Issue Brief on the Single Conversion Factor
AMERICAN SOCIETY OF INTERNAL MEDICINE

In 1989, Congress mandated that Medicare payments be based on relative differences in the "resource costs" of providing physician services. Implementation was phased in over four years, beginning on January 1, 1992. It was fully implemented on January 1, 1996. Under the Medicare fee schedule (MFS), payments are determined by the sum of the relative value units (RVUs) for each service based on the resource based relative value scale (RBRVS) plus charged-based practice expense and medical liability RVUs, as adjusted by geographic practice cost indices (GPCIs). The geographically-adjusted RVUs are then multiplied by separate dollar conversion factors (CFs) for surgical procedures, primary care services, and other nonsurgical services. (For the purposes of the separate conversion factors, surgical procedures are defined by law as procedures done most of the time by surgeons. "Primary care services" are defined as office, nursing home, home and emergency room services. "Other nonsurgical services" include virtually all other services that physicians provide: hospital visits, consultation, and diagnostic procedures such as EKGs, stress tests, sigmoidoscopies, etc).

ASIM believes that Congress should mandate a *single* conversion factor, established at the level of the current CF for primary care services, updated by the weighted average default update for 1998. A single conversion factor:

1. **Would end the unfair policy of reimbursing for some physician services at a dollar rate that is higher than other services that involve the same amount of physician work.** As shown in the attached tables, from 1992-1997, the CF for surgical procedures increased by far more than other services: in 1997, surgery is paid 14 percent more per RVU than primary care services and 21 percent more than other nonsurgical services.

2. **Is supported by a large majority of physicians and at least 21 medical specialty societies with a combined membership of more than 200,000 physicians.** A large majority of physician services would experience modest gains under a single CF. For most surgeons, the impact of a single CF would be extremely modest--a loss of only 1-6% in total Medicare payments, according to AMA data. Although payments for their surgical procedures would be reduced by a greater percentage, surgeons provide other services--such as consultations, hospital visits, and office visits, and diagnostic procedures--that *gain* under a single CF. In addition to ASIM, the groups that support full implementation of a single CF on 1/1/98 include:

American Academy of Family Physicians, American Academy of Neurology, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Clinical Endocrinologists, American College of Physicians, American College of Cardiology, American College of Emergency Physicians, American College of Rheumatology, American Gastroenterological Association, American Geriatrics Society, American Medical Directors Association, American Osteopathic Association, American Sleep Disorders Association, American Society for Gastrointestinal Endoscopy, American Society of Clinical Oncology, College of American Pathologists, Joint Council on Allergy, Asthma and Immunology, The Endocrine Society, and the Renal Physicians Association.

3. **Would help offset the reductions that some medical specialists expect under resource-based practice expenses (RBPEs).** Cardiologists, neurologists, radiologists, gastroenterologists, pathologists, emergency physicians and nephrologists *may* see reductions under RBPEs, but they *gain* from a single CF.

4. **Has broad bipartisan support.** A single conversion factor is included in the president's Budget, was passed by Congress as part of the Balanced Budget Act (BBA) of 1995 (subsequently vetoed by President Clinton for unrelated reasons) and is in the "Blue Dog" budget proposal from House Democrats.

5. **Should be fully implemented on 1/1/98, rather than phased in.** The inequities created by current law have been in effect for five years and should not be continued longer. Surgeons have had a de facto

transition: the two years from the 1/1/96 implementation date in the BBA to the proposed 1/1/98 implementation. A transition would reduce the $7.3 billion savings over five years that CBO projects from a single CF and changes in the update formula, by maintaining higher pay rates for surgery during the transition. The single CF should be considered independent of the debate over implementing RBPEs--unlike RBPEs, no one argues that more study is needed to implement a single CF.

6. **Should be established at no less than the current primary care CF, updated by the weighted average default update for 1998 (estimated to be $37.13 in CY 1998).** Anything less would rollback fees for undervalued primary care services, increase the loss for surgeons, provide less of a gain for medical specialties whose services have been the most disadvantaged under the separate CF updates (and less of a gain to offset to possible RBPE reductions).