of these endeavors.[4]

AMA Policy on the RBRVS Study

Immediately after the study's release, the AMA began an intensive evaluation to determine whether it could support the Harvard RBRVS as the basis for a Medicare payment schedule. It conducted an internal evaluation of the study's final report and retained the Consolidated Consulting Group, Inc, to provide an independent assessment of the RBRVS study. In November 1988, the AMA convened a meeting of 300 representatives of national medical specialty societies, state medical associations, and county medical societies to solicit their views on the study. To draft the AMA's policy positions on the RBRVS and related implementation issues, the AMA Board of Trustees appointed a physician payment task force, which comprised members of the Board and the AMA Councils on Medical Service and Legislation.

After considering the recommendations of this task force, findings from the internal and external reviews of the study, and the views of medical society representatives, the AMA Board of Trustees prepared a 40-page report containing its recommendations on the RBRVS, balance billing, geographic adjustments, and other policy issues. These recommendations became the focus of a hearing at the December 1988 meeting of the AMA's House of Delegates, at which more than 100 delegates testified.[i]

A principal theme of this testimony was the delegates' desire to maintain the AMA's leadership role in Medicare physician payment reform. Recognizing that change was coming, the key question was whether the change would be acceptable to the profession or a government-designed system without input from the medical profession would be enacted. They also recognized that organized medicine would need to remain unified for the AMA's policy proposals to be politically viable.

After a committee of the delegates amended the Board's recommendations to reflect the testimony presented at the hearing, the full House of Delegates unanimously adopted the revised recommendations. Unanimity was possible only because so many groups within the House agreed to compromise on policies that might concern their own specialty or locality, in order to create a new payment system that would serve the interests of the entire medical profession.

The key policy the AMA adopted at the December 1988 meeting was that the "Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system." In addition, this policy specified which parts of the study needed improvement and acknowledged that specialties whose RBRVS data had significant, documented technical deficiencies needed to be restudied. The AMA committed itself to work with Harvard, the national medical specialty societies, CMS, Congress, and the PPRC to obtain the necessary refinements and modifications.

Besides these policies on the Harvard RBRVS study, the AMA's recommendations provided a blueprint for all the major features of a new Medicare physician payment system:

- Payment schedule amounts should be adjusted to reflect geographic differences in physicians' practice costs, such as office rent and wages of nonphysician personnel. Geographic differences in the costs of professional liability insurance (PLI) would be especially important, and these differences should be reflected separately from other practice costs.

- A transition period should be part of any new system to minimize disruptions in patient care and access.
- Organized medicine would seek to play a major role in updating the RBRVS.

The AMA reemphasized its long-standing policy on balance billing that physicians should have the right to decide on a claim-by-claim basis whether to accept the Medicare approved amount (including the patient's 20% coinsurance) as payment in full. The AMA also stated its intention to oppose any attempt to use implementation of an RBRVS-based system as a means to obtain federal budget savings, and to oppose "expenditure targets" for Medicare—a scheme that would automatically tie the payment schedule's monetary CF to projected increases in utilization of services. Finally, the AMA sought to eliminate differences between specialties in payment for the same service.

The PPRC's Recommendations

Immediately after this momentous House of Delegates meeting, the AMA began advocating its Medicare physician payment reform policies before the PPRC, hoping to influence the recommendations the Commission would include in its 1989 Annual Report to Congress. These advocacy efforts were largely successful, and the Commission's recommendations, with several noteworthy exceptions, closely paralleled those of the AMA. Like the AMA, the PPRC endorsed the Harvard RBRVS study as the basis for a new Medicare payment schedule. Its list of necessary improvements was like those identified by the AMA. It also recommended using adjustment factors to reflect geographic differences in practice costs, eliminating specialty differentials, and opposing the use of the RBRVS's initial CF to obtain budget savings.

The views of organized medicine and those of the PPRC sharply diverged, however, on two policies: balance billing and expenditure targets. Given the widespread support for mandated assignment, which would have required physicians to accept the Medicare approved amount as payment in full, the AMA was pleased that the PPRC did not make such a recommendation. Against strong AMA opposition, however, the Commission did recommend placing percentage limits on the amount physi-cians could charge above the Medicare approved amount, although it did not specify a percentage. In contrast, the AMA believed that Medicare should establish only what it would pay and allow physicians to determine what they would charge.

The Commission's recommendation for a Medicare expenditure target was essentially its response to those who criticized payment-for-service payment systems because they did not control growth in costs or utilization. The AMA believed, in contrast, that an expenditure target could adversely affect patient access, and that profession-developed practice parameters held considerably more promise for reducing unnecessary utilization. Despite these differences, the AMA and PPRC core recommendations advanced the same fundamental reform: a Medicare payment schedule based on an expanded and refined Harvard RBRVS, with appropriate adjustments for geographic differences in practice costs and PLI costs. Congress had been under increasing pressure to take action to stem the flight of physicians from rural areas and primary care specialties and to change Medicare's physician payment system rather than continue its piecemeal, budget-driven approach. In early 1989, these factors heightened congressional interest in an RBRVS-based system, prompting initial legislative proposals from three different congressional subcommittees, which eventually became the foundation for the current payment-for-service payment system.

Medicare Reform

The Balanced Budget Act (BBA) of 1997 led to systemic Medicare program changes, including a wider array of health plan choices for beneficiaries, referred to as Medicare + Choice or Medicare Part C. It also altered the methodology for determining traditional payment-for-service payments under the Medicare RBRVS and permitted physicians to furnish health care services to Medicare patients on a private payment-for-service basis. Under the BBA, Medicare beneficiaries elected to receive benefits through either of two options: (1) the traditional Medicare payment-for-service program, or (2) Medicare + Choice plan.

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). This legislation replaced the Medicare + Choice plan with Medicare Advantage.

Medicare Advantage (formerly Medicare + Choice) plans include the following:

- Private payment-for-service (PFFS)
- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPOs)
- Special needs plans (SNPs)
- Medical savings account (MSA)

Under Medicare Advantage (MA), payments received by insurers to fund their MA plans are determined in part from insurer bids submitted to CMS. Bids reflect the amount for which an insurer believes it can provide standard Medicare benefits. Once CMS receives the bids, it creates benchmarks (target amounts) for each county across the nation. Each insurer's bid is then compared to the benchmark set for its county. If an insurer's bid is below the established benchmark, CMS will pay the insurer the benchmark. All payments to MA plans are risk adjusted, meaning that payment to plans is adjusted based on the relative health of the individual member. A brief description of traditional Medicare payment methodology, as well Medicare Advantage health plan options, follows:

Traditional payment-for-service. Physician payments under the Medicare RBRVS will be determined according to a single CF. Updates to the CF will be determined by a sustainable growth rate. The other elements of the RBRVS include the physician work relative values, the professional liability insurance (PLI) relative values, and the practice expense relative values. Practice expense relative values for 1999 and beyond include separate values de-pending on where the service is performed. Services provided in a physician's office are assigned a nonfacility practice expense RVU while services performed in a hospital and other settings are assigned a facility practice expense RVU.

Private fee-for-service (PFFS). The MMA established a PFFS plan option. Under PFFS, physicians traditionally chose whether to provide care to PFFS enrollees on a case-by-case basis and agreed to the insurer's terms and conditions of service when treating enrollees. When a physician treated a PFFS patient, the physician was considered as deemed by the insurer. This deeming process only covered this single event, and the physician was under no obligation to treat that patient, or any other PFFS patient, in the future. In most cases, physicians would be reimbursed no less than the Medicare Payment Schedule. However, in 2011, the deeming authority for many PFFS plans was removed. Many PFFS plans (nonemployer-sponsored plans in areas where there are at least two other Medicare Advantage plans with contracted networks of providers) are now required to establish networks. Health insurers that intend to offer the network model must contract with a group of physicians or pro-viders to provide health care services to their PFFS enrollees. The health insurers must also provide CMS with any categories of service for which they will be paying *less* than the Medicare allowable payment rates.

Health maintenance organizations (HMOs). Medicare Advantage HMOs contract with physician and provider networks to deliver Medicare services to beneficiaries. Beneficiaries with HMOs must see physicians in their networks.

Preferred provider organizations (PPOs). Medicare Advantage PPOs also contract with physician and provider networks to deliver Medicare services to beneficiaries. PPO beneficiaries may access physicians outside their plan's network but may pay more in co-insurance. Physicians without a contract may also bill patients for the difference between the plan's payment level and the allowed price the physician charges.

Special Needs Plans (SNPs). SNPs were created to improve access to MA plans for special needs individuals and allow health insurers to tailor programs to meet these beneficiaries' unique needs. SNPs differ from other Medicare Advantage plans in that they exclusively or disproportionately serve special needs individuals.

Medical Savings Account (MSA). An MSA is a high-deductible Medicare Advantage plan combined with a tax-free medical savings account that is funded by Medicare. The enrollee can use the money in the account to pay for his/her deductible ex-penses or other health care services not eligible for Medicare coverage. A medical savings account does not offer Part D drug coverage.

Private Contracting

In addition to these Medicare Advantage options, the BBA permits physicians and their Medicare patients to enter into private contracts to provide health care services. Private contracting arrangements are permitted only if certain conditions are met, including: (1) the physician does not receive Medicare payment for any items or services, either directly from Medicare or on a capitated basis; (2) inclusion in the contract of specified beneficiary protections, such as disclosure that Medicare balance billing requirements will not apply and the patient has the right to receive items and services offered by other physicians participating in Medicare; and (3) physician agreement through an affidavit filed with CMS to file no Medicare claims for any services provided to Medicare patients for a two-year period.

Congressional and Regulatory Commissions

In 1997, Congress merged two prior commissions to form the Medicare Payment Advisory Commission (MedPAC). The Commission is charged with advising Congress on payments to health plans, hospitals, physicians, and other Medicare provider groups. The Practicing Physician's Advisory Council (PPAC) was created by Congress as a federal advisory committee in the late 1980s in legislation backed by the AMA to provide physician input on prospective Medicare policies the Administration was considering. However, the Affordable Care Act discontinued PPAC in March 2010.

Note

i. The AMA's House of Delegates comprises voting representatives from all 50 states, as well as Puerto Rico, Guam, the Virgin Islands, and the District of Columbia; approximately 125 national medical specialty societies; three professional interest medical associations; five Federal military service groups; and representatives of the 11 AMA sections, such as the Medical Student Section, International Medical Graduates Section, Organized Medical Staff Section, and the Young Physicians Section. The House is, therefore, an extremely democratic organization representing all types of physicians from all areas of the country.

References

1. Committee on Ways and Means. *Overview of Entitlement Programs: 1992 Green Book*. Washington, DC: Committee on Ways and Means. 1992:453.
2. *American Medical Association, et al v Bowen*, US Court of Appeals, Fifth Circuit, No. 87-1755, October 14, 1988. 857 FW 267 (5th Cir 1988).

   American Medical Association, et al v Bowen, US District Court, Northern District of Texas, Dallas Div, No. 3-86-3181-H, January 20, 1987. 659 FSupp 1143 (ND Tex 1987).

   Massachusetts Medical Society, et al v Dukakis, US District Court, District of Massachusetts, No. 85-4312-K, June 5, 1986. 637 FSupp 684 (DMass 1986).

   Massachusetts Medical Society, et al v Dukakis, US Court of Appeals, First Circuit, No. 86-1575, March 30, 1987. 815 FW 790 (1st Cir 1987), cert denied, 484 US 896 (1987).

   Whitney v Heckler, US Court of Appeals, 11th Circuit, No. 85-8129, January 22, 1986. 780 FW 963 (11th Cir 1986), cert denied, 479 US 813 (1986).

   Whitney v Heckler, US District Court, Northern District of Georgia, Atlanta Division, No. C84-1926, February 4, 1985. 603 FSupp 821 (ND Ga 1985).

   American Medical Association, et al v Heckler, US District Court, Southern District of Indiana, Indianapolis Division, No. IP 84-1317-C, April 18, 1985. 606 FSupp 1422 (SD Ind 1985).

   Pennsylvania Medical Society v Marconis, 755 FSupp 1305 (WD Pa), aff'd, 942 FW 842 (3rd Cir 1991).

   Medical Society of the State of New York v Cuomo, 1991 US Dist LEXIS 16405 (SDNY 1991).

3. Roper WR. Perspectives on physician payment reform. *N Engl J Med*. 1988;319:866.
4. Todd JS. At last, a rational way to pay for physicians' services? *JAMA*. 1988;260:2439–2440.