

now used in that index. This would reduce the index value, so that only a small increase in MEI-adjusted prevailing fees would be made in fiscal year 1987. ^{3/}

- o Carriers for Supplementary Medical Insurance would be instructed to examine payment rates for selected services that have become less costly to provide because of automation or other technological change. Carriers initially are to focus on payments for cataract surgery, for bypass operations, and for pacemaker implants. Administration estimates indicate that rate reductions of about 10 percent, on average, will result.
- o Payment rates for standby anesthesia services would be reduced by paying only for the anesthesiologists' time and not for the services that would have been rendered had general anesthesia been required.
- o Payment for assistant surgeons would be denied for specified procedures unless justified by extraordinary circumstances.

The Congressional Budget Office's estimates of the savings from these proposals are shown in Table 14.

The Administration also has proposed legislation that would expand the capitation options available to Medicare enrollees, by permitting them to use a Medicare voucher to purchase private insurance coverage that was actuarially equivalent to the Medicare package. Further, the Administration is considering demonstration studies of an areawide capitation approach ("carrier capitation"), in which selected agencies would agree to ensure that Medicare benefits were provided to all enrollees in a given geographic area in return for a per-person payment determined in advance.

The remainder of this section examines some of the Administration's proposals for refining the CPR system. Administration proposals for expanding Medicare enrollment in capitated systems are discussed in Chapter VI.

There are two components to the Administration's proposal to adjust the Medicare Economic Index. First, future increases in the MEI would be based on the new index using rental equivalence in place of homeownership, to eliminate the sometimes volatile and unrepresentative effects of

3. Before enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, CBO estimated that the MEI increase would be 0.8 percent with the technical adjustment, and 3.2 percent without it.

mortgage rate changes on the index. Second, the new (lower) index value would be used to correct for past increases in the MEI--and hence in payment rates--that would not have occurred had the rental equivalence component been used all along. The two components are separable--future increases could be based on the adjusted index, with or without correction for past increases.

The Administration's intention to correct for past increases in the MEI as part of its proposed revision of the index would move the CPR system more rapidly toward a fee schedule based on MEI-adjusted prevailing fees, thereby more quickly weakening the incentives for fee inflation in the system. Without the MEI revision, CBO estimates that about 50 percent of

TABLE 14. ESTIMATED SAVINGS FROM SELECTED ADMINISTRATION PROPOSALS, FISCAL YEARS 1987-1991
(In millions of dollars)

Administration Proposal	Annual Savings from CBO Baseline					Cumulative Five-Year Savings
	1987	1988	1989	1990	1991	
Adjust MEI <u>a/</u>	120	200	240	280	310	1,150
Reduce Payment for Overpriced Procedures	100	110	120	130	150	610
Reduce Payment for Standby Anesthesia Services	60	60	70	80	90	360
Deny Payment for Unnecessary Assistants at Surgery	<u>10</u>	<u>20</u>	<u>30</u>	<u>40</u>	<u>50</u>	<u>150</u>
Total	290	390	460	530	600	2,270

SOURCE: Congressional Budget Office.

- a. These estimates assume that the differential in prevailing fees for participating and nonparticipating physicians established under the Consolidated Omnibus Budget Reconciliation Act of 1985 will continue, but that the different prevailing fees would be increased by the same percentage amount following the MEI adjustment.

approved charges would be set by MEI-adjusted prevailing fees in fiscal year 1987. With the adjustment, the share of approved charges set by MEI-adjusted prevailing fees would increase to 56 percent (see Table 15).

Proposed reductions in payment rates for selected overpriced procedures would begin to address complaints about inappropriate fee differentials among services, in a very limited way. Only three generic procedures would be targeted, although other specific services and some service categories are generally believed to be overpriced. Targeting only a few procedures rather than implementing a comprehensive restructuring of payment rates could be seen as unfair to the physicians most affected, but the proposed reductions in payment rates are only a fraction of the reductions that would, by some estimates, be justified on the basis of resource costs (that is, the costs to physicians of providing the service).

TABLE 15. CBO PROJECTIONS OF PERCENT OF ALLOWED AMOUNTS SET BY PREVAILING FEE SCREENS, WITH AND WITHOUT TECHNICAL ADJUSTMENT TO THE MEDICARE ECONOMIC INDEX, FISCAL YEARS 1987-1991

	1987	1988	1989	1990	1991
Without Technical Adjustment to MEI					
Percent of Allowed Amounts at the Unadjusted or MEI-adjusted Prevailing Fee	63	67	69	71	72
Percent of Allowed Amounts at the MEI-adjusted Prevailing Fee	50	52	53	54	56
With Technical Adjustment to MEI					
Percent of Allowed Amounts at the Unadjusted or MEI-adjusted Prevailing Fee	68	70	71	72	74
Percent of Allowed Amounts at the MEI-adjusted Prevailing Fee	56	57	58	58	59

SOURCE: Congressional Budget Office based on information on charges for 110 common services reported by the Health Care Financing Administration.

NOTE: These projections assume that the proportion of allowed amounts equal to submitted charges will be constant, at 14.5 percent.

If resource cost estimates developed by researchers at the Harvard School of Public Health were used, for example, cataract extractions would be paid at only 14 percent of current rates, pacemaker implants at 24 percent of current rates, and bypass surgery at 40 percent of current rates (see Table 16). If such rate reductions were implemented, Medicare's payments for these services would be about 20 percent of current payments, on average; under the Administration's proposal, new payments would average about 90 percent of current levels. The methods used to develop the Harvard estimates of resource costs have been criticized, however, for placing too much weight on the time required to do the procedure and too little weight on other factors such as skills required and risks incurred.

TABLE 16. COMPARISON OF RELATIVE VALUES CALCULATED FROM MEDICARE'S ALLOWED AMOUNTS AND ESTIMATES OF RESOURCE COSTS, FOR SELECTED SERVICES, 1983

Service	Average Allowed Amount <u>a</u> /	Allowed Amounts if Based On Resource Costs Estimated by Stason	Stason's Resource Cost-Based Amounts As a Percent of Current Allowed Amounts
For Cardiovascular Surgeons			
Base Service:			
Initial Office Visit	80	80	100
Coronary Artery Bypass	3,000	1,200	40
Pacemaker Implant	1,060	256	24
For Ophthalmologists			
Base Service: Initial			
Eye Examination	50	50	100
Cataract Extraction	1,100	150	14

SOURCE: Adapted by the Congressional Budget Office from testimony by William B. Stason, Harvard School of Public Health, before the Subcommittee on Health, Senate Finance Committee, December 6, 1985.

a. Average amounts allowed by Medicare carriers for this service in 1983.

Further, most analysts would argue that although costs, broadly defined, are an important component of payment rates, other factors--such as the supply of physicians with the requisite skills relative to the demand for their services--must also be considered. 4/

The Administration's proposal to require carriers to reduce payments for standby anesthesia would make uniform a practice that is followed by a few carriers now. The rationale behind the proposal is that anesthesiologists' responsibilities are reduced when they are only standing by, compared with instances when they actually administer general anesthesia, and that Medicare's payment rates should be based on actual services performed. Payment rates for the services of anesthesiologists have two components--time units that reflect the length of time the anesthesiologist was present, and base units that vary depending on the procedure performed and the complexity of the case. Most carriers currently do not differentiate between instances in which general anesthesia is administered and those in which an anesthesiologist is only standing by in the event general anesthesia is required.

The Administration's proposal to deny payment for assistants at surgery unless medically required would expand current utilization review requirements, which already require carrier review prior to payment for claims for assistants at cataract surgery. Until now, carriers have had considerable discretion in establishing criteria to determine whether the services of assistants at surgery were reasonable and necessary. Some have defined medical necessity very restrictively, while most carriers have paid for assistants at surgery even during routine operations if such use was common in the community.

The Administration is also planning to develop more rigorous guidelines for carriers to use in conducting their postpayment utilization reviews. Carriers currently examine physicians' claims histories to identify those with unusually heavy service patterns, but in many instances the methods used are not effective at identifying inappropriate patterns. In some cases, for example, the types of physicians grouped together are so diverse that the individual physicians identified for further review are specialists treating very sick patients, for whom heavy use of services can be readily justified. Carriers thus are able to satisfy HCFA's requirements for utilization review with little effort and little result. More effective utilization review

4. See Chapter V in Jack Hadley and others, "Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services," Project Report No. 3075-07 (Urban Institute, Washington, D.C., October 1984).

programs, while reducing costs for program benefits, would increase administrative expenses. No apparent provision for these increased administrative costs has been made in the Administration's budget request.

The Administration is also considering ways to reduce the number of specialties and pricing localities identified for separate prevailing rates within each carrier's jurisdiction, not only to simplify administration of payments but also to create a more consistent basis for the differentials that would remain. It is unknown whether Medicare's costs would increase or fall as a result of combining larger physician groups to define prevailing fees. These changes apparently would not involve any attempt to modify CPR-generated fee differentials between the specialty groups that were retained or between different carrier jurisdictions. As a result, the substantial differentials that exist currently would remain, although the size of current differentials may not be justified by costs or any other factors except past practice.

CHAPTER IV

FEE SCHEDULES

The Congress could substitute a fee schedule for Medicare's customary, prevailing, and reasonable (CPR) method of setting physicians' reimbursement rates. This might leave the unit of payment--the service--unchanged, but would alter the method of determining payment rates. Under a fee schedule, Medicare might pay the lesser of the fee schedule rate or the submitted charge, but the maximum payment for any given service would be uniform for all physicians, at least in the same specialty and location. Under the CPR system, each physician may be paid a different amount for a given service--physician-specific fee schedules, in effect.

Modifying the CPR system by introducing a fee schedule would be a relatively straightforward change. Over time, the Medicare Economic Index, which is currently used to limit growth in prevailing fees under the CPR system, will affect a larger proportion of physicians' claims, so that the CPR system will eventually evolve into a set of specialty- and location-specific fee schedules anyway. Differences by procedure, specialty, and location in the fee schedule that will evolve under the CPR system, however, will not necessarily be systematically related to factors, such as costs, that the Congress might want them to reflect.

Implementing a fee schedule would not preclude more far-reaching changes in the way Medicare pays for physicians' services at a later date and could, in fact, relieve pressures for making changes that were ill-considered--permitting Medicare to modify its payment methods for physicians incrementally, after careful consideration. In addition, there are long-standing examples of the use of fee schedules both in the United States and in other countries from which to learn, whereas other approaches are largely untried. Fee schedules are the dominant method of paying for physicians' services in other countries with health care delivery systems similar to that of the United States, such as Canada and West Germany. Despite the incentives for high service volume inherent in fee schedule payment systems, both Canada and West Germany have successfully controlled volume increases through a combination of reviewing use of services and placing caps on total spending under their health insurance programs (see Appendix A).

A fee schedule might differ from the CPR system in several ways, and this chapter discusses some alternatives. The definition of some services might be changed. The method of setting payment rates would certainly be different. Requirements for assignment of benefits might be altered. Finally, stronger volume controls could be introduced.

UNIT OF PAYMENT

Under a fee schedule, the unit of payment could continue to be the services defined by HCFA's Common Procedure Coding System (HCPCS). Medicare only recently imposed this common coding system on all its carriers, and another change would not likely be well received by carriers in the near future. On the other hand, many analysts believe that some coding changes would be desirable because the current coding system permits inconsistent billing by physicians, code creep, and unbundling of services, perhaps resulting in higher costs.

If a fee schedule were implemented, uniform payment rates would be established for each service code but, unless physicians were consistent in their use of the service codes, Medicare's effective payment rates could be quite different among physicians. For example, visits are poorly defined under HCPCS, and there is evidence that physicians differ in how they use the codes. Even for procedures, which are more clearly defined, physicians differ in whether they bill for a visit along with the procedure and in whether they bill for any follow-up visits associated with the procedure.

Three specific coding changes are discussed: collapsing the number of distinct codes recognized for payment for certain generic services, redefining visits by either time or content, and packaging services associated with certain therapeutic procedures together for reimbursement. 1/

Collapse the Number of Distinct Codes for Certain Generic Services

The number of distinct codes in the American Medical Association's Common Procedural Terminology (CPT-4) system (on which HCPCS is based) is large--more than 7,000 in 1985, up from about 2,000 in 1966. There are

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1. See Janet B. Mitchell and others, "Alternative Methods for Describing Physician Services Performed and Billed," Report No. 84-4 (Health Economics Research, Chestnut Hill, Massachusetts, May 1984), for a more detailed discussion of these approaches.

11 codes for office visits. A set of 10 or more distinct codes for a single generic diagnostic or surgical procedure is not uncommon.

Although the rationale for the proliferation of codes is to enable physicians to describe accurately the services they provide, people concerned with cost containment have criticized the CPT-4 system for allowing physicians too much latitude in billing. By reducing the number of distinct codes for a given generic service, the potential for inadvertent or deliberate code creep by physicians would be reduced, perhaps resulting in some reduction in the growth of costs. Administration of payments by carriers might be simplified somewhat as well, once sets of services to be collapsed had been determined, although the significance of this effect would depend on the extent to which the number of codes was reduced.

The services to be combined would need to be chosen carefully, however, to ensure that the same payment rate was appropriate for all of the services collapsed into one. Otherwise, physicians might be reluctant to perform underpriced services. Medical judgment would be required to determine which services within a generic group were sufficiently different to require a separate code and payment rate, and agreement on a reduced set of services could be difficult to achieve.

Redefine Visits

Distinctions among visit categories are poorly defined under the CPT-4 system, with no specifications concerning time and unclear specifications on content (see Table 17). As a result, physicians apparently differ in how they interpret current visit definitions. For example, one survey found that a "limited" office visit for general practitioners lasted only three-quarters as long as the same type of visit for internists, on average.^{2/} The potential for inconsistent billing and code creep might be reduced if visits were defined by time. Alternatively, office visit packages might be defined based on the patient's diagnosis, with appropriate ancillary services included in a single payment rate for visits to reduce costs caused by unbundling of services.

Time-based Visits. Payment for visits might be determined on the basis of time, with a fixed amount paid for the first 10 minutes, for example, and (perhaps declining) amounts paid for each additional 10-minute increment. This method could provide an unambiguous definition of each visit, reducing the potential for inconsistent billing and code creep, although it would be necessary to specify how to count time spent with the physicians' assistants

2. Robert C. Mendenhall, *Medical Practice in the United States* (Princeton, New Jersey: Robert Wood Johnson Foundation, 1981).

TABLE 17. CPT-4 DEFINITIONS OF CATEGORIES FOR PHYSICIAN OFFICE VISITS FOR NEW AND ESTABLISHED PATIENTS

Level of Service	Definition
Minimal <u>a/</u>	A level of service supervised by a physician but not necessarily requiring his presence.
Brief	A level of service pertaining to the evaluation and treatment of a condition requiring only an abbreviated history and examination.
Limited	A level of service pertaining to the evaluation of a circumscribed acute illness or to the periodic reevaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings and/or medical management.
Intermediate	A level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis that necessitates the obtaining and evaluation of pertinent history and physical or mental status findings, diagnostic tests and procedures, and the ordering of appropriate therapeutic management; or a formal patient, family, or hospital staff conference regarding patient medical management and progress.
Extended	A level of service requiring an unusual amount of effort or judgment including a detailed history, review of medical records, examination, and a formal conference with patient, family or staff; or a comparable medical diagnostic and/or therapeutic service.
Comprehensive	A level of service providing an in-depth evaluation of a patient with a new or existing problem requiring the development or complete reevaluation of medical data. This procedure includes the recording of a chief complaint(s) and present illness, family history, past medical history, personal history, system review, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures.

SOURCE: American Medical Association, *Current Procedural Terminology*, 4th ed. (AMA, Chicago, Illinois).

a. There is no "minimal visit" category for new patients.

and nurses. Patients would be able to verify that they were billed only for the time they spent with the physician or assistants, in contrast to the current system under which patients have no clear idea whether they received a "limited" or an "intermediate" visit. Physicians might increase reimbursements by spending more time with each patient when their appointment books were not filled, but they are able to do that now, without the checks by both patients and carriers that visits defined by time would permit.

Office Visit Packages. Packages of services might be defined to replace the current visit codes, where visit packages would include ancillary services provided or ordered as a result of the visit. Criteria would need to be established to classify patient visits for payment purposes, though, because of the tremendous variation in medical problems encountered in the office. Visits could be classified by visit type (initial or follow-up), by reason for visit, by diagnosis, or by some combination of these. One system for classifying office visits based on diagnosis and physicians' time--known as ambulatory visit groups--is being developed, but this system does not yet account sufficiently for variation in appropriate services within each group.^{3/} Further development is under way, with the likelihood that the number of categories defined by the system will increase from 154 to about 400. It is uncertain, however, whether the potential benefits from this system would be large enough to justify the considerable expansion in visit codes that would apparently be required.

Office visit packages would generate both the advantages and the disadvantages of packaging. The principal advantage is that physicians would have financial incentives to reduce ancillary tests and other services, because these costs would come out of the physician's payment for the office package. One disadvantage is that some physicians might inadvertently reduce medically necessary services as well as those that were of little or no value. In addition, there would be financial incentives to shift services out of the office visit package--for example, to refer patients to specialists (so long as consultants' services were excluded from the package), or to request follow-up visits for services that might have been provided in one office visit. Further, if the classification system was not sufficiently sensitive to real differences in severity among types of visits--that is, if packages that were not homogeneous in terms of the services required were paid at the same rate--physicians treating sicker patients would be penalized and might become reluctant to accept them.

3. R.B. Fetter and others, "Ambulatory Visit Groups: A Framework for Measuring Productivity on Ambulatory Care," *Health Services Research*, vol. 19, no. 4 (October 1984), pp. 415-437.

Package Services for Certain Therapeutic Procedures

Some or all of the services usually associated with a single therapeutic procedure could be incorporated into a package for payment purposes. Therapeutic packages could be limited to procedures for which there was medical consensus on the appropriate services required.^{4/} A fixed package payment could be made to the primary physician regardless of the resources actually used.

A therapeutic package could vary in comprehensiveness. The package might include only the services and tests provided or ordered by the primary physician, such as visits related to the procedure, laboratory tests, and the procedure itself. A more comprehensive package might also include the services of supporting physicians such as radiologists, anesthesiologists, pathologists, and assistant surgeons. Finally, the most comprehensive package would include facility costs, such as hospital or outpatient department charges, in addition to physicians' services. Physicians' financial incentives to limit services would be stronger with a more comprehensive package, but financial risks to physicians from inadequate payment and risks to patients from inadequate care would also be larger.

In the most comprehensive package--covering all physicians' and facility costs--the physician would have strong financial incentives to perform the procedure in the least costly site and to minimize the use of consultants and tests. Physicians could face tremendous financial risks, though, in the event that complications developed and patients had to be hospitalized for an extended period, for example. The risks that patients might receive inadequate care would also be high under this option because the costs of all services and supplies would have to be paid by the primary physician.

If the package were limited to physicians' services, including consultants, the primary physician might choose, sometimes inappropriately, to interpret patients' x-rays rather than consult a radiologist, for example, or to perform a difficult colonoscopy rather than call in a gastroenterologist, with adverse effects for patients. This approach would have the same benefits and problems as paying physicians according to diagnosis-related groups (DRGs), discussed in Chapter V. Packaging for therapeutic procedures could apply, however, regardless of place of service, and could be limited to procedures for which appropriate physicians' services were reasonably uniform so that physicians' risks of underpayment would be small.

4. Diagnostic procedures would not generally be suitable candidates for packaging, because the underlying condition and the resources necessary to identify it are uncertain.

The package with the least financial risk for the physician, the least risk of inadequate care for the patient, and the least potential for slowing the growth in costs would be a package that included only services provided by the primary physician. Limited packaging of this sort already exists; some surgeons include pre- and postoperative visits in their charges for surgery, for instance. This practice varies among physicians, however, and Medicare has no uniform requirements. If a fee schedule were implemented, it would be important to specify what services were to be incorporated in the fee for specific procedures, to ensure consistent payment for all physicians.

PAYMENT RATES

Medicare could take an active role in setting fee differentials and annual increases in fees under a fee schedule, rather than accepting the differentials and increases that result under the CPR system. Payment differentials thought to be inappropriate could be altered by service, specialty, and location; the automatic and inflationary link between Medicare's payment rates and physicians' submitted charges for the previous year could be cut.

A fee schedule could be implemented quite soon if the schedule of payment rates was based, initially at least, on Medicare's allowed amounts or some other representative measure of current charges. Adjustments could be made over time to a charge-based fee schedule for fees that were thought to be inappropriate. Alternatively, implementation could be delayed until a comprehensive schedule of revised rates had been developed.

It is helpful for the following discussion to think of a fee schedule as having two components:

- o A relative value scale (RVS) giving each service a weight to indicate its value relative to any other service, where the weights might differ by specialty for some services; and
- o A monetary multiplier (or location-specific multipliers) that would convert the RVS weights into payment rates.

The RVS would likely be uniform nationwide, since the relative value of services would generally be the same for all regions.^{5/} Location-specific

5. The correlation between an RVS based on average submitted charges nationwide and RVSs based on submitted charges by individual carriers was very high, using data from HCFA's 1984 Medicare Annual Data Procedure file. Correlation coefficients were 0.96 or above in all instances but two. For Hawaii, the coefficient was 0.94; for southern California, the coefficient was 0.90. A coefficient of 1.00 indicates perfect correlation.

multipliers could be used to account for differences in the level of costs or the supply of physicians across regions.

Once a fee schedule was in place, the monetary multipliers could be adjusted as frequently as necessary to account for inflation, while the more complex task of recalibrating the RVS weights could be done less frequently, as required by changes in medical technology or other considerations.^{6/} The newly authorized Physician Payment Review Commission could recommend changes in both the RVS weights and the monetary multipliers, just as the Prospective Payment Assessment Commission advises on changes to the PPS. (The Physician Commission was authorized by the Consolidated Omnibus Budget Reconciliation Act of 1985, but no funding has yet been provided for it.)

The Relative Value Scale

Any one or a combination of three bases could be used to develop a relative value scale--resource costs, charges, or the judgment of a panel of experts. As discussed in Chapter II, it would be desirable for payment rates to mirror costs except where Medicare wanted to influence physicians' decisions. In some instances, for example, fees might be set below costs to discourage use of procedures that were ineffective or that were no more effective than less costly alternatives. In areas where the supply of physicians was inadequate, fees might be set higher relative to costs than in other areas to encourage physicians to locate in the underserved areas.

Hence, while costs would not be the only consideration, they would be an important determinant of the appropriate payment rates in a fee schedule. Estimating the resource costs necessary to produce each of the 7,500 distinct services reimbursed by Medicare would be a formidable task, though. In fact, one study submitted to the Health Care Financing Administration concluded that it is probably not feasible to construct a comprehensive schedule of costs by measuring resource costs for each service directly.^{7/}

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6. This is analogous to the rate-setting process under the prospective payment system for hospitals, where each diagnosis-related group has a weight assigned to it that represents its relative value, while the basic payment is determined by applying location-specific multipliers times the weight. (Other adjustments for factors such as the size of any teaching program are also made.)
 7. Jack Hadley and others, "Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services," Project Report No. 3075-07 (Urban Institute, Washington, D.C., October 1984).

An alternative method--one that would recognize the relevance of factors other than resource costs at the outset--would start from the current charge structure and "back into" an appropriate schedule of rates by making selective adjustments based on consensus by a panel of experts as to which services would be inappropriately priced at current rates. One consideration in determining whether a fee was appropriate would be whether the experts believed that the service would be unusually profitable or unprofitable. Estimates of costs for a few key services could be obtained and used as benchmarks by the experts to help in this assessment. 8/

The charge structure used as the initial base for this process could be average allowed amounts under Medicare or a representative measure of submitted charges (the mean or the median of billed amounts, for example). Previous studies have shown that RVSs developed from alternative charge bases are highly correlated, whether they are derived from billed amounts, allowed amounts, or prevailing fees.^{9/} There are some differences among these bases, however, that could appreciably alter the effects on particular specialty groups. For example, a fee schedule based on Medicare's allowed amounts would pay relatively less for hospital visits, compared with a schedule based on average amounts billed to Medicare (see Table 18). Because hospital visits comprise a large part of the services provided by internists, these physicians would fare better under a fee schedule based on average billed amounts than one based on average allowed amounts (see Appendix B).

However the RVS was obtained, the fee schedule derived from it could be scaled to be budget-neutral or to increase or reduce total payments by any desired amount. This would be accomplished by setting an appropriate value for the monetary multiplier.

An important issue to resolve in establishing an RVS would be whether given services differ--and therefore deserve different weights--depending on the physician's specialty. This issue primarily concerns visits, since visits are a major source of billings for physicians in most specialties.^{10/} Billing

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8. In January 1986, the Health Care Financing Administration contracted with the Harvard University School of Public Health, in conjunction with the American Medical Association, to develop a relative value scale along these lines. Completion was scheduled for mid-1988. Subsequently, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (which was signed into law in April 1986), the Congress instructed the Secretary of the Department of Health and Human Services to develop a relative value scale for physicians' services by July 1, 1987.
 9. See Chapter I, Section E, in Hadley and others, "Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services."
 10. The specialties of radiology, anesthesiology, and pathology do not typically have visit charges.

for procedures is more likely to be specialty-specific. (Lens procedures, for example, are provided almost exclusively by ophthalmologists).

If the costs of the resources actually used to provide each service were the only consideration, payment rates for all services would be higher

TABLE 18. MEDICARE'S ALLOWED AMOUNTS AS A PERCENT OF SUBMITTED CHARGES, BY MAJOR SERVICE GROUP, 1984

Service Group	Allowed Amounts for Each Service Group as a Percent of:	
	Submitted Charges for Each Service Group	Total Allowed Amounts for All Services
All Services <u>a/</u>	77.2	100.0
Office Visits	79.7	11.2
Hospital Visits	75.0	13.7
Emergency Room Visits <u>b/</u>	64.1	0.5
Home Visits	73.1	1.2
Consultations	79.1	3.5
Surgical Procedures	77.6	35.8
Nonsurgical Procedures	77.7	34.1

SOURCE: Congressional Budget Office tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider and Procedure files.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. The ratio for emergency room visits is unusually low because of HCFA regulations limiting payments for certain services rendered in hospital outpatient departments to 60 percent of the prevailing fee for similar services rendered in physicians' offices.

when provided by specialists than when provided by generalists, because specialists' training costs are higher. Higher rates would be justified on this basis, however, only for physicians who had incurred the additional training costs and were board-certified. Although higher rates might also be paid to physicians who were board-eligible but not certified, this would be more difficult for carriers to administer. Further, many analysts would argue that education alone, without board-certification of competence, should not merit higher payment rates.^{11/} The proportion of physicians paid specialty rates by Medicare would drop if the higher rates were paid only to board-certified physicians, since some physicians who are not board-certified currently bill as specialists. In 1983, only 56 percent of physicians claiming a specialty were certified in that specialty (see Table 19). Further, to achieve consistency across the country, Medicare would have to impose common standards about what specialties to group together for payment purposes, and what differentials between the specialty groups would be appropriate. The number of distinct specialties currently recognized for payment differentials varies from one carrier to another.

Alternatively, the costs of providing a given service might be based on the minimum resources required to provide the service rather than the resources actually used. The costs of performing a pacemaker implant, for example, could reflect the training costs of a general surgeon rather than the higher training costs of a thoracic surgeon, whose specialized skills are generally not required for this procedure. Under this approach, specialty differentials for well-defined procedures would be eliminated; a single rate would be set at a level appropriate for the least costly physician specialty generally competent to perform the procedure. This approach might, however, make insufficient allowance for the quality of judgment required to determine whether a procedure was required, while compensating adequately for the manual skills necessary to do the procedure. Further, cases where complications were likely to develop might require a more highly trained physician.

The issue with respect to visits is more complicated, because the services provided are not as well defined as they are for procedures. The services obtained during a visit with a specialist may or may not be more

11. A physician is board-certified in a specialty after passing an examination on the subject that is administered periodically by a national board of examiners. A physician is board-eligible--that is, eligible to take the examination--upon completion of the graduate medical education (residency training) required by the board.