

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Health Care Financing Administration**

[BPD-853-FN]

RIN 0938-AH41

Medicare Program; Physician Fee Schedule Update for Calendar Year 1997 and Physician Volume Performance Standard Rates of Increase for Federal Fiscal Year 1997**AGENCY:** Health Care Financing Administration (HCFA), HHS.**ACTION:** Final notice.

SUMMARY: This final notice announces the calendar year 1997 updates to the Medicare physician fee schedule and the Federal fiscal year 1997 volume performance standard rates of increase for expenditures for physicians' services under the Medicare Supplementary Medical Insurance (Part B) program as required by sections 1848 (d) and (f), respectively, of the Social Security Act. The fee schedule updates for calendar year 1997 are 1.9 percent for surgical services, 2.5 percent for primary care services, and -0.8 percent for other nonsurgical services. While it does not affect payment for any particular service, there was a 0.6 percent increase in the update for all physicians' services for 1997. The physician volume performance standard rates of increase for Federal fiscal year 1997 are -3.7 percent for surgical services, 4.5 percent for primary care services, -0.5 percent for other nonsurgical services, and a weighted average of -0.3 percent for all physicians' services.

EFFECTIVE DATE: The provisions in this final notice pertaining to the Medicare volume performance standard rates of increase are effective October 1, 1996, and the provisions pertaining to the Medicare physician fee schedule update are effective January 1, 1997, as provided by the Medicare statute. Ordinarily, 5 U.S.C. section 801 requires that agencies submit major rules to Congress 60 days before the rules are scheduled to become effective. However, the 104th Congress adjourned on October 4, 1996, and the 105th Congress is not scheduled to convene until January 7, 1997. The Department has concluded that, in this instance, a further delay in the effective dates in order to satisfy section 801 would not serve the law's intent, since Congress will not be in session during this period, and such delay in the effective dates established by the Medicare statute is unnecessary and contrary to the public interest. The Department finds, on this

basis, that there is good cause for establishing these effective dates pursuant to 5 U.S.C. section 808(2).

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SUPPLEMENTARY INFORMATION:**I. Background and Summary of Legislation****A. The Physician Fee Schedule Update and Medicare Volume Performance Standard**

Section 1848 of the Social Security Act (the Act) requires the Secretary of Health and Human Services to—

- Establish annual updates to payment rates under the Medicare physician fee schedule, and
- Establish volume performance standard rates of increase to help control the rate of growth in expenditures for physicians' services.

Under section 1848(b)(1) of the Act, payment for physicians' services, except for anesthesia services, equals the product of the relative value units (RVUs) for a service, a geographic adjustment factor, and a conversion factor. Anesthesia services are paid under a different relative value system, and payment is equal to the sum of the base and time units for the service multiplied by a geographically adjusted anesthesia-specific conversion factor. The RVUs and anesthesia base units reflect the relative amount of resources used by physicians to furnish the service, and the geographic adjustment factor measures practice cost differences between areas. The geographically adjusted RVUs are multiplied by a conversion factor to obtain the physician fee schedule payment amounts. As is discussed in section IV.C.1. of the final rule for the 1997 physician fee schedule, "Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1997," published elsewhere in this Federal Register issue, there is a separate adjustment to the work RVUs in 1997. (This rule is referenced from now on as the 1997 physician fee schedule final rule.) Therefore, for 1997, the work RVUs are adjusted by this separate factor, and all RVUs are adjusted by a geographic practice cost index and multiplied by a conversion factor to obtain the physician fee schedule payment amounts. We plan on eliminating this separate adjuster in 1998 when we implement resource-based practice expense RVUs.

The 1997 conversion factors are \$16.68 for anesthesia services, \$40.9603 for surgical services, \$35.7671 for primary care services, and \$33.8454 for other nonsurgical services.

1. Physician Fee Schedule Update

Section 1848(d) of the Act requires the Secretary to provide the Congress with her recommendation of a physician fee schedule update by April 15 of each year. Under section 1848(d)(2)(A) of the Act, the Secretary is required to consider a number of factors, including the following:

- The percentage change in the Medicare economic index (MEI), a measure of the change in the cost of operating a medical practice.
- The growth in actual expenditures for physicians' services in the prior fiscal year.
- The relationship between that growth and the volume performance standard rate of increase.
- Changes in the volume and intensity of services.
- Access to services.
- Other factors that may contribute to changes in the volume and intensity of services or access to services.

If the Congress does not set the update, section 1848(d)(3) of the Act establishes the process for updating the physician fee schedule. Under section 1848(d)(3), unless otherwise specified by the Congress, the fee schedule update for a category of physicians' services equals the appropriate update index (the MEI) adjusted by the number of percentage points by which expenditure growth exceeded or was less than the volume performance standard rates of increase for the second preceding year for that category of physicians' services. That is, the calendar year 1997 update would equal the 1997 MEI increased or decreased by the difference between the rate of increase in expenditures for fiscal year 1995 and the volume performance standard for that year. However, section 1848(d)(3)(B) of the Act limits the maximum downward adjustment for 1995 and any succeeding year to 5.0 percentage points. There is no restriction on upward adjustments to the MEI.

Section 1848(d)(1)(C) of the Act requires the Secretary to publish in the Federal Register, within the last 15 days of October, the updates for the following calendar year.

The updates are required by the Medicare statute, and any budget implications associated with them are

due to the requirements of the law and not this notice.

2. Medicare Volume Performance Standard Rates of Increase

Section 1848(f) of the Act requires the Secretary to establish volume performance standard rates of increase for Medicare expenditures for physicians' services. The use of volume performance standard rates of increase is intended to control the rate of increase in expenditures for physicians' services.

The volume performance standard rates of increase are not limits on expenditures. Payments for services are not withheld if volume performance standard rates of increase are exceeded. Rather, the appropriate fee schedule update, as specified in section 1848(d)(3)(A) of the Act, is adjusted to reflect the success or failure in meeting the volume performance standard rates of increase.

Section 1848(f) of the Act sets forth the process for establishing the volume performance standard rates of increase by requiring the Secretary to recommend to the Congress the physician volume performance standard rates of increase for the following Federal fiscal year by not later than April 15. The Secretary is required to recommend MVPS rates for surgical, primary care, other nonsurgical, and all physicians' services. In making the recommendations, the Secretary is required to confer with organizations that represent physicians and to consider the following factors:

- Inflation.
- Changes in the number and age composition of Medicare enrollees under Part B (excluding risk health maintenance organization enrollees).
- Changes in technology.
- Evidence of inappropriate utilization of services.
- Evidence of lack of access to necessary physicians' services.
- Other appropriate factors as determined by the Secretary.

If the Congress does not set the volume performance standard rates of increase, section 1848(f)(2)(A) and (B) of the Act requires the Secretary to set MVPS rates for all physicians' services and each category of physicians' services equal to the product of the

following four factors reduced by a performance standard factor, which for fiscal year 1997 is 4.0 percentage points:

- 1.0 plus the Secretary's estimate of the weighted-average percentage increase (divided by 100) in fees for all physicians' services or for the category of physicians' services for the portions of calendar year 1996 and calendar year 1997 contained in fiscal year 1997.
- 1.0 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of Part B enrollees (excluding risk health maintenance organization enrollees) from fiscal year 1996 to fiscal year 1997.
- 1.0 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in the volume and intensity of all physicians' services or of the category of physicians' services for fiscal year 1991 through fiscal year 1996.
- 1.0 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services or of the category of physicians' services that will result from changes in law or regulations in fiscal year 1997 as compared with expenditures for physicians' services in fiscal year 1996.

Section 1848(f)(1)(C) of the Act requires the Secretary to publish in the Federal Register within the last 15 days of October of each year the volume performance standard rates of increase for all physicians' services and for each category of physicians' services for the Federal fiscal year that began on October 1 of that year. (The MVPS for all physicians' services has no practical effect on the update. We publish it only because we are required to do so by section 1848(f) of the Act.)

3. Past Years' Medicare Volume Performance Standard Rates of Increase and Physician Fee Schedule Updates

MVPS rates have been established under section 1848 of the Act since fiscal year 1990. Calendar year 1992 was the first year in which the update was affected by expenditures under the MVPS system. The following tables illustrate the MVPS rates in each fiscal year since their inception, the actual rates of increase, and the corresponding updates in the second subsequent calendar year.

FEE SCHEDULE UPDATE

[In Percent]

Calendar year	MEI	Performance adjustment	Legislative adjustment	Update
CY 1992:				
All services	3.2	-0.9	-0.4	1.9
CY 1993:				
Surgical	2.7	0.4	.....	3.1
Nonsurgical	2.7	-1.9	.....	0.8
All services ¹ .....	.....	.....	.....	1.4
CY 1994:				
Surgical	2.3	11.3	-3.6	10.0
Primary care	2.3	5.6	0.0	7.9
Other nonsurgical	2.3	5.6	-2.6	5.3
All services ¹ .....	.....	.....	.....	7.0
CY 1995:				
Surgical	2.1	12.8	-2.7	12.2
Primary care	2.1	5.8	0.0	7.9
Other nonsurgical	2.1	5.8	-2.7	5.2
All services ¹ .....	.....	.....	.....	7.7
CY 1996:				
Surgical	2.0	1.8	.....	3.8
Primary care	2.0	-4.3	.....	-2.3
Other nonsurgical	2.0	-1.6	.....	0.4
All services ¹ .....	.....	.....	.....	0.8
CY 1997:				
Surgical	2.0	-0.1	.....	1.9
Primary care	2.0	0.5	.....	2.5
Other nonsurgical	2.0	-2.8	.....	-0.8
All services ¹ .....	.....	.....	.....	0.6

¹ The all services update is the weighted average of the category updates and, except for 1992, does not affect payment.

MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE

(In Percent)

Fiscal Year	MVPS	Actual	Difference
FY 1990:			
All services	9.1	10.0	-0.9
FY 1991:			
Surgical	3.3	2.9	0.4
Nonsurgical	8.6	10.5	-1.9
FY 1992:			
Surgical	6.5	-4.8	11.3
Nonsurgical	11.2	5.6	5.6
FY 1993:			
Surgical	8.4	-4.4	12.8
Nonsurgical	10.8	5.0	5.8
FY 1994:			
Surgical	9.1	7.3	1.8
Primary care	10.5	14.8	-4.3
Other nonsurgical	9.2	10.8	-1.6
FY 1995:			
Surgical	9.2	9.3	-0.1
Primary care	13.8	13.3	0.5
Other nonsurgical	4.4	7.2	-2.8
FY 1996:			
Surgical	-0.5		
Primary care	9.3		
Other nonsurgical	0.6		
FY 1997:			
Surgical	-3.7		
Primary care	4.5		
Other nonsurgical	-0.5		

Separate MVPS rates for surgical and nonsurgical services were not required until fiscal year 1991. Separate fee schedule updates were not required until calendar year 1993. Beginning with the calendar year 1994 fee schedule update and the fiscal year 1994 MVPS, we established separate updates and MVPS rates of increase for surgical, primary care, and other nonsurgical services.

B. Physicians' Services

Section 1848(f)(5)(A) of the Act defines physicians' services for purposes of the volume performance standard rates of increase as including other items or services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed by a physician or furnished in a physician's office. Section 1861(s) of the Act defines medical and other health services covered under Part B. As provided for in the fiscal year 1990 volume performance standard rates of increase notice in the Federal Register on December 29, 1989 (54 FR 53819), we are including the following medical and other health services in section 1861(s) of the Act in the physician volume performance standard rates of increase if bills for the items are processed and paid for by Medicare carriers:

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient physical therapy and speech therapy services, and outpatient occupational therapy services.
- Antigens prepared by or under the direct supervision of a physician.
- Services of physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests.
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.

As stated in our December 8, 1994 final notice (59 FR 63638) announcing the fiscal year 1995 volume performance standard rates of increase, we included outpatient diagnostic laboratory tests paid through intermediaries in the MVPS definition of physicians' services beginning in fiscal year 1996 (59 FR 63640).

C. Definition of Surgical, Primary Care, and Other Nonsurgical Services

As described in the December 2, 1993 notice (58 FR 63858) containing our definitions of surgical, primary care, or other nonsurgical services, we consider a procedure to be surgical if the following conditions are met:

- In the HCFA Part B data system, the service is classified under "type of service" as a "surgery."

- The service is performed by surgical specialists more than 50 percent of the time.

As also discussed in the December 1993 notice, section 1842(i)(4) of the Act defines primary care services as "office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services." Since this language was the result of an amendment to the Act made by section 4042(b) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Pub. L. 100-203), enacted on December 22, 1987, we rely on the conference report accompanying OBRA 1987 (H. R. Rep. No. 100-495, 100th Congress, 1st Session 594-595 (1987)) to determine the HCFA Common Procedure Coding System (HCPCS) codes to be included in the definition of primary care services. In addition, section 6102(f)(10) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Pub. L. 101-239), enacted on December 19, 1989, indicated intermediate and comprehensive office visits for eye examinations and treatments for new patients were to be considered primary care services.

We classify physicians' services not meeting the surgical or primary care definitions as nonsurgical services.

For a procedure code that is new in 1997 and does not meet the primary care definition, we do not have any data for determining how often the procedure is performed by surgical specialists and therefore whether the service should be classified as surgical or nonsurgical. We categorized these codes as surgical or nonsurgical based on the judgment of our medical staff. To assist us in making these determinations, we considered the type-of-service classification within the Physicians' Current Procedural Terminology (CPT) and the relationship of services represented by the new codes to surgical services meeting the above-described criteria. We followed a similar process to classify codes that were new in 1996. For the 1997 classification of the new 1996 codes, however, we used 6 months of 1996 data to determine whether they meet the criteria for being considered surgical

services. Based on these data, we did not need to reclassify any codes as surgical or nonsurgical.

Beginning in 1996, we classified monthly end-stage renal disease services (HCPCS codes 90918 through 90921) as primary care services. For a full discussion of this classification, see the final rule with comment period entitled "Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1996" published in the Federal Register on December 8, 1995 (60 FR 63155 through 63156).

Also, Addendum B of the 1997 physician fee schedule final rule, published elsewhere in this Federal Register issue, lists the RVUs and related information used in determining Medicare payments for HCPCS codes. For the purposes of the physician fee schedule, we have assigned the following surgical, primary care, or other nonsurgical service update indicators to these codes:

Update indicator	Interpretation
S	Surgical services.
P	Primary care services.
N	The physician fee schedule update applies, but the code is not defined as surgical or primary care.
O	The physician fee schedule update does not apply.

The MVPS indicator for a procedure code is identical to the update indicator for codes that have a surgical, primary care, or other nonsurgical service update indicator. However, we consider some codes with an update indicator of "O" to be nonsurgical for the purposes of the MVPS, most notably the clinical diagnostic laboratory codes.

II. Provisions of This Final Notice

A. Physician Fee Schedule Update for Calendar Year 1997

Under the requirements of section 1848(d)(3) of the Act, the fee schedule update for calendar year 1997 will be 1.9 percent for surgical services, 2.5 percent for primary care services, and -0.8 percent for other nonsurgical services. The weighted average update across all services for 1997 will be 0.6 percent. We determined this update as follows:

	Surgical services	Primary care services	Nonsurgical services
	(In Percent)		
1997 MEI	2.0	2.0	2.0
MVPS Adjustment	-0.1	0.5	-2.8
1997 Update	1.9	2.5	-0.8

As discussed in our December 8, 1995 final rule for the 1996 physician fee schedule (60 FR 63172 through 63173), we began applying budget-neutrality adjustments to the conversion factors rather than to the RVUs in 1996. As we discuss in section IX of the 1997 physician fee schedule final rule, published elsewhere in this Federal Register issue, there will be two separate budget neutrality adjustments in 1997. The first will be a budget neutrality adjustment applied to the work RVUs when calculating Medicare physicians' fees for 1997. This budget neutrality adjustment, 8.3 percent, will account for fee changes related to the 5-year review of work RVUs. The second budget neutrality adjustment, 1.5 percent, will be applied uniformly to the conversion factors to account for both the fee schedule changes unrelated to the 5-year review and the anticipated

volume and intensity response to all fee schedule changes unrelated to the conversion factor updates. Because anesthesia services are not paid on the basis of work RVUs, an equivalent -7.5 percent adjustment will be made to the anesthesia conversion factor to account for both these budget neutrality adjustments.

Applying the updates and conversion factor budget neutrality adjustment to the 1996 conversion factors of \$40.7986 for surgical services (other than anesthesia services), \$35.4173 for primary care services, and \$34.6293 for nonsurgical services yields 1997 conversion factors of \$40.9603 for surgical services, \$35.7671 for primary care services, and \$33.8454 for other nonsurgical services. The 1996 anesthesia conversion factor of \$15.28, which includes the effect of the 1996 budget neutrality adjustment, will be updated by the surgical update to

\$16.68 for 1997, after adjusting for the 1997 budget neutrality adjustments.

The specific calculations to determine the fee schedule updates for physicians' services for calendar year 1997 are explained in section III.A. of this notice.

B. Physician Volume Performance Standard Rates of Increase for Fiscal Year 1997

Under the requirements in section 1848(f)(2)(A) and (B) of the Act, we have determined that the volume performance standard rates of increase for physicians' services for fiscal year 1997 are -3.7 percent for surgical services, 4.5 percent for primary care services, -0.5 percent for other nonsurgical services, and a weighted average of -0.3 percent for all physicians' services.

This determination is based on the following statutory factors:

Statutory factors	Surgical services	Primary care services	Nonsurgical services
	(In Percent)		
Fees	2.0	2.0	2.2
Enrollment	-1.1	-1.1	-1.1
	(In Percent)		
Volume and Intensity	1.6	4.0	4.0
Legislation	-2.1	3.4	-1.5
Performance Standard Factor	4.0	4.0	4.0
Total	-3.7	4.5	-0.5

The specific calculations to determine the volume performance standard rates of increase for physicians' services for fiscal year 1997 are explained in section III.B. of this notice.

III. Detail on Calculation of the Calendar Year 1997 Physician Fee Schedule Update and the Fiscal Year 1997 Physician Volume Performance Standard Rates of Increase

A. Physician Fee Schedule Update

1. The Percentage Change in the Medicare Economic Index

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide labor

productivity. This index, which has 1989 base weights, is comprised of two broad categories: (1) Physician's own time, and (2) physician's practice expense.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents, wages and salaries and fringe benefits. These components are adjusted by the 10-year moving average percent change in output per man-hour for the nonfarm business sector to eliminate double counting for productivity growth in physicians' offices and the general economy.

The physician's practice expense category represents the rate of price growth in nonphysician inputs to the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. Like physician's own time, the nonphysician staff categories are adjusted for productivity using the 10-year moving average percent change in output per man-hour for the nonfarm business sector. The physician's practice expense component also includes the following categories of nonlabor inputs: office expense, medical materials and supplies, professional liability insurance, medical equipment, professional car, and other expense. The table below presents a listing of the MEI cost categories with associated weights

and percent changes for price proxies for the 1997 update. The calendar year 1997 MEI is 2.0 percent.

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 1997¹

	1989 weights ²	CY 1997 percent changes
Medicare Economic Index Total	100.0	2.0
1. Physician's Own Time ^{3,4}	54.2	2.0
a. Wages and Salaries: Average hourly earnings private nonfarm, net of productivity	45.3	2.2
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm, net of productivity	8.8	1.0
2. Physician's Practice Expense ³	45.8	2.0
a. Nonphysician Employee Compensation	16.3	1.9
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation, net of productivity	13.8	2.0
2. Fringe Benefits: Employment Cost Index, fringe benefits, white collar, net of productivity	2.5	1.4
b. Office Expense: Consumer Price Index for Urban Consumers (CPI-U), housing	10.3	2.8
c. Medical Materials and Supplies: Producer Price Index (PPI), ethical drugs/PPI, surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted)	5.2	2.2
d. Professional Liability Insurance: HCFA professional liability insurance survey ⁵	4.8	-1.1
e. Medical Equipment: PPI, medical instruments and equipment	2.3	1.6
f. Other Professional Expense	6.9	2.8
1. Professional Car: CPI-U, private transportation	1.4	2.3
2. Other: CPI-U, all items less food and energy	5.5	2.9
Addendum:		
Productivity: 10-year moving average of output per man-hour, nonfarm business sector	N/A	0.9
Physician's Own Time, not productivity adjusted	54.2	2.9
Wages and salaries, not productivity adjusted	45.3	3.1
Fringe benefits, not productivity adjusted	8.8	1.9
Nonphysician Employee Compensation, not productivity adjusted	16.3	2.8
Wages and salaries, not productivity adjusted	13.8	2.9
Fringe benefits, not productivity adjusted	2.5	2.3

¹ The rates of change are for the 12-month period ending June 30, 1996, which is the period used for computing the calendar year 1997 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 1996.

² The weights shown for the MEI components are the 1989 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for calendar year 1989. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 1989 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

³ The Physician's Own Time and Nonphysician Employee Compensation category price measures include an adjustment for productivity. The price measure for each category is divided by the 10-year moving average of output per man-hour in the nonfarm business sector. For example, the wages and salaries component of Physician's Own Time is calculated by dividing the rate of growth in average hourly earnings by the 10-year moving average rate of growth of output per man-hour for the nonfarm business sector. Dividing one plus the decimal form of the percent change in the average hourly earnings (1+.031=1.031) by one plus the decimal form of the percent change in the 10-year moving average of labor productivity (1+.009=1.009) equals one plus the change in average hourly earnings net of the change in output per manhour (1.031/1.009=1.022). All Physician's Own Time and Nonphysician Employee Compensation categories are adjusted in this way. Due to a higher level of precision the computer calculated quotient may differ from the quotient calculated from rounded individual percent changes.

⁴ The average hourly earnings proxy, the Employment Cost Index proxies, as well as the CPI-U, housing and CPI-U, private transportation are published in the Current Labor Statistics Section of the Bureau of Labor Statistics' Monthly Labor Review. The remaining CPIs and PPIs in the revised index can be obtained from the Bureau of Labor Statistics' CPI Detailed Report or Producer Price Indexes.

⁵ Derived from a HCFA survey of several major insurers (the latest available historical percent change data are for calendar year 1995). This is consistent with prior computations of the professional liability insurance component of the MEI.

N/A Productivity is factored into the MEI compensation categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.

2. Medicare Volume Performance Standard Performance Adjustment

As required by section 1848(d)(3)(B)(i) of the Act, we are increasing the update by 0.5 percentage points for primary care services and decreasing it by 0.1 percentage points for surgical and 2.8 percentage points for other nonsurgical services to reflect the percentage increase in expenditures between fiscal year 1994 and fiscal year 1995 relative to the volume performance standard rates of increase for fiscal year 1995.

Our estimate of the percentage growth in surgical services between fiscal year

1994 and fiscal year 1995 is 9.3 percent. Because the volume performance standard rate of increase for fiscal year 1995 was 9.2 percent, the rate of increase in expenditures for surgical services was greater than the volume performance standard rate of increase by 0.1 percentage points. For primary care services, the rate of increase in expenditures was 13.3 percent, 0.5 percentage points less than the volume performance standard rate of increase of 13.8 percent. For other nonsurgical services, the rate of increase in expenditures was 7.2 percent, 2.8

percentage points greater than the volume performance standard rate of increase of 4.4 percent.

B. Fiscal Year 1997 Physician Volume Performance Standard Rates of Increase

Below we explain how we determined the increases for each of the four factors used in determining the volume performance standard rates of increase for fiscal year 1997.

Factor 1—Weighted-Average Percentage Increase in Fees for Physicians' Services (Before Applying Legislative Reductions) for Months of Calendar Years 1996 and 1997 Included in Fiscal Year 1997

This factor was calculated as a weighted average of the fee increases that apply to fiscal year 1997; that is, the fee increases that apply to the last 3 months of calendar year 1996 multiplied by 25 percent plus the fee increases that apply to the first 9 months of calendar year 1997 multiplied by 75 percent. Beginning with calendar year 1992, physicians' services are updated by a physician fee schedule update factor that is based on the MEI adjusted for several statutory factors. The update factor for a category of physicians' services for calendar year 1997 is adjusted by the number of percentage points that the rate of increase in expenditures in fiscal year 1995 compared to fiscal year 1994 was less than the volume performance standard rate of increase for the category of physicians' services in fiscal year 1995. Laboratory services are updated by increases in the Consumer Price Index for Urban Consumers (CPI-U).

Table 2 shows the updates that were used to determine the weighted-average percentage increase in physicians' fees.

TABLE 2.—MEDICARE ECONOMIC INDEX AND CONSUMER PRICE INDEX FOR URBAN CONSUMERS FOR CALENDAR YEARS 1996 AND 1997

	1996	1997
MEI	2.0	2.0
CPI-U	3.2	2.7

Physicians' services make up approximately 90 percent of the total expenditures in the definition of physicians' services used for purposes of the volume performance standard rates of increase; laboratory services represent approximately 10 percent.

In addition to the annual updates and individual weights of the above services, one other element has an effect on the rate of increase in physician fees. Section 1842(h)(1) of the Act provides for "participating physicians" who agree to accept Medicare payment as payment in full and to bill Medicare beneficiaries only for the 20 percent coinsurance amount and any unmet portion of the \$100 annual deductible amount. Sections 1842(b)(4)(A)(iv) and 1848(a)(3) of the Act provide that nonparticipating physicians are paid 5 percent less for their Medicare services than participating physicians. The

nonparticipating physicians are given an opportunity at the end of each calendar year to enroll as participating physicians for the next calendar year. Participation rates have increased each year, and we assume that this trend will continue. The increase in the number of participating physicians and the fact that they are paid at a rate higher than nonparticipating physicians also add to the rate of increase in the weighted-average percentage increase in physician fees.

After taking into account all the elements described above, we estimate that the weighted-average increase in fees for physicians' services in fiscal year 1997 before applying the legislative changes will be 2.0 percent for surgical services, 2.0 percent for primary care services, 2.2 percent for other nonsurgical services, and a weighted average of 2.1 percent for all physicians' services.

Factor 2—The Percentage Increase in the Average Number of Part B Enrollees from Fiscal Year 1996 to Fiscal Year 1997

We estimate that average Medicare Part B enrollment in fiscal year 1997, excluding those enrolled in risk health maintenance organizations (whose Medicare-covered medical care is paid for through the adjusted average per capita cost mechanism and is therefore outside the scope of the MVPS) will be 32.170 million.

The corresponding figure for 1996 is estimated to be 32.532 million total Part B enrollees not enrolled in risk health maintenance organizations. This represents a 1.1 percent decrease in enrollment from fiscal year 1996 to fiscal year 1997 for surgical services, primary care services, other nonsurgical services, and the average of all physicians' services.

Factor 3—Average Annual Growth in the Volume and Intensity of Physicians' Services for Fiscal Year 1992 Through Fiscal Year 1996

Section 1848(f)(2)(A)(iii) of the Act requires the Secretary to estimate the average annual percentage growth in the volume and intensity of physicians' services or of the category of physicians' services for fiscal year 1992 through fiscal year 1996. This estimate must be based upon information contained in the most recent annual report issued by the Board of Trustees of the Supplementary Medical Insurance Trust Fund (Trustees' Report).

The data on the percentage increase in the volume and intensity of services in the Trustees' Report are based on historical trends in increases in allowed

charges, which are not influenced by the Part B deductible. Increases in expenditures, however, are influenced by the Part B deductible. Section 1832(b) of the Act specifies that the Part B deductible will be \$100 for calendar year 1991 and subsequent years. The effect of the deductible remaining fixed at \$100 is that the overall annual increases in allowed charges for MVPS physicians' services are lower than the overall annual increases in expenditures. Although we believe it would be consistent with a literal interpretation of section 1848(f)(2)(A)(iii) of the Act, it would be inappropriate to base the volume and intensity component on the lower 5-year growth in allowed charges and compare the volume performance standards to the higher growth in expenditures, so we instead compare the standards to the growth in allowed charges.

Consistent with data contained in the Trustees' Report, we estimated Factor 3 using a definition of physicians' services that includes certain supplies and nonphysician services not otherwise included in computing the volume performance standard rates of increase (primarily durable medical equipment and ambulance services). We included data for these services because we were required to base the estimate on data contained in the Trustees' Report, and it was not feasible to recompute the data from the 5-year period to exclude these supplies and nonphysician services. We believe the inclusion of these nonphysician supplies and services in this component has a minimal effect on the estimate because the component measures rates of change. Since durable medical equipment and ambulance services constitute only about 10 percent of the total charges used in the Trustees' Report, the rate of change for these nonphysician services and supplies would have to be significantly different from the rate of change for physicians' services to have any measurable impact on this volume and intensity increase factor. (Factor 3 is the only component of the volume performance standard rate of increase that was estimated using data that included nonphysician services and supplies.) The volume increases for services performed in independent laboratories were included in the calculation of the physician increases, as were the volume increases for clinical laboratory tests performed in hospital outpatient departments.

As described earlier, the fiscal year 1997 volume performance standards were calculated using category-specific volume and intensity. The 5-year average rate of increase in volume and

intensity equals 1.6 percent for surgical services, 4.0 percent for primary care services, and 4.0 percent for other nonsurgical services. The weighted-average increase for all physicians' services is 3.4 percent.

Factor 4—Percentage Increase in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in Fiscal Year 1997 Compared With Fiscal Year 1996

Legislative changes enacted in OBRA 1993 and changes in the regulations required by this law, as well as implementation of the physician fee schedule (including changes made in the RVUs for 1996 and 1997) will have an impact on the volume performance standard rates of increase for fiscal year 1997.

The net effect of implementing the physician fee schedule after making RVU changes for 1996 and 1997 is to increase payment rates for primary care services and the volume performance standard for those services. Similarly, the net effect of refining the RVUs and implementing the fee schedule reduces payment rates for most surgical services and many nonsurgical services other than primary care, thus, lowering the volume performance standard rates of increase for these services. Implementing the fee schedule will increase the volume performance standard rates of increase for all physicians' services because, although the net effect of increases in fees for certain services and decreases in fees for other services will have a budget neutral effect on fees for all physicians' services, an adjustment is required to ensure that changes in volume and intensity related to the fee changes do not cause an increase in expenditures. The MVPS targets are increased by this volume and intensity adjustment.

After taking into account these provisions, this factor equals -2.1

percent for surgical services, 3.4 percent for primary care services, and -1.5 percent for other nonsurgical services, and a weighted average of -0.7 percent for all physicians' services.

IV. Inapplicability of 30-Day Delay in Effective Date

We usually provide a delay of 30 days in the effective date for final Federal Register documents. In this case, however, the volume performance standard rates of increase are required by law to be published in the last 15 days of October 1996 and are effective on October 1, 1996. Thus, the Congress has clearly indicated its intent that the rates of increase be implemented without the usual 30-day delay in the effective date and has foreclosed any discretion by us in this matter. Therefore, the requirement for a 30-day delay in the effective date does not apply to this notice. With regard to the physician fee schedule, the effective date will be January 1, 1997, which is more than 30 days beyond the publication date of this notice.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Regulatory Impact Statement

A. Regulatory Flexibility Act

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, States

and individuals are not entities, but we consider all physicians to be small entities.

We are not preparing a regulatory flexibility analysis since we have determined, and the Secretary certifies, that this notice will not have a significant economic impact on a substantial number of small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We are not preparing a rural impact analysis since we have determined, and the Secretary certifies, that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

(Sections 1848 (d) and (f) of the Social Security Act)

(42 U.S.C. 1395w-4 (d) and (f))

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 7, 1996.

Bruce C. Vladeck,
Administrator, Health Care Financing Administration.

Dated: November 12, 1996.

Donna E. Shalala,
Secretary.

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