

Legislation Creating the Medicare RBRVS Payment System

In 1989, after years of debate within the medical profession about the distortions in historical charges, battles with Congress and the administration over rising expenditures, and a four-year wait for the results of the Harvard resource-based relative value scale (RBRVS) study, Congress finally enacted a new Medicare physician payment system. The process that led to enactment of the payment reform legislation was in many ways more historic than the law itself: the partnership forged between the medical profession, beneficiary groups, the Congress, and the Bush administration was unprecedented in the development of US health policy. The law resulting from this process gave participants a reasonable measure of what they had sought:

- An RBRVS-based payment schedule for physicians that narrowed specialty and geographic differences
- Continued balance billing limits for patients
- A system for monitoring expenditure increases for the government

This overview provides a brief history and an overview of the physician payment reform legislation and the regulations promulgated since its enactment.

Prescription for Changing the Medicare Physician Payment System

During the spring of 1989, the American Medical Association (AMA), the Physician Payment Review Commission (PPRC), Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration [HCFA]), and others presented their recommendations at several congressional hearings on Medicare physician payment reform. As the 1989 budget reconciliation process began, the following three congressional subcommittees with jurisdiction over the Medicare program presented proposals for such a reform for inclusion in what became the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, PL 101-239):

- The Health Subcommittee of the House Ways and Means Committee
- The Subcommittee on Health and the Environment of the House Energy and Commerce Committee
- The Subcommittee on Medicare and Long-Term Care of the Senate Finance Committee

From the outset, the process of developing the payment reform legislation was controversial. The key parties to the legislative process presented markedly different initial proposals. Accepting the consensus between the AMA and the PPRC, however, all three included a geographically adjusted payment schedule based on an RBRVS.

The two most critical areas of contention for physicians were expenditure targets and balance billing limits. Although the AMA continued to oppose billing limits within Congress, balance billing limits were not an issue, only the specific percentage. Because Congress had enacted limits on Medicare balance billing under its “customary, prevailing, and reasonable” (CPR) payment system several years earlier (the maximum allowable actual charges [MAACs]), balance billing limits were considered a continuation of an existing policy rather than a completely new proposal. Moreover, balance billing limitations were necessary to obtain support for payment reform from beneficiary organizations, such as the American Association of Retired Persons (AARP).

The AMA opposed expenditure targets, believing they would simply reduce payment reform to another federal budget cutting tool. Under the Ways and Means provision, if the annual increase in Medicare expenditures exceeded a predetermined target increase, payments would automatically be reduced to recoup the overage. At the AMA’s urging, the Energy and Commerce bill

did not contain an expenditure target provision. Throughout the summer and fall of 1989, the AMA and the specialty societies worked closely with the three committees to forge a bill they all could support. As a result of this unprecedented joint effort by organized medicine, Congress, and the administration, the Senate finance bill emerged with a provision for a Medicare volume performance standard (MVPS), which addressed the difficult issue of increases in utilization but eliminated the most objectionable aspects of the expenditure target proposal.

OBRA 89 Physician Payment Reform Provisions

In December 1989, Congress passed and President Bush signed OBRA 89, which enacted the Medicare physician payment reform provisions into law. The legislation called for a payment schedule based on an RBRVS composed of the following three components:

- The relative physician work involved in providing a service
- Practice expenses (PE)
- Professional liability insurance (PLI) costs

The OBRA 89 defined the following key features of Medicare's new payment system for physicians' services:

- A five-year transition to the new system beginning on January 1, 1992
- Adjusting each component of the three RBRVS components for each service for geographic differences in resource costs
- Eliminating specialty differentials in payment for the same service
- Calculating a "budget neutral" conversion factor (CF) for 1992 that would neither increase nor decrease Medicare expenditures from what they would have been under a continuation of the CPR
- A process for determining the annual update in the CF
- Tighter limits on balance billing beginning in 1991
- An MVPS to help Congress understand and respond to increases in the volume and intensity of services provided to Medicare beneficiaries

Each of these key legislative provisions is described briefly in the following sections.

RBRVS

As the AMA and PPRC had recommended, the physician work component of the RBRVS was to be based (implicitly) on data from the Harvard study, and the 1992 start date allowed Phase II of this study to be completed and reviewed prior to implementation. Physician work refers to the physician's individual effort in providing the service: the physician's time, the technical difficulty of the procedure, the average severity of the patient's medical problems, and the physical and mental effort required. A serious shortcoming in Phase I of the Harvard study was its approach to estimating physicians' relative practice costs. Therefore, the legislation provided a different method to determine the relative values for this component and for the PLI component.

In the Harvard study, the practice cost relative value of a service was related to the physician work relative value. In the transition to an RBRVS-based payment schedule, such an approach would mean that if the relative work of a service would lead to a reduction in its Medicare payment level, the relative practice costs would reduce the payment for the service even more. Both the AMA and the PPRC had identified this method as unfair and technically flawed. Their concern was that if physicians were not adequately compensated for their overhead costs, patient access would be impaired.

The practice cost method included in OBRA 89 separated practice costs from physician work and attempted to maintain the

total practice cost revenue of a physician specialty at roughly the same as it had been under the CPR. Practice cost relative values were, therefore, based on the average proportion of a specialty's overall revenues devoted to practice expense as a percentage of the average Medicare payment under the CPR. For example, if practice costs on average account for 45% of general surgeons' gross revenue for a service that is provided only by general surgeons and for which the average Medicare approved amount under the CPR was \$1000, the practice cost component of the new payment schedule would be about \$450. The actual calculation is a bit more complicated with other factors coming into play. However, the example illustrates the basic idea.

In response to these concerns, Congress adopted legislation in 1994 that required the development of resource-based practice expenses, with full implementation in 1998. Since that time, however, new legislation signed by President Clinton in August 1997 revised the implementation timeline. The Balanced Budget Act (BBA) of 1997 called for the CMS to collect additional data for use in developing the new practice expenses. Proposed values were published in May 1998, with a 60-day period for public comment. CMS received over 14,000 comments on its proposed rule and issued its Final Rule on November 2, 1998. CMS began implementation of the new practice expense values on January 1, 1999. The resource-based practice expense relative values became fully implemented on January 1, 2002.

Initially, the PLI relative values were also determined in the same fashion as the practice expense relative values; they were based on the average proportion of a specialty's overall revenues that is devoted to PLI costs as a percentage of the average Medicare approved amount under the CPR. For instance, if the PLI cost percentage in the previous example was 5%, the PLI component of the new payment schedule would have been approximately \$50. Although several concerns surfaced about this method, two factors account for the wide support it received when OBRA 89 was drafted. First, it was considered more equitable than the Harvard study's method; and second, no other alternatives would have been ready for 1992 implementation. In 2000, CMS implemented resource-based PLI relatives.

Geographic Adjustments

Opinions varied on the degree to which the RBRVS should be geographically adjusted under the new system. Many physicians, especially those in rural areas, believed that Medicare should pay the same amount for a service regardless of where it was provided. Others believed that payments in a resource-based system should reflect geographic differences in physicians' resource costs, ie, differences in office rents, wages of nonphysician office staff, PLI costs, and cost of living.

The AMA's policy position represented one compromise on this issue, and the OBRA 89 method represented another. The AMA had stated that payments should be adjusted to reflect only differences in physicians' practice costs and PLI costs, and that geographic differences in costs of living should be ignored. Geographic differences in cost of living would be reflected in the physician work component of the payment schedule.

In the payment schedule, geographic differences in all three components are determined by three geographic cost indices known as geographic practice cost index (GPCIs). Under the OBRA 89 compromise, differences in cost of living are measured according to a geographic index of cost of living, but this index measures only one quarter of the geographic difference in cost of living. Practice cost differences are measured by a geographic index of overhead cost differences, and PLI differences by a geographic index of PLI costs.

In practice, the OBRA 89 compromise means that, if practice costs in a particular state are 10% higher than the national average, PLI costs are 12% higher, and costs of living are 8% higher, then the practice cost component of the payment will be increased by 10% above the national average payment and the PLI component will be increased by 12%, but the physician work component will be only 2% higher than the national average, because the cost-of-living index only reflects one quarter of the difference. The OBRA 89 provision substantially reduced the degree of geographic variation in payments. Whereas under the CPR, payments in one community could be three or four times greater than payments in another community for the same service, the RBRVS payment system reduced this variation to within 10% to 15% of the national average for most services.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 required that the physician work GPCIs cannot be less than 1.00, effective January 1, 2004, through December 31, 2006. This provision was extended through December 31, 2007, by the Tax Relief and Health Care Act of 2006 and extended once again through June 30, 2008, by the Medicare, Medicaid, and SCHIP Extension Act of 2007. This important provision continues to be extended through legislative action, typically on an annual basis.

Balance Billing Limits

Retaining the right to charge patients the difference between the Medicare approved amount and the physician's full payment for the service has been a cornerstone of AMA policy since the inception of the Medicare program. Under physician DRGs or HMOs, balance billing would not have been permitted given the nature of these payment approaches. Many physicians also feared that this right would be lost if an RBRVS-based payment schedule was adopted. The PPRC's decision not to recommend mandatory assignment and the absence of such a provision from all three legislative proposals was, therefore, a major victory for organized medicine.

In the late 1980s under the CPR, balance billing was limited by MAACs, which were different for each physician because they were based on each physician's customary charges in the second quarter of 1984. The OBRA 89 eliminated MAACs over a three-year transition period that began in 1991 and replaced them with "limiting charges." The major difference between limiting charges and MAACs is that limiting charges are a specified percentage above the Medicare approved amount (including the patient's 20% coinsurance), whereas MAACs were based on what physicians charged in a base period.

Since January 1, 1993, the limiting charge for a given service in a given Medicare payment locality has been 15% greater than the Medicare approved amount for the service. It is the same for every physician who provides that service.

In addition, effective January 1, 1995, CMS has statutory authority to prohibit physicians and suppliers from billing Medicare patients, as well as supplemental insurers, above the limiting charge and to require that any excess charges be refunded or credited to the patient.

The OBRA 89 also retained the Participating Physician Program under the new Medicare payment system. "Participating" physicians are those who agree to accept assignment for all services that they provide to patients enrolled in the Medicare program. To give physicians an incentive to sign such an agreement, the full Medicare payment schedule amount for "non-participating" physicians is only 95% of the full payment schedule for participating physicians. Because the limiting charge is, in turn, based on the payment schedule for nonparticipating physicians, the effective limiting charge is 9.25% above the full Medicare payment schedule (ie, 115%, 95%, 109.25%).

Payment Updates and the Medicare Volume Performance Standard

A relative value scale can produce any level of payment for a given specialty or service; it all depends on the conversion factor.

James S. Todd, MD¹

During the development of the OBRA 89 payment system provisions, much of the process for updating payments over time was widely debated. The problems caused by the historical charge patterns that developed under the CPR, the government's previous attempts to control Medicare's rising costs, and the PPRC's expenditure target proposal had combined to generate substantial interest in this aspect of the new payment system. In addition, physicians were skeptical that a Congress intent on reducing the federal budget deficit would all too willingly use the new payment schedule's dollar CF to achieve budget savings.

The OBRA 89 provisions that were ultimately adopted authorized Congress to annually update the CF based on the percentage increase in the Medicare Economic Index (MEI), a comparison of the MVPS with the actual increase in spending, and other factors. The MVPS is set annually, by either Congress or a statutory default formula, to reflect the expected growth rate in Medicare spending for physicians' services. It is supposed to encompass all the factors that contribute to this growth, including changes in payment levels, the size and age composition of the Medicare population, technology, utilization patterns, and access to care. The concept behind the CF updating process is that establishing a link between payment updates and increases in the volume of services provided to Medicare patients gives physicians an incentive to decrease unnecessary and inappropriate services. Enacting the MVPS instead of expenditure targets allowed the AMA and other physician organizations to relax that link.

The Balanced Budget Act of 1997, however, replaced the MVPS with a new sustainable growth rate (SGR) system to control Medicare expenditure growth. The SGR did not rely on historical patterns of growth in volume and intensity of physician services, as did the MVPS; rather, it used projected growth in real gross domestic product per capita. MACRA was signed into law on April 16, 2015. The legislation (P.L. 114-10) repealed the SGR update methodology for physicians' services, provided positive annual payment updates of 0.5% from July 1, 2015, through 2019, and required the Centers for Medicare & Medicaid Services (CMS) to establish a merit-based incentive payment system (MIPS), under which MIPS-eligible professionals receive annual payment adjustments based on their performance in a prior period.

Budget-Neutrality Adjustment

The OBRA 89 mandated that revisions to relative values resulting from changes in medical practice, coding, new data, or the addition of new services may not cause Part B expenditures to differ by more than \$20 million from the spending level that would have occurred without these adjustments. Every year since 1993, CMS has projected net expenditure increases exceeding this limitation and, to limit the increase in Medicare expenditures, has made budget-neutrality adjustments to the payment schedule.

CMS has applied different types of “budget neutrality” adjustments. For the 1993 through 1995 payment schedules, CMS uniformly reduced all relative value units (RVUs) across all services; in 1996, it adjusted the CFs. For 1997, CMS made two separate adjustments: one to the physician work RVUs and another to the CFs. For 1998, it also made separate adjustments, including a –0.7% adjustment for increased work RVUs for global surgical services and –0.1% applied as a behavioral offset. The latter adjustment reflects CMS’ belief that the volume and intensity of physician services will increase in response to payment schedule reductions, thus lessening their impact on overall Medicare expenditures.

Annually rescaling the RVUs created an administrative burden for physician practices and third-party payers in setting compensation levels, greatly impairing the usefulness of the RBRVS to these groups. In addition, the rescaling also masks any real changes in relative values due to changes in medical practice and refinements to the RBRVS. Beginning in 1999, CMS eliminated its separate adjustment to the work RVU and instead applied budget-neutrality adjustments directly to the CF. However, in 2003 CMS applied a volume and intensity offset by 0.49% to the practice expense relative values, rather than the CF. Despite comments from organized medicine requesting stability in the RVUs, CMS re-scaled the work (–0.15%), practice expense (–1.320%), and professional liability insurance (+20.61%) relative values in 2004 to match the new Medicare economic index (MEI) weights.

In 2007, CMS returned to the use of a separate work adjustor applied directly to work RVUs to achieve budget neutrality. CMS estimated in the CY 2007 MFS Final Rule that the improvements resulting from the third Five-Year Review would account for an additional \$4 billion in expenditures. Rather than achieve budget neutrality through a reduction in the CF, CMS introduced a 10.1% adjustment to all work RVUs. After this recommendation by CMS, the AMA RUC sent its recommendations on additional CPT codes from the Five-Year Review and recommendations for an increase in the work of anesthesia services. After these recommendations were reviewed, CMS determined that a revised work adjustor for 2008 would need to be implemented to account for the impact of these additional recommendations. CMS implemented a 11.94% adjustment to all work RVUs for 2008.

The AMA opposed the application of this separate work adjustor. Because the MFS is used widely by private and public payers to determine physician payment and physician group practices to determine compensation plans and/or to utilize as a benchmarking tool, adjusting work RVUs may compromise the integrity and relativity of the RBRVS. Since CMS first indicated that a work adjustor may be used, the AMA along with most specialty societies have advocated for the adjustment to be applied to the CF. Efforts included the AMA and RUC comments to the June 29, 2006, August 22, 2006, and July 12, 2007, Proposed Rules, a joint letter from the AMA and 74 specialty societies, and numerous meetings with senior CMS officials. Despite these efforts, CMS moved forward with the separate work adjustor for 2008. However, because of these tremendous efforts made by the AMA, as well as the specialty societies, MIPPA was enacted on July 15, 2008, and required that the budget-neutrality adjustment be applied to the CF and not the work relative values for 2010 and subsequent years.

The annual determination of the CF accounts for both the statutory update factor and the budget-neutrality adjustment required by law.

Transition to the New System

The OBRA 89 established a five-year transition to the new system, which began on January 1, 1992. The transition was consistent with the AMA’s desire to postpone implementation until Phase II of the Harvard RBRVS study was completed, and then to proceed incrementally to avoid precipitous changes in payments and potential disruptions in patient care. In addition, the OBRA 89 transition method was intended to accelerate payment increases, principally for visits and consultations, while providing a slower transition for payment reductions.

Much of the change to the new payment levels occurred in the first year of the transition period. The first step in determining the 1992 payment levels was to adjust the CPR prevailing charges, thereby eliminating specialty differentials. The adjustment was essentially a weighted average that accounted for the frequency of each payment amount. In other words, if six different spe-

cialties in an area provided a service and six Medicare prevailing charge levels existed under the CPR, the averaging process would reflect the frequency of the service provided by physicians in each specialty. The averaging process also reflected the CPR customary charges of physicians who charged less than the prevailing charge. As a result, it was possible for an adjusted prevailing charge to be somewhat less than the average prevailing charge. CMS referred to this average charge as the “historical -payment basis” for a service.

Eliminating specialty differentials placed no limit on the degree to which payments could change in 1992 because of this adjustment. For visit services formerly provided by both internists and family practitioners, for which the internists received higher payments, the adjustment created a double increase for the family practitioners: one because of the adjustment and one because of the transition to the RBRVS. For the internists, the adjustment would mean payments might be decreased and then increased in the process of calculating the 1992 payment, although the internist would only see the net effect. Medicare payments are now the same for all physicians who provide a service in a locality regardless of their specialty.

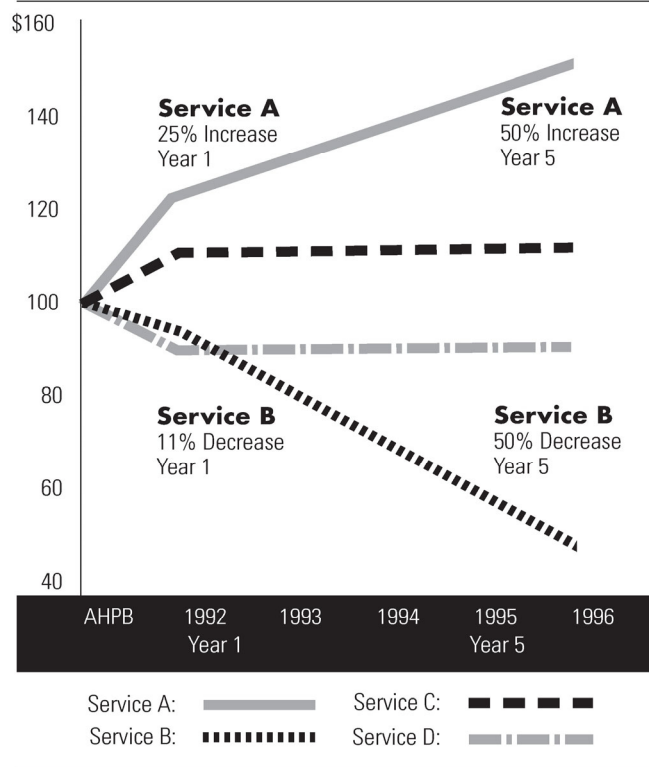
Many Medicare carriers did not recognize specialty differentials under the CPR, however, and maintained only one prevailing charge level for each service. In addition, because many services are only provided by physicians in one specialty, only one prevailing charge level existed in the area. Where there was only one CPR prevailing charge, the historical payment basis may have been closer to the 1991 prevailing charge for the service, although the presence of customary charges less than the prevailing charge, in general, would still have reduced the historical basis below the prevailing charge level.

In calculating the CF for 1992, CMS determined that the historical payment basis for each service should be reduced by 5.5%. This reduction was intended to compensate for the fact that payments for visits were increasing faster than payments for procedures and other services were decreasing, thus increasing expenditures over what they otherwise would have been. Finally, the historical payment basis was increased by the payment update for 1992 of 1.9%. This 1.9% update was also applied to the CF for the RBRVS-based payment schedule. After the 5.5% reduction and the 1.9% increase were applied, the historical payment basis was referred to as the adjusted historical payment basis (AHPB).

The next step was the actual transition to the payment schedule. In this step, the statute required that services for which the AHPB was neither 15% higher nor 15% lower than the RBRVS payment schedule be paid entirely based on the new payment schedule. Services for which the schedule represented a change of more than 15% were increased or decreased from the AHPB by 15% of the full payment schedule amount in 1992. As Figure 2-1 illustrates, this process was intended to accelerate the change for payment increases because such increases were based on 15% of a dollar figure larger than the AHPB and payment decreases were based on 15% of a dollar amount smaller than the AHPB.

During 1993–1995, payments for services that did not move entirely to their RBRVS amounts in 1992 were incrementally increased or decreased using a blend of the 1992 transition approved amount and the RBRVS, with the proportion of the blend that is based on the full payment schedule increased each year. The annual payment update also is applied. Since 1996, payments for all services have been based entirely on the RBRVS payment schedule.

Figure 2-1. OBRA 89 Transition Asymmetry: Percentage Change in Years 1 and 5



Standardization

The final major component of the RBRVS payment system is the process of standardization. The move to a nationally standardized payment schedule based on an RBRVS, with some variation due to geographic differences in practice costs, was a major change in Medicare's payment system. The twofold, threefold, and fourfold differences in payments across geographic areas have been eliminated. Differences by specialty in payments for the same service within a geographic area also have been eliminated.

Standardization of Medicare payment policies across local Medicare carriers also was initiated under the RBRVS payment system. Until 1992, each Medicare carrier had broad latitude to establish its own policies, including issues such as which services were included in the payment for a surgical procedure, local codes in addition to the national coding system, and policies for comparing Medicare payments to payments for privately insured patients.

One of the RBRVS payment system's most significant provisions substantially eliminated variation in national Medicare payment policies. Although the law did not spell out the details, it required CMS to adopt a uniform coding system for Medicare and a uniform global surgical policy and to standardize its approaches to payment for nonphysician providers, drugs and supplies, and other facets of Part B of Medicare.

Changes in Law and Regulations

In addition to defining these key components of the new Medicare payment system, OBRA 89 required CMS and PPRC to conduct a number of studies on issues related to the new physician payment system and make recommendations on these issues to Congress. One of these requirements directed the secretary of Health and Human Services (HHS) to publish a model payment schedule (ie, MFS) in September 1990.

The MFS, published in the *Federal Register* on September 4, 1990, provided an added step in CMS' normal regulatory process,

giving physicians and their organizations an opportunity to review and comment on CMS' proposals for implementing the new payment system prior to a formal proposed rule. The MFS provided a detailed explanation of the new system; identified the options that CMS was considering on issues such as coding and site-of-service differentials in payment; and provided preliminary estimates of payment schedule amounts and geographic adjustments. In November 1990, Congress enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, PL 101-508), which changed some Medicare payment policies related to physician payment under the Medicare RBRVS. The three most significant changes:

- Sharply curtailed payments for interpreting electrocardiograms (ECGs)
- Reduced payments for assistants-at-surgery from 20% to 16% of the global payment for the surgery
- Extended payment reductions for "new" physicians from their first two years of providing Medicare services to their first four years

The legislation's ECG provision eliminated payment for interpreting ECGs whenever the ECG was provided as part of or in conjunction with a visit or consultation. Payment for these ECG services, however, as well as for "new" physicians, was restored in 1994 under provisions of Omnibus Budget Reconciliation Act of 1993 (OBRA 93).

Notice of Proposed Rule Making: 1991

On June 5, 1991, the payment reform process was almost derailed when CMS' publication of the *Notice of Proposed Rule Making (NPRM)* on Medicare physician payment in the *Federal Register* included a proposal to reduce the payment schedule's CF by 16% from an otherwise budget-neutral level. The proposed reduction was clearly at odds with congressional intent as described in OBRA 89 to maintain overall Medicare spending in 1992 at the level it would have been under a continuation of the CPR.

The NPRM prompted the AMA to initiate an extensive grassroots campaign to reverse the proposed cut before the Final Rule was issued. The campaign resulted in more than 100,000 comments on the *NPRM* and thousands of letters to Congress. Besides the campaign, the AMA testified before Congress and submitted detailed comments on the *NPRM*, including a legal analysis of the budget neutrality issue by the law firm of Sidley and Austin, which provided clear support for the AMA's position. As a result, 92 of the 99 members of the three congressional committees with authority over Medicare signed letters to Secretary Sullivan opposing the cuts, and 82% of the Congress indicated its support. In addition, two chairmen of the relevant subcommittees introduced legislation to prevent the reduction.

Although three factors contributed to the proposed reduction, the most offensive to physicians was CMS' "behavioral offset." Its premise was that physicians would increase the volume of their services in response to the payment reductions caused by the new payment system, and that payment levels must be reduced to compensate for this expected increase in utilization.

The AMA's comments on the *NPRM* provided a persuasive analysis opposing the proposed reduction in the CF, demonstrating that the cuts clearly violated the language and intent of the law, with potentially disastrous consequences for patient access. These comments also commended CMS for its decisions to adopt the AMA's coding system as its uniform system, to allow a major role for organized medicine in updating the RBRVS, and to eliminate several of the CPR policies that physicians had long opposed.

Final Rule: 1991

The Final Rule for the new Medicare physician payment system appeared in the *Federal Register* on November 25, 1991. It contained a summary of the regulation, an analysis of comments on the *NPRM* and CMS' responses, impact estimates for physicians and beneficiaries, and the regulations for the new system. It also listed the relative values for each service and geographic adjustment factors for each locality.

The Final Rule reflected several extremely positive changes from the *NPRM* that the AMA and other physician organizations had advocated. Most notable was the CF of \$30.423, which exceeded the *NPRM* CF of \$26.873 by 13.2%. This increase restored an estimated \$10 billion to Medicare Part B over the period 1992 through 1996. CMS also announced the payment update for 1992 of 1.9%, thus making the 1992 CF \$31.001.

Besides the CF, the Final Rule contained many other substantial changes compared to the *NPRM*, such as the following:

- In using a “baseline adjustment” to account for projected volume changes instead of the “behavioral offset,” CMS acknowledged that volume increases result from many factors, including patient demand, rather than resulting from increases in unnecessary care.
- CMS further increased the CF consistent with AMA suggestions on several technical issues.
- Relative values for specific services were increased based on *NPRM* comments.
- CMS treated all relative values as “initial” for 1992 and allowed a 120-day period for public comment.
- Policies on global surgical packages were substantially improved.
- Medicare payments for drugs were limited to the average wholesale price, rather than to 85% of this price, as proposed in the *NPRM*.

Despite these changes, the AMA’s House of Delegates called for substantial improvements in many important features of the payment system, including better data for the geographic indices and eliminating discriminatory payment limits for “new” physicians and for the services of assistants-at-surgery. To help identify problems arising during implementation of the new system, the AMA established a comprehensive program to monitor changes in patient access, physician practice patterns, and errors in carrier implementation, working closely with state and county medical societies.

During 1992, the first year of implementation, the AMA worked with CMS to make the system more responsive to physician needs:

- CMS enabled carriers to calculate transition amounts for about 50 new services that had dropped to full RBRVS amounts and increased about 150 technical components, which was consistent with the AMA’s March 1992 comments on the 1991 Final Rule.
- CMS agreed to a grace period for the old system of visit codes, allowing physicians to use these codes for the first two months of 1992.
- CMS revised its definition of “new” patient for group practices to be consistent with the original intent of the CPT Editorial Panel. A “new patient” is one who has not been seen by a member of the group in the same specialty in the prior three-year period.
- CMS clarified several provisions of its global surgery, critical care, and other payment policies to reflect physician needs. Many of the problems identified in the first year of implementation have been resolved through either the legislative or the regulatory process, although the AMA continues to work with physicians and others in organized medicine for improvements to the Medicare RBRVS payment system.
- CMS converted the original Harvard scale to the same dollar scale as used for the practice expense and PLI RVUs, which aligned the three components on a common scale. It then assigned a total relative value of 1.00 to established patient office visit code 99213 and rescaled all other services accordingly. The common scale comprising the total RVUs for all services relative to 99213 is the complete Medicare RBRVS.

Early Legislative Activity

Several problems with Medicare’s RBRVS payment system stemmed from statutory provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and could be corrected only through legislative action. These problems included payment reductions that further reduced Medicare payments to “new” physicians and eliminating payment for interpreting ECGs.

The AMA’s legislative advocacy efforts led to the introduction in 1991 and 1992 of bills that would have restored payment for ECG interpretations, repealed payment reductions for new physicians, and required CMS to use the most recent data available for compiling the GPCIs. Many medical specialty societies supported these bills, even though their enactment would mean slight across-the-board reductions in physician payments pursuant to budget-neutrality requirements.

In August 1993, organized medicine won a substantial victory for physicians when provisions were included in OBRA 93 to

restore payment for ECG interpretation and rescind payment reductions for “new” physicians. To ensure that these provisions were implemented in a budget-neutral manner, as required by OBRA 89, CMS reduced all RVUs in the 1994 payment schedule by 1.2%.

The Balanced Budget Act of 1997 gave physicians the right to contract privately with their Medicare patients for health care services, beginning in 1998. This new ability came with a heavy price, however. Physicians who contract with one or more of their Medicare patients for Medicare covered services may not bill the program for any Medicare services for two years. To correct this flaw, the AMA vigorously supported legislative proposals that would permit Medicare beneficiaries to pursue private contracts with their physicians, without isolating physicians from the Medicare program for two years.

Legislative Actions Impacting the Conversion Factor (CF)

The Consolidated Appropriations Resolution of 2003 (Pub. L. 108-7), signed into law on February 20, 2003, included language to allow CMS to correct mistakes in 1998 and 1999 SGR. This legislation resulted in a positive update in the 2003 CF of 1.6%, rather than the projected cut of 4.4%.

The MMA was signed by President George W. Bush on December 8, 2003. This legislation expanded Medicare to include prescription drug coverage. The law also included provisions related to the MFS. Most importantly, Congress halted another 4.5% cut to the 2004 CF, replacing it with 1.5% increases in both 2004 and 2005.

After a two-year respite following the MMA, the AMA faced a prospective cut to the CF in 2006 of 4.5%. The AMA’s aggressive lobbying efforts, including an extensive grassroots network and broad media campaign, paid off in early 2006 as Congress passed the 2005 Deficit Reduction Act, which included a one-year freeze to the CF.

The AMA increased its lobbying efforts in 2006, knowing that January 1, 2007, would bring cuts to the CF of roughly 5% yet again. In addition to grassroots efforts and a media blitz, the AMA organized numerous physician fly-ins to Washington, DC. In deference to the collective voice of physicians, Congress passed the Tax Relief and Health Care Act of 2006. Not only did the new law contain a freeze to the CF for 2007, but it allowed a 1.5% increase for physicians who participated in a new quality reporting program.

On January 1, 2008, physicians faced a 10.1% reduction to the CF. Fortunately, the AMA succeeded in postponing this cut until July 1, 2008; Congress instead implemented a 0.5% increase to the Medicare CF from January 1 through June 30, 2008. By providing a temporary six-month reprieve from the 10% pay cut, the legislation passed by Congress left the outlook for the remainder of 2008 highly uncertain. The AMA mounted an aggressive effort in the beginning of 2008 to secure a longer-term solution to this continuing Medicare crisis. This hard work was rewarded through the passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). MIPPA mandated an 18-month Medicare physician payment fix, stopping the 10.6% Medicare physician cut on July 1, 2008, and the 5.4% cut on January 1, 2009, continuing the June 2008 rates through December 31, 2008, and providing an additional 1.1% update for 2009. This triumph would not have been possible without the support of the AMA members.

The following legislative acts from 2009 through 2015, directly impacted the CFs and culminated with the repeal of the flawed Medicare sustainable growth rate (SGR) formula:

- **The Department of Defense Appropriation Act of 2010**—Signed into law on December 19, 2009; this Act applied a zero percent update to the 2010 CF from January 1, 2010, through February 28, 2010.
- **The Temporary Extension Act of 2010**—Signed into law on March 2, 2010; this Act further delayed the scheduled 21% Medicare payment reduction for physician services by applying a zero percent update to the 2010 CF from March 1-31, 2010.
- **The Continuing Extension Act of 2010**—Signed into law on April 15, 2010; this Act was the third time in 2010 that the 21% reduction to the CF was postponed. This Act extended the postponement of the reduction by again applying a zero percent update to the 2010 CF from April 1, 2010, through May 31, 2010.
- **The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010**—Signed into law by President Barack Obama on June 25, 2010; this Act replaces the 21% Medicare physician payment cut to the 2010 CF that took effect June 1, 2010, with a retroactive 2.2% payment update to the 2010 CF from June 1, 2010, through November 30, 2010.

- **The Physician Payment and Therapy Relief Act of 2010**—Signed into law on November 30, 2010; this Act maintained the 2010 CF established by the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act from December 1-31, 2010. The cost (\$1 billion over 10 years) of this one-month postponement will be paid for by changes in Medicare payment for outpatient therapy services.
- **The Medicare and Medicaid Extenders Act of 2010**—Signed into law December 15, 2010; this Act provides a one-year freeze on the Medicare CF for 2011 established by the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act and avoided a 25% reduction to the CF that was set to take effect on January 1, 2011. Further provisions of this Act include: (1) extending the Work Geographic Practice Cost Indices (GPCI) floor of 1.00, created in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) through December 31, 2011; (2) extending the exceptions process for Medicare therapy caps through December 31, 2011; (3) extending the payment for the technical component of certain physician pathology services; and (4) extending the mental health add-on payment of 5% for certain mental health services through December 31, 2011.
- **The Temporary Payroll Tax Continuation Act of 2011**—Signed into law December 23, 2011; this Act delayed the 27.4% reduction to the CF that was to be implemented on January 1, 2012. Instead, a zero percent update to the CF and the other provisions listed above in the Medicare and Medicaid Extenders Act of 2010 were continued through February 29, 2012.
- **The Middle Class Tax Relief and Job Creation Act of 2012**—Signed into law on February 22, 2012; this Act further delayed the 27.4% reduction to the conversion factor and continued the zero percent update through -December 31, 2012.
- **American Taxpayer Relief Act of 2012**—Signed into law on January 2, 2013; this Act prevented a scheduled payment cut of 25.5% from taking effect on January 1, 2013. This new law provides a zero percent update through December 31, 2013.
- **Pathway for SGR Reform**—Signed into law on -December 26, 2013; this Act further delayed a scheduled payment cut of 24% and replaced it with a 0.5% increase until April 1, 2014.
- **Protecting Access to Medicare Act of 2014 (PAMA)**—On March 31, 2014, the Senate passed H.R. 4302, which postponed the imminent 24% Medicare physician payment cut for 12 months, until April 1, 2015. Section 220 of the Act established an annual target for reductions in the payment schedule expenditures that result from adjustments to relative values of mis-valued codes. If the net reduction in expenditures for the year is equal to or greater than the target for the year, reduced expenditures attributable to such adjustments shall be redistributed in a budget-neutral manner within the payment schedule.
- **Achieving a Better Life Experience Act of 2014 (ABLE)**—Signed into law on December 19, 2014; this Act subsequently established the percent target recapture amount for the above provision in PAMA, setting a 1% target for reduced expenditures for CY 2016 and a 0.5% target for CYs 2017 and 2018. Physician payments must be reduced by the difference between the target for the year and the estimated net reduction in expenditures. For 2016 the target recapture amount produced a reduction to the CF of 0.77%. For 2017 the target recapture amount produced a reduction to the CF of 0.18%. For 2018 the target recapture amount produced a reduction to the CF of 0.09%.
- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**—Signed into law on April 16, 2015; this Act permanently repealed the flawed Medicare sustainable growth rate (SGR) formula, to provide positive annual payment updates of 0.5%, starting July 1, 2015, and lasting through 2019.

Following years of extensive advocacy by the AMA, Congress permanently repealed the SGR formula with MACRA. Passage of this historic legislation finally brought an end to an era of uncertainty for Medicare beneficiaries and their physicians.

The AMA believed that the previous short-term fixes to the annual CF exacerbated the problem. In 2005, the Congressional Budget Office (CBO) said that freezing physician payments would cost \$48.6 billion over the next 10 years, and in 2011, the CBO estimated the cost at \$245 billion. In March 2015, the CBO estimated the permanent repeal of the SGR to cost \$141 billion.

Prior to the full repeal of the SGR, the AMA was also successful in advocating and achieving certain corrections within the SGR formula. These lobbying efforts resulted in CMS' determination to retroactively remove physician administered drugs from the SGR beginning January 1, 2010. In addition to the payments physicians receive for administering drugs, the cost of the

drug itself had been included in the spending that is used to calculate the SGR. While the drug administration is a true physician service and should be included, the drug product is not a physician service and should not be included. As a result of CMS' agreement with the AMA's lobbying efforts to remove physician administered drugs from the SGR, the cost of eliminating the debt burden and freezing current payment rates fell by \$50 billion over 10 years.

Reference

1. Todd JS. At last, a rational way to pay for physicians' services? *JAMA*. 1988;260:2439–2440.