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PHYSICIAN SHORTAGE AREAS

Medicare Incentive Payments Not an Effective Approach to Improve Access

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The Honorable John L. Mica
Chairman, Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
House of Representatives

The Honorable Christopher Shays
House of Representatives

Many Americans face difficulties obtaining health care. In many areas of the country, ranging from remote rural areas to inner cities, these difficulties may be the result of a shortage of physicians. Recognizing this need, the federal government identifies areas with shortages of primary care physicians and administers a variety of programs designed to improve access to care for people living in those areas. One of these programs is the Medicare Incentive Payment program.

The Medicare Incentive Payment program pays physicians a 10-percent bonus payment for Medicare services they provide in areas identified as having a shortage of primary care physicians. The program, administered by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS), is viewed as a method to attract and retain physicians in underserved areas and improve access to care, both for Medicare beneficiaries and for others who may have difficulty obtaining health care. In 1997, bonus payments paid from the Medicare Supplemental Medical Insurance trust fund amounted to over $92 million.

In recent years, both the Administration and the Congress have considered expanding or otherwise modifying the program to address continuing concerns about medical underservice. Proposed approaches include increasing the bonus percentage for primary care services; expanding bonus payments to other providers, such as nurse practitioners and physician assistants; and allowing more areas to become eligible for bonus payments. In light of these proposed modifications and our prior work identifying problems with federal efforts to target resources to underserved areas, you asked us to determine if the program is an effective mechanism for improving access to care for (1) Medicare beneficiaries and (2) underserved populations other than Medicare beneficiaries. You also asked us to determine if the program's goals,

performance measures, and financial controls provide a sound structure for continuing or expanding the program.

We focused our work on the extent to which the program design addresses access to health care needs. Our work included analyzing HCFA data for all physician claims for which bonus payments were made in calendar year 1996 and the results of HCFA's Medicare Current Beneficiary Survey for that year. We supplemented this analysis with reviews of agency documents and studies on physician practice location decisions and interviews with agency officials, contractors who process the bonus payments, and health services researchers. We conducted our work from May through December 1998 in accordance with generally accepted government auditing standards. For more on our scope and methodology, see appendix I.

Results in Brief

The Medicare Incentive Payment program is not an effective mechanism for improving Medicare beneficiaries' ability to obtain health care. The program was created out of concern that low Medicare payment rates for primary care services, particularly in areas with a shortage of physicians, could cause access problems for Medicare beneficiaries. However, since the program began, the Congress has taken additional action to address this concern. This action generally increased reimbursement rates for primary care services and reduced the geographic variation in physician reimbursement rates. In addition, HCFA survey data show that Medicare beneficiaries who have access problems, including those who may live in underserved areas, generally cite reasons other than the unavailability of a physician—such as the cost of services not paid by Medicare—for their access problems.

The Medicare Incentive Payment program is also not an effective mechanism for improving access to care for people not covered by Medicare in underserved areas. Although the program is considered a means of attracting and retaining physicians in shortage areas, the program does not appear to play a significant role in this regard. The relatively small bonus payments most physicians receive—a median payment of $341 for the year in 1996—are unlikely to have a significant impact on physician recruitment and retention. The program has two other severe limitations that restrict its ability to address identified needs of those in underserved areas. First, specialists receive most of the program dollars, even though primary care physicians have been identified as being in short supply, while shortages of specialists, if any, have not been

determined. Second, the program provides no incentives or assurance that physicians receiving bonuses will actually treat people who have problems obtaining health care.

HHS has not developed goals or related performance measures for the Medicare Incentive Payment program to clarify what the program is expected to accomplish. Without such goals and measures, it is difficult—if not impossible—for HHS to determine what the program is accomplishing. As it stands, the program provides no assurance that the more than $90 million spent each year is improving access to care in underserved areas. HCFA's oversight of the program also has limitations that allow physicians and other providers to receive and retain bonus payments they claimed in error.

This report contains matters for congressional consideration, including a determination of the program's appropriateness for addressing medical underservice. In addition, the report contains recommendations to the Secretary of HHS to strengthen program accountability and financial controls.

Background

The Medicare Incentive Payment program was originally proposed because of concerns that low Medicare reimbursement rates, particularly for primary care services, could cause access problems for Medicare beneficiaries in some areas. Since the program began, it has also come to be viewed as a mechanism to address the medical underservice problems of a broader population.

In a 1987 report to the Congress, the Physician Payment Review Commission (PPRC)[1] reported that geographic variations in Medicare payments might contribute to access problems for beneficiaries in some rural and low-income urban areas. PPRC was concerned that low Medicare payments in such areas might affect physicians' willingness to see Medicare beneficiaries and could affect their decisions to establish and maintain practices there. As an initial step to address these problems, PPRC recommended that Medicare pay an increment above approved charges for primary care services delivered in underserved areas. In response, the Congress included language in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) that established a new section 1833(m) of the Social

[1]PPRC was established to advise the Congress on reforms in physician payment under the Medicare program. In 1997, PPRC was merged with the Prospective Payment Assessment Commission to create the Medicare Payment Advisory Commission.

Security Act.[2] The new provision provided for a 5-percent bonus payment effective January 1, 1989, for all physician services provided in rural areas with the greatest degree of physician shortages.[3] OBRA 87 also provided for the bonus payments to be extended to urban areas with the greatest degree of physician shortages, effective January 1, 1991.[4]

In its report accompanying OBRA 87, the House Budget Committee expressed concern that low Medicare payment rates for primary care services, particularly in areas with a shortage of physicians, could lead to Medicare beneficiaries having difficulty accessing care. The committee acknowledged that higher payments for services might not be a complete solution to the problem but asserted that such payments were "a necessary ingredient in the solution" and were likely to significantly improve access to such services.[5] The program requirements were amended in 1989, increasing the bonus payments to 10 percent, effective January 1, 1991, and they were extended, as provided under OBRA 87, to urban areas with physician shortages on that same date.[6] The amendments also extended bonus payments to all areas identified with a shortage of physicians by removing the requirement that the services be provided in those areas with the greatest degree of physician shortages.

More recently, the program has been viewed as serving a broader goal of benefitting underserved areas in general, not just helping ensure that Medicare beneficiaries have adequate access to care. Some health services researchers, physician groups, and rural health advocates see the program as a mechanism to provide assistance to underserved areas, particularly in recruiting and retaining physicians.

How Bonus Payments Are Made

The program's bonuses are based on payments to physicians for services in both hospital and nonhospital settings paid by Medicare's medical insurance (part B). These payments include office visits and physician evaluations of hospitalized patients. Bonuses are not paid for other health care costs covered by Medicare's hospital insurance (part A), such as inpatient hospital care. In addition, bonuses are not paid for services provided under Medicare managed care plans.

[2]P.L. 100-203, sec. 4043, 101 Stat. 1330, 1330-85 (42 U.S.C. 1395l(m)).

[3]The federal government classifies shortage areas into four classes. OBRA 87 restricted the bonus payments to class 1 and class 2 rural areas, which have the greatest degree of shortage.

[4]OBRA 87 also charged the Secretary of HHS with studying and reporting on the feasibility of such an extension.

[5]H.R. Rep. No. 100-391(I), at 389 (1987). No Senate report was submitted with this legislation.

[6]Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, sec. 6102(c)(1), 103 Stat. 2106, 2184.

Bonus payments are made when the location where the services are provided is in an area designated by HHS' Health Resources and Services Administration (HRSA) as a primary care health professional shortage area (HPSA). All types of physicians, including specialists, are eligible for these payments, while nonphysician providers, such as nurse practitioners, are not. Physicians providing services in HHS program sites serving underserved areas and populations—such as rural health clinics, community health centers, and other federally qualified health centers—are not eligible for bonus payments.[7]

To be designated a primary care HPSA, an area must be a rational service area and have a population-to-physician ratio of at least 3,500 to 1.[8] HHS designates primary care HPSAs in one of three ways: (1) a general shortage of providers within a geographic area; (2) a shortage of providers willing to treat a specific population group, such as poor people or migrant farmworkers, within a defined area; or (3) a shortage of providers for a public or nonprofit facility, such as a prison or a hospital. Only HPSAs in the first category—geographic HPSAs—are eligible for Medicare incentive payments. Geographic primary care HPSAs can include an entire county or only part of a county such as specific census tracts. In practice, areas are designated as geographic HPSAs even when only a portion of the population is underserved. HPSA designations are made without accounting for the presence of health care facilities, such as hospitals, or physicians not in primary care fields. As of March 31, 1998, over 1,800 areas were designated as geographic primary care HPSAs eligible for bonus payments.

Program Expenditures

Program expenditures have increased dramatically since the program began, paying more than $400 million dollars in bonuses over the past 5 years. Because it is tied to Medicare payments for physician services, the program is not exposed to the same routine legislative scrutiny as many other programs.[9] Program payments totaled less than $2 million in 1989 and grew to nearly $32 million in 1991, the first year program amendments were implemented. Since that time, without any further changes in the program, expenditures have grown to over $100 million in 1996 and over

[7]These clinics and health centers receive cost-based reimbursements under Medicare part B, which covers their actual costs of providing care.

[8]Under certain circumstances, a population-to-physician ratio of 3,000 to 1 is used. This ratio is calculated by counting nonfederal physicians providing direct patient care who practice principally in one of the four primary care specialties—general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology. See 42 C.F.R. Appendix A to Part 5 (1998).

[9]Medicare payments for physician services are financed by monthly premiums as well as federal general revenues.

$90 million in 1997. Of the amount paid in 1996, $57 million was paid for services provided in urban areas; the remaining $49 million was paid for services provided in rural areas.[10]

We and others have reported on concerns about the program's operation, particularly about the effectiveness of using the HPSA designation system as the primary tool for determining where such bonus payments should be targeted.[11] Since the issuance of these reports, numerous proposals for expanding or otherwise modifying the program have been considered, but none has been enacted.[12]

Program Is Not an Effective Mechanism for Improving Medicare Beneficiaries' Access to Care

Since the inception of the Medicare Incentive Payment program the basis for Medicare physician reimbursement has changed. The program began out of concern that low Medicare rates, particularly for primary care services, were causing access problems for Medicare beneficiaries in some areas. However, in 1989 the Congress required the Secretary to establish a Medicare fee schedule for physician services.[13] Implementation of the fee schedule, which began in 1992, generally increased reimbursement rates for primary care services and decreased the geographic variation in physician reimbursement rates. For example, between 1991 and 1993, the payment rates for services provided by general and family practice physicians increased 17 percent. PPRC has reported on the fee schedule implementation since 1992 and has found no evidence linking changes in Medicare reimbursement rates with health care access problems for Medicare beneficiaries. For five reports issued between 1993 and 1997, PPRC analyzed changes in beneficiaries' use of services, satisfaction with care, and ability to obtain care and found no relationship between the fee-schedule payment rates and access problems for beneficiaries. In 1998, PPRC's successor, the Medicare Payment Advisory Commission, reported similar findings.

[10]When physicians claim the bonus payment, they indicate on the claim form whether the service was provided in an urban or a rural HPSA. We used these self-reported categorizations for our analysis of urban and rural bonus payments.

[11]See Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995), and Medicare Incentive Payments in Health Professional Shortage Areas: Do They Promote Access to Primary Care?, HHS Office of Inspector General (OEI-01-93-00050, June 1994).

[12]In 1995, as part of a budget reconciliation bill, the Congress approved a provision to increase bonus payments to 20 percent, limit the payment to primary care services, and extend bonus payments for 3 years after a HPSA designation is withdrawn. However, the bill was vetoed by the President.

[13]P.L. 101-239, sec. 6102, 103 Stat. 2106, 2169 (42 U.S.C. 1395w-4).

While some Medicare beneficiaries have reported difficulty obtaining health care, the reasons cited for these problems are generally not addressed by the Medicare Incentive Payment program. On the basis of its 1996 Medicare Current Beneficiary Survey,[14] HCFA estimates that about 904,000 of more than 29 million beneficiaries enrolled in Medicare fee-for-service experienced some trouble obtaining health care.[15] However, most of the primary reasons for trouble obtaining health care identified in the survey were not directly related to the lack of a physician. These reasons included services and supplies not covered by Medicare and the lack of transportation to the doctor or hospital. Among the beneficiaries estimated to have trouble obtaining care, HCFA's projections indicate that the portion having problems for reasons the Medicare Incentive Payment program could address is relatively small.[16]

HCFA's survey data do not break out the extent to which those Medicare beneficiaries whose trouble obtaining care relates to physician reimbursement rates may be concentrated in HPSAs. However, even if most or all of these beneficiaries resided in HPSAs, in aggregate they would represent a very small percentage of the estimated 6.2 million Medicare beneficiaries who live within a HPSA.

[14]HCFA's Medicare Current Beneficiary Survey is a continuous, multipurpose survey of a representative sample of the Medicare population, including both aged and disabled enrollees. In 1996, the access to care portion of the survey included a sample of over 17,000 Medicare beneficiaries. The survey collects information about demographic characteristics, health status and functioning, access to care, insurance coverage, and financial support. See appendix I for more information on our analysis of survey results.

[15]At the 95-percent confidence level, HCFA estimates the number of beneficiaries who reported difficulty obtaining health care to be between 815,023 and 993,292. These survey results are for an estimated 29 million beneficiaries under Medicare fee-for-service who were enrolled in one or both parts of the Medicare program as of January 1, 1996, and were alive and enrolled at the time of the Medicare Current Beneficiary Survey interview (September to December 1996). Beneficiaries living in long-term-care facilities, such as nursing homes, were excluded from these estimates.

[16]At the 95-percent confidence level, HCFA estimates that between 19,502 and 70,524 beneficiaries had trouble primarily because the wait was too long or the doctor was too busy; between 14,448 and 57,442 beneficiaries had trouble primarily because they could not find a doctor who would accept Medicare; and between 6,368 and 23,424 beneficiaries had trouble primarily because of difficulty or delays getting an appointment because they were on Medicare.

Program Is Not an Effective Mechanism for Addressing Access Problems in Underserved Areas

The Medicare Incentive Payment program is also not an effective mechanism for improving access to care for other residents of HPSAs for two reasons. First, typical bonus payments are small and are unlikely to play a significant role in attracting or retaining physicians to work in HPSAs. Second, the program dollars that are paid are not linked to primary care physicians, who have been identified as needed in HPSAs; nor are dollars linked to the treatment of people who actually have problems obtaining health care.

Influence on Physician Recruitment and Retention Is Questionable

The program's ability to influence a physician's decision to locate and remain in an underserved area is questionable. Most physicians who are paid a bonus receive an insignificant amount each year, both nominally and in comparison to a physician's total income. In addition, the impact of financial incentives on practice location decisions may be limited, as many other factors can also influence these decisions.

In 1996, half of the more than 49,000 physicians receiving a bonus payment received $341 or less for the year; three-fourths, or about 37,000 physicians, received less than $2,130.[17] This larger amount represents less than 2 percent of the median net income for physicians during the year.[18] In urban areas, the median payment is somewhat higher for specialists; in rural areas the opposite is true. As shown in table 1, however, the highest median bonus payment is only $427.

[17]In rural areas, three-fourths of, or about 18,700, physicians received less than $1,520 for the year. In urban areas, three-fourths of, or about 16,300, physicians received less than $2,558 for the year.

[18]According to survey data from the American Medical Association (AMA), the median net income in 1996 for all physicians after expenses and before taxes was $166,000; for general or family practitioners, it was $130,000. Seventy-five percent of all physicians had net incomes over $120,000.

Table 1: Median Annual Bonus Payments for Physicians Receiving a Bonus Payment, by Physician Type and Location, 1996

	Median annual bonus payment[a]	
Physician type	**Urban**	**Rural**
Primary care physician	$352	$370
Specialist	427	99
All physicians[b]	403	161

Note: The table excludes 328 physicians who submitted valid claims for bonus payments but received no bonus payments because Medicare did not pay for the services (for example, if the beneficiary had not met his or her deductible and paid the entire claim). The table also excludes 2,319 physicians who received bonus payments in both urban and rural areas.

[a]The median bonus payment is the amount at which half of the physicians receiving bonus payments received less for the year and half received more. Median bonus payments were calculated for physicians who received bonus payments in 1996, based on Medicare's identification numbers for unique physicians.

[b]Physicians who received bonus payments and who were listed as both a primary care and specialty physician in HCFA's claims data were excluded from the median calculations. If these physicians were included, the median annual bonus payments would increase to $488 in urban areas and $193 in rural areas.

Regardless of the size of these payments, studies and surveys have suggested that factors other than income play a role that is of equal or greater importance in physicians' decisions about where to practice. Opportunities to pursue professional interests, availability of colleagues and continuing education, and quality of life issues have been cited in studies and ranked in surveys of physicians as being as influential as or more influential than income on their practice location decisions.[19] In a 1992 PPRC report, the commission questioned the impact of financial incentives on attracting physicians to underserved communities. PPRC observed that to recruit physicians who have established a practice elsewhere, a payment incentive would in theory have to offset the costs associated with starting a new practice and the nonfinancial costs of relocating. Even for new physicians, income differentials do not significantly affect the decision to locate in a nonmetropolitan versus metropolitan area, PPRC reported.

[19]In its 1991 report to the Congress, PPRC reviewed the range of factors that affect a physician's decision where to practice. Among the most important from the perspective of rural physicians are proximity to hospital facilities; access to continuing medical education; and the presence of other physicians, which provides opportunities to join a group practice, interact with colleagues, and obtain coverage for patients when off-call. In addition to professional considerations, the physical environment and amenities of an area have some bearing on a physician's location decision. Also, in a 1994 AMA survey of physicians under age 40, location preference, personal autonomy, opportunity to pursue professional interests, and convenience of work hours were cited more often than income potential or guaranteed income as important factors influencing their employment decisions.

In some instances, such as for physicians operating at the financial margin, the bonus payments may be a factor in a physician's decision to stay in a community. However, we were unable to find evidence regarding the relative influence of a small financial incentive compared to other factors. One study of primary care physicians who moved to rural areas found that only physicians' satisfaction with their communities and opportunities to achieve professional goals lengthened retention. While the study found that satisfaction with income also tended to predict longer retention, this did not quite reach levels of statistical significance.[20] The study did not examine the influence of small financial incentives on retention.

Program Expenditures May Not Address Access Problems of Underserved Areas

In addition to providing little incentive to recruit physicians to HPSAs, the Medicare Incentive Payment program does not link program dollars to need. Access to primary care providers is viewed by the federal government and health services researchers as one of the most critical access needs in underserved areas. However, most program dollars are paid to specialists—even though the extent of specialist shortages, if any, has not been identified. In addition, bonus payments provide no incentive or requirement for physicians to treat people who are having problems obtaining health care.

Primary Care Physicians Are in Short Supply in Underserved Areas, but Most Program Dollars Go to Specialists

Primary care providers provide continuous, basic, and preventive health care and coordinate patient needs for specialty care; for this reason, the federal government has a variety of programs that spend over $1 billion each year in an effort to address the primary care needs in underserved areas.[21] States also view the availability of primary care providers in underserved areas as a critical need.[22] Forty-six states participate in a rural recruitment and retention network to inform health care providers about employment opportunities in rural areas, including underserved areas. All states in the network are seeking primary care providers.

[20]D. Pathman, E. Williams, and T. Konrad, "Rural Physician Satisfaction: Its Sources and Relationship to Retention," The Journal of Rural Health, Vol. 12, No. 5 (1996), pp. 366-77.

[21]These programs include the Health Center program, the National Health Service Corps, the Rural Health Clinic program, and various health professions education programs.

[22]In 1990, 90 percent of states cited availability of primary care physicians as one of their top concerns regarding health care shortages, according to HHS' report States' Assessment of Health Personnel Shortages: Issues and Concerns, Pub. No. HRS-p-OD 90-6 (Washington, D.C.: HHS, Oct. 1990).

Despite the need for primary care physicians, specialists received the majority of Medicare Incentive Payment program dollars in 1996.[23] This occurs because of the disconnect between the types of physicians identified as needed in HPSAs and the physicians eligible to receive bonus payments. HPSA designations only identify shortages of primary care physicians and do not identify whether shortages of specialists exist.

Areas that have a shortage of primary care physicians do not necessarily have a shortage of specialists. In general, a smaller portion of a given population needs specialty care. For example, researchers estimate that to sustain a practice, a cardiologist would need a population base that is nine times larger than the population base needed by a family practice physician.[24]

Even though the need for specialists in shortage areas is unknown, bonus payments to specialists amounted to over 60 percent ($65 million) of all program dollars.[25] A larger proportion of these payments—and many of the substantial bonus payments—were made to specialists in urban areas, where they are typically concentrated.[26] For example, in 1996, specialists in urban areas received more than $41 million.[27] One cardiac surgeon received over $75,000, a dermatologist received over $69,000, and a neurosurgeon received over $57,000 in bonus payments. While many specialists provide some primary care services, 84 percent—or about $35 million—of the 1996 bonus payments to specialists in urban areas was for specialty services.[28]

[23]We considered physicians practicing in general or family medicine, internal medicine, obstetrics/gynecology, and pediatrics as primary care physicians, and physicians practicing in other specialties as specialists.

[24]L. L. Hicks and J. K. Glenn, "Rural Populations and Rural Physicians: Estimates of Critical Mass Ratios, by Specialty," Journal of Rural Health, Vol. 7, No. 4, Supplemental (1991).

[25]In rural areas, specialists received 49 percent of bonus payment dollars; in urban areas, specialists received 73 percent of bonus payment dollars.

[26]See appendix II for information on the distribution of bonus payments by the type of county of the Medicare beneficiaries' residence in relation to metropolitan areas.

[27]Of this amount, 29 percent was paid to physicians in the specialties of cardiology, ophthalmology, and diagnostic radiology. Specialties receiving more than $1 million in bonus payments for services provided in urban HPSAs include anesthesiology, emergency medicine, gastroenterology, general surgery, nephrology, orthopedic surgery, pulmonary disease, psychiatry, and urology. Appendix III lists the different specialty areas in which physicians received bonus payments in urban areas and the total amount of bonus payments each type received in 1996.

[28]Similar results are found in rural areas. In 1996, 79 percent—or about $19 million—of the $24 million in bonus payments to specialists in rural areas was for specialty services.

In a 1994 HHS Inspector General report, the necessity of paying bonuses to specialists, particularly in urban areas, was questioned. The Inspector General reported that these physicians generally provide few primary care services and are attracted to urban areas for reasons other than bonus payments. In its response to the report, HCFA agreed that making incentive payments to specialists in urban areas was an unnecessary expenditure for the trust fund but said that provisions in the President's Health Security Act, then under consideration, would limit bonus payments in urban HPSAs to primary care services.[29] However, the President's Health Security Act was not enacted, and HCFA has not proposed any other legislative solution to the problem.

Payments Are Not Linked to Treating Those Actually Underserved

In addition to paying the majority of program dollars to specialists, the program does not require physicians receiving bonus payments to treat people who are actually underserved, such as the uninsured.[30] Thus, a physician treating a large number of Medicare beneficiaries and receiving bonus payments for each could have few or no uninsured patients but would receive a relatively large amount in bonus payments. Conversely, a physician with a large number of uninsured patients but few Medicare patients would receive a relatively small amount in bonus payments.

The program also does not target all types of primary care services needed to address an area's access problems. For example, many states report the need for more pediatricians, obstetricians, and gynecologists, in particular, to improve health care services for populations such as young children and pregnant women in underserved areas. However, children and pregnant women are typically not eligible for Medicare; as such, the program pays few, if any, bonuses to those pediatricians, obstetricians, and gynecologists who treat them.[31]

[29]This bill also included an increase in incentive payments for primary care service in both urban and rural HPSAs from 10 percent to 20 percent.

[30]Not all residents of a geographic HPSA have difficulty obtaining health care; rather, many of the geographic HPSA designations actually mean a specific segment of the population living in the area is underserved. In addition, according to a report by the Agency for Health Care Policy and Research (AHCPR), families with one or more uninsured family members were two to three times more likely to have experienced barriers to receiving needed health care services than insured families. According to the report, the inability to afford medical care and insurance-related problems were the main reasons families reported for their difficulty, delay, or inability to obtain health care in 1996. See Access to Health Care in America—1996, MEPS Highlights 3, AHCPR Pub. No. 98-0002 (Oct. 1997).

[31]Medicare may cover pregnant women or children under certain circumstances if they are disabled or have chronic kidney disease. For most physicians with specialties of pediatrics or obstetrics/gynecology, Medicare payments comprise a relatively small percentage of their revenues. According to AMA survey data, Medicare comprised an average of 1.3 percent of revenues for pediatrics and an average of 8.7 percent of revenues for obstetrics/gynecology in 1996. In contrast, Medicare comprised an average of 24 percent of revenues for general/family practice physicians.

Bonus payments are also made for beneficiaries who are treated but do not live in a geographic HPSA. For example, both the physician's office and the beneficiary's residence could be in an suburb outside a HPSA, but the physician would receive a bonus payment for treating the beneficiary in a hospital located in a HPSA. This problem is more pronounced in urban areas. We estimate that of the $57 million paid in urban areas in 1996, about 1 out of every 2 dollars, or about $31 million, was paid for treating beneficiaries who did not live in a geographic HPSA.[32]

HHS officials have acknowledged that the HPSA system is not structured to effectively identify areas where the Medicare Incentive Payment program should be implemented and that it was not set up to do so. HHS has proposed some revisions to address a number of other problems related to the HPSA designation system, but these changes are not directed at the problems in using the designation for the Medicare Incentive Payment program.[33] Therefore, the proposed changes do little, if anything, to improve the link between Medicare incentive payments and the treatment of people who are actually underserved.

Program Lacks Sound Administrative Structure

The Medicare Incentive Payment program's goals, performance measures, and financial controls do not provide a sound structure for continuing or expanding the program. HHS has not defined program goals or related performance measures against which to measure the program's accomplishments. In addition, HCFA may be able to implement at no additional cost more effective financial controls that could save millions of dollars in erroneous bonus payments.

Goals or Related Performance Measures Are Absent

HCFA officials said they administer the program as required by law—making bonus payments when a service is provided in an eligible HPSA—and that the agency's flexibility to target payments is limited by

[32]In rural areas, we estimate that about 1 of every 10 dollars in bonus payments was paid for treating beneficiaries who lived outside a geographic HPSA. These estimates are based on random samples of claims for which bonus payments were made. At the 95-percent confidence level, we estimate that the total bonus payments made for beneficiaries who lived outside a geographic HPSA was between $18.5 and $43.9 million in urban areas and between $3.2 and $5.8 million in rural areas.

[33]HHS began developing the proposed revisions in 1992 to accomplish several goals and alleviate problems associated with the existing methods of HPSA designation. HHS describes various purposes for these revisions, including (1) consolidating the HPSA designation process with another HHS process for designating medically underserved areas, (2) reducing the need for time-consuming population group designations by including indicators representing access barriers experienced by these groups in the criteria applied to area data, and (3) ensuring that current services to underserved populations are not disrupted in the transition to the new system. See 63 Fed. Reg. 46538, 46539 (Sept. 1, 1998).

statute. While changing the eligibility for receiving bonus payments would require legislative action, the agency can nonetheless develop clear program goals and related performance measures to monitor the program as part of its implementation of the Government Performance and Results Act of 1993 (Results Act). Thus far, however, the program has not been part of HHS' Results Act planning. For example, HHS has a strategic goal to "improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs." One of the objectives to achieve this goal is to "improve access to primary care services." The Medicare Incentive Payment program has not been incorporated into this goal or objective.

Department-level action is important because the Medicare Incentive Payment program is within the domain of two different HHS agencies—HCFA and HRSA—and neither has incorporated the program into its performance plans. Moreover, HHS has not developed goals or performance measures for the program. For HCFA, which administers the Medicare Incentive Payment program, three core dimensions—content of care, access, and satisfaction—are central to its performance measurement. However, the only access-related goal in its fiscal year 1999 performance plan is to improve access for Medicare beneficiaries who do not have supplemental insurance. The performance plan does not establish any objectives or related performance measures for the Medicare Incentive Payment program or clarify how it relates to the Department's other access to care programs. HRSA is responsible for administering other federal programs addressing access problems in underserved areas, including the Health Center Program and the National Health Service Corps program—the federal government's main program for placing providers in shortage areas. In fiscal year 1998, these two programs received $826 million and $112 million, respectively. However, HRSA's fiscal year 1999 performance plan is silent on how these or its other programs relate to the Medicare Incentive Payment program.

As we have stated in other reviews of HHS activities, the Results Act provides an opportunity for HHS to make sure that its programs for improving access to care are on track and to identify how each program's efforts will contribute to overall access goals.[34] However, without clear goals and related performance measures for the Medicare Incentive Payment program, HHS cannot identify what the program is trying to

[34]See Department of Health and Human Services: Strategic Planning and Accountability Challenges (GAO/T-HEHS-98-96, Feb. 26, 1998).

achieve or recognize when it is going off course and develop corrective actions.

HCFA Policy for Financial Controls Allows Erroneous Payments

In addition to program goals and related performance measures, the program's financial controls also warrant attention. HCFA's limited approach for ensuring that erroneous bonus payments are returned to the Medicare trust fund may allow millions of misspent bonus payment dollars to be retained by physicians. When claiming bonus payments on their bills to Medicare, physicians self-report that a service was provided in a HPSA. As a check against fraudulent or erroneous billing, HCFA requires its contractors that process and pay Medicare claims to select 25 percent of the physicians who received bonus payments each quarter, review five claims for each physician, and recover any incorrect payments for those five claims. If a contractor finds that a physician was paid in error, it is not required to review more claims to identify additional overpayments. However, the contractor is required to review all of the claims for this physician in the following quarter. These reviews are conducted for a new group of physicians each quarter. In fiscal year 1997, the most common errors identified by these post-payment reviews included cases where the area was no longer a HPSA; a physician's office was in a HPSA, but the service was provided outside a HPSA; and neither the place of service nor the physician's office was in a HPSA. Postpayment reviews also identified cases in which the payments were made for practitioners who were not physicians.[35]

More cost-effective and extensive reviews provide HCFA an opportunity to identify and collect millions of dollars in additional payments made in error. We found one contractor that prevented substantial amounts in erroneous bonus payments by increasing its review beyond HCFA requirements—without increasing its staffing or budget. Instead of reviewing a 25-percent sample of physicians, the contractor reviewed claims for all physicians and looked at a larger number of claims per physician than required.[36] Because its review included more physicians and more claims, the contractor identified and prevented payment on

[35]In our review of HCFA claims data for bonus payments made in 1996, we found that bonuses were paid for 23 nonphysician specialties that are not eligible for bonus payments. These included nurse practitioners, physician assistants, certified nurse anesthetists, clinical laboratories, and medical equipment suppliers. These nonphysician providers received over $1.1 million in bonus payments in 1996.

[36]The contractor reviewed physicians' claims prior to totaling bonus payment checks and, as a result, was able to identify amounts ineligible for payment and deduct them before sending the checks.

$1.2 million in ineligible bonus payment claims for its jurisdiction in 1997.[37] This amount nearly matches the $1.5 million in erroneous bonus payments reported in 1997 by the 23 contractors that reviewed claims for the rest of the country. We also found other contractors that reviewed more claims than required by HCFA, and without additional staffing, two of these contractors had a tenfold increase in the amount of erroneous payments they identified and collected.[38]

Conclusions

Our review underscores the need for the Congress to rethink the role of the Medicare Incentive Payment program, especially since other congressional action has addressed the initial concern about low Medicare reimbursement rates. The program's design has fundamental problems that undermine its ability to improve access to care for either Medicare beneficiaries or other people living in underserved areas. Bonus payments are not linked to the reasons Medicare beneficiaries have difficulties in obtaining care. Nor are they linked to the physicians and services identified as being needed in underserved areas and the people who actually have trouble obtaining care. In addition, the program has problems with planning, performance measurement, and financial controls. As a result, it is unlikely that much of the more than $400 million spent on the program in the past 5 years has actually improved access in underserved areas.

Because the Medicare Incentive Payment program is linked to Medicare payments, it is not exposed to the same routine legislative scrutiny as many other programs. As a result, it is important to decide whether providing bonus payments for physicians based on Medicare reimbursement is still a sound mechanism for improving access to care or whether it is preferable to direct limited federal resources to other strategies. Medicare Incentive Payment program expenditures have grown 50-fold since the program began, and there is nothing to check continued growth in the future. While the amount spent on the program—$106 million in 1996—is a small fraction of the Medicare budget, it is a sizeable amount when compared to other HHS programs, such as the $112-million National Health Service Corps program, that are aimed at improving access to care in underserved areas.

[37]In 1997, the contractor was responsible for paying bonus payments for physicians in Delaware, New Jersey, Pennsylvania, and the District of Columbia.

[38]This increase is based on data for the first quarter of 1998. These two contractors reviewed all claims for that quarter for those physicians in the 25-percent sample for whom they found an erroneous payment. We also interviewed three other contractors that had similar procedures. However, these contractors were unable to provide data on the additional amounts of erroneous bonus payments that they identified and collected as a result of these procedures.

Nevertheless, if the program is to continue or expand, it needs (1) a clear definition of the intended outcomes of the program and a design that links program dollars to those outcomes, (2) clear program goals and performance measures to track its progress and identify any necessary corrections, and (3) improved financial controls to better ensure the appropriateness of bonus payments.

Matters for Congressional Consideration

The Congress should consider whether the Medicare Incentive Payment program is an appropriate vehicle for addressing medical underservice. If the Congress decides to continue or expand the program, it should consider clarifying the intent of the program and taking steps to better structure the program to link limited federal funds to the intended outcomes.

Recommendations to the Secretary of HHS

To improve management and oversight of the program, we recommend that the Secretary of HHS (1) integrate the program into the Department's overall access-to-care strategic planning and performance measurement activities and (2) direct the Administrator of HCFA to establish more intensive bonus payment review standards for all contractors.

Agency Comments and Our Evaluation

In written comments on a draft of our report, HHS generally agreed with our conclusions and recommendations. While HHS did not specifically comment on our matters for congressional consideration regarding the program's appropriateness as a vehicle for addressing medical underservice, HHS agreed with our overall conclusion that the program has design problems. However, HHS' comments indicate that in the Department's view the problems with the program may be limited to bonus payments to urban specialists. HHS commented that bonus payments should be more appropriately targeted at primary care physicians in underserved urban areas and all physicians in rural underserved areas. We disagree with this view. While some problems are more pronounced in urban areas, the program also has fundamental design problems that are not limited to specialists in urban areas. These problems undermine the program's ability to improve access to care for Medicare beneficiaries or other people living in rural underserved areas as well.

HHS also raised several other specific issues. For example, HHS commented that our report's analysis of the impact of small bonus payments needed to be supplemented with more data on payments to rural physicians.

Accordingly, we have incorporated additional data showing that most rural physicians receive relatively small bonus payments. In addition, HHS suggested that we consider information from a 1994 Inspector General report on the importance of bonus payments. We did not use this physician questionnaire data because the report advised that it probably exaggerated the true importance of the incentive payments.

HHS also provided technical comments that we incorporated as appropriate. HHS' letter is printed in appendix IV.

We are sending copies of this report to the Secretary of HHS and other interested parties. We will also make copies available to others upon request.

This report was prepared by Frank Pasquier, Assistant Director; Kim Yamane; Tim S. Bushfield; Evan Stoll; and Bernice Steinhardt. Please contact me at (202) 512-6802 or Laura Dummit, Associate Director, at (202) 512-7114 if you or your staff have any questions.

Sincerely yours,

Richard Hembra
Assistant Comptroller General
Health, Education, and Human Services Division

Contents

Figure

Abbreviations

AHCPR	Agency for Health Care Policy and Research
AMA	American Medical Association
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
OBRA	Omnibus Budget Reconciliation Act
PPRC	Physician Payment Review Commission

Scope and Methodology

To accomplish our objectives, we focused on the extent to which the design of the Medicare Incentive Payment program addresses access to care needs. We interviewed (1) Health Care Financing Administration (HCFA) officials, at both central office and HCFA field offices; (2) Medicare contractors responsible for processing the bonus payments and conducting postpayment reviews; (3) officials at HHS' Health Resources and Services Administration (HRSA) and the Agency for Health Care Policy and Research; (4) officials at the Medicare Payment Advisory Commission who worked on Physician Payment Review Commission (PPRC) reports and other health services researchers; and (5) representatives from the American Medical Association, the Council on Graduate Medical Education, the National Rural Health Association, and the Rural Policy Research Institute. We also reviewed relevant legislation, the Medicare carrier manual, studies on physician practice location decisions, and Medicare contractor documents. We also reviewed HHS' strategic plan, HCFA's strategic plan, and the fiscal year 1999 performance plans prepared by HCFA and HRSA. We obtained and analyzed data from HCFA on claims for bonus payments in 1996, the addresses of a sample of beneficiaries for whom bonus payments were made, contractor quarterly reports, and the results of the 1996 Medicare Current Beneficiary Survey. We relied on data from HCFA, including contractor quarterly reports, for program expenditures since 1992 and data reported by PPRC for program expenditures in prior years. In addition, we obtained and analyzed the September 1998 Federal Register Notice discussing the proposed changes in HHS' health professional shortage area (HPSA) designation system.

We conducted our work from May through December 1998 in accordance with generally accepted government auditing standards.

Reasons Cited by Medicare Beneficiaries Who Have Difficulty Obtaining Care

To identify the reasons cited by Medicare beneficiaries who have difficulty obtaining health care, we used the results of HCFA's 1996 Medicare Current Beneficiary Survey—a continuous, multipurpose survey of a representative sample of the Medicare population, including both aged and disabled enrollees. The survey collects information about demographic characteristics, health status and functioning, access to care, insurance coverage, and financial support. In 1996, the access to care portion of the survey included a sample of over 17,000 Medicare beneficiaries.

In using the survey results, we relied on analysis of survey responses conducted by officials in HCFA's Office of Strategic Planning. Because Medicare incentive payments only apply to beneficiaries under Medicare

fee-for-service, the analysis was limited to these beneficiaries and did not include beneficiaries enrolled in Medicare managed care.

Bonus Payments by Type of Physician or Specialty of Service

To determine bonus payment amounts by type of physician specialty or specialty of service, we analyzed HCFA data for all claims for which bonus payments were made in 1996. In 1996, physicians submitted over 20 million claims for bonus payments. While we did not independently test or verify computer data generated by HCFA, we did not find any evidence that caused us to doubt the reliability or acceptability of the data. We discussed our data requests with various HCFA officials familiar with HCFA data systems and former PPRC analysts to verify that the HCFA claims data was the best source for HCFA data. In addition, we selected 1996 data because it was the last year for which final claims were available—these data had been updated for any adjustments made to the initial claims data.

To determine median bonus payments, payment amounts at the 75th percentile, and bonus payments for individual physicians, we used HCFA's unique physician identification numbers. We counted each number as an individual physician.

For our analysis of whether physicians receiving bonus payments were primary care or specialty physicians, we considered physicians practicing in general or family medicine, internal medicine, obstetrics or gynecology, and pediatrics as primary care physicians. We counted these four specialties as primary care because they are the specialties HHS counts as primary care physicians when designating primary care HPSAs. Because HCFA's claims data do not specify if physicians who claim internal medicine as their specialty are practicing general internal medicine or an internal medicine subspecialty, we counted all physicians with a specialty of internal medicine as primary care physicians. All other physicians were considered specialists. To identify nonphysician providers who received bonus payments, we compared the specialty codes on HCFA's claims data to the eligible physician specialty codes provided by HCFA officials.

To determine the amount of bonus payments spent for primary care services and specialty services, we used HCFA's Common Procedure Coding System to classify primary care services. This classification was based on the Congress' definition of primary care services in the Omnibus Reconciliation Act of 1987 (OBRA 87). All other services were counted as specialty services.

Amount Paid for Treating Beneficiaries Who Lived Outside a HPSA

To estimate how much of the bonus payments were paid for treating beneficiaries who did not live in a primary care geographic HPSA, we selected a simple random sample of (1) 500 bonus payments made for services provided in rural areas and (2) 500 bonus payments for services provided in urban areas. For each sampled case, we determined whether the beneficiary's address was within an area designated as a geographic primary care HPSA in 1996. To be conservative, we assumed that for those cases for which we could not make this determination, the beneficiary lived in a geographic primary care HPSA. For example, we assumed that the beneficiary lived within a HPSA if the address listed was a post office box. In addition, because we were only able to obtain 1998 address information from HCFA, we assumed that the 1998 address was accurate for 1996. However, if the county information on the 1998 address data differed from that of the 1996 claims data, we assumed that the person had lived in a HPSA at the time of the claim. Table I.1 shows the results of these determinations.

Table I.1: Number of Cases and Percent of Bonus Payment Amounts Made for Serving Beneficiaries Having Addresses Within and Outside a HPSA

	Rural		Urban	
Beneficiary type	**Number of cases**	**Percent of bonus payment amount**	**Number of cases**	**Percent of bonus payment amount**
Address was within a HPSA	361	76%	218	30%
Address was not in a HPSA	62	9	182	54
Location undetermined (assumed in a HPSA)	77	15	100	15
Total	**500**	**100**	**500**	**100[a]**

[a]Numbers may not total due to rounding.

Projecting these results to the total bonus payments made in 1996, we estimate that at the 95-percent confidence level, between 6.5 percent and 11.9 percent of bonus payments made in rural areas and between 32.1 percent and 76.3 percent of bonus payments made in urban areas were paid for treating beneficiaries who lived outside a geographic HPSA.

Rural and Urban County Categories

To categorize the counties where Medicare beneficiaries for whom bonus payments were made lived, we used the U.S. Department of Agriculture's rural-urban continuum codes for metropolitan and nonmetropolitan counties. These codes separate counties into 10 different types of urban or

rural categories. We grouped these 10 types into three categories—metropolitan counties, nonmetropolitan counties adjacent to metropolitan areas, and nonmetropolitan counties not adjacent to metropolitan areas (see table I.2).

Table I.2: Rural-Urban Continuum Codes and Categories for Metropolitan and Nonmetropolitan Counties

Code	County Category[a]
Metropolitan counties (urban)	
0	Central counties of metropolitan areas having a population of 1 million or more
1	Fringe counties of metropolitan areas having a population of 1 million or more
2	Counties in metropolitan areas having a population of 250,000 to 999,999
3	Counties in metropolitan areas having a population of fewer than 250,000
Nonmetropolitan counties adjacent to metropolitan areas	
4	Counties adjacent to a metropolitan area and having an urban population of 20,000 or more
6	Counties adjacent to a metropolitan area and having an urban population of 2,500 to 19,999
8	Counties adjacent to a metropolitan area and completely rural or having an urban population of fewer than 2,500
Nonmetropolitan counties not adjacent to metropolitan areas	
5	Counties not adjacent to a metropolitan area and having an urban population of 20,000 or more
7	Counties not adjacent to a metropolitan area and having an urban population of 2,500 to 19,999
9	Counties not adjacent to a metropolitan area and completely rural or having an urban population of fewer than 2,500

[a]Categories are based on the size of the urbanized population, and rural areas are separated into those that are adjacent to metropolitan areas and those that are more remote.

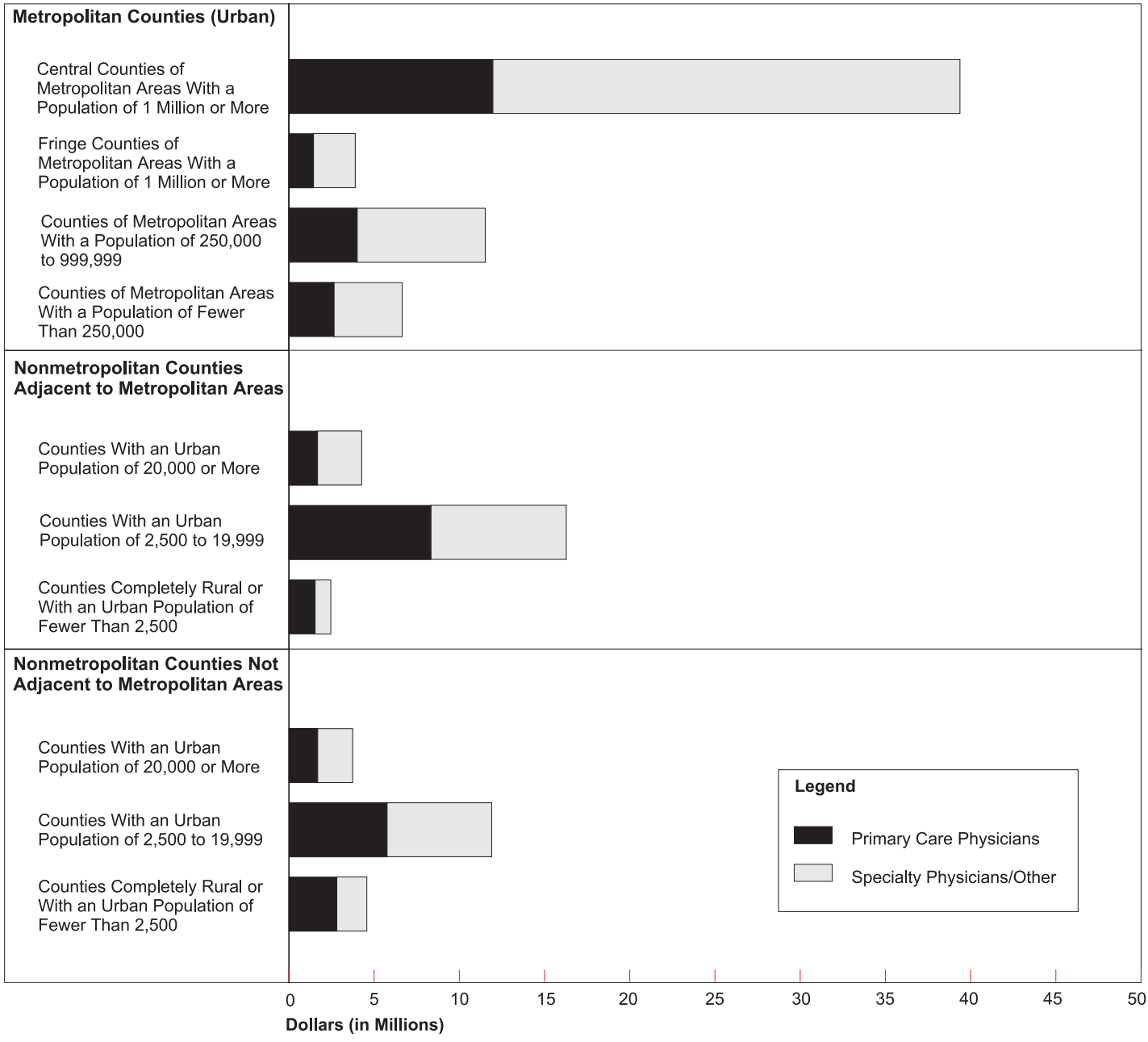
Source: U.S. Department of Agriculture.

The bonus payment amounts made to physicians in 1996 by county type of beneficiary are provided in appendix II.

Bonus Payments Made to Physicians in 1996, by Beneficiary County Type

In 1996, bonus payments totaling nearly $40 million were paid to physicians for treating beneficiaries who lived in central counties of large urban areas. In addition, over $16 million was paid for treating residents of nonmetropolitan counties adjacent to metropolitan areas having urban populations from 2,500 to 19,999. Only a small portion of bonus payments were made for treating beneficiaries living in the most remote rural areas. (See fig. II.1.)

Figure II.1: Bonus Payments by Beneficiary County Type, 1996



Bonus Payments Made in 1996 to Specialists in Urban Areas

In 1996, the Medicare Incentive Payment program made bonus payments to specialists in urban areas totaling approximately $41 million. Physicians in the specialty area of cardiology received bonus payments totaling about $4.6 million. Table III.1 shows the total and average payments and the number of physicians receiving bonus payments for services provided in 49 specialties in urban areas.

Table III.1: Total and Average Bonus Payments Paid to Specialists in Urban Areas in 1996 and Number of Physicians Paid, by Specialty

Specialty	Bonus payment		Number of physicians
	Total	Average	
Cardiology	$4,586,230	$3,614	1,269
Ophthalmology	4,112,967	3,936	1,045
General surgery	3,412,324	2,962	1,152
Diagnostic radiology	3,267,655	2,291	1,426
Multispecialty clinic or group practice	2,414,936	968	2,495
Orthopedic surgery	1,875,943	2,829	663
Gastroenterology	1,871,086	3,842	487
Urology	1,818,148	3,961	459
Anesthesiology	1,792,283	1,629	1,100
Podiatry	1,565,311	1,285	1,218
Nephrology	1,556,334	4,925	316
Pulmonary disease	1,362,111	3,632	375
Psychiatry	1,080,679	1,099	983
Emergency medicine	1,010,351	847	1,193
Thoracic surgery	979,562	5,901	166
Neurology	960,978	2,080	462
Dermatology	710,362	2,853	249
Pathology	642,036	1,589	404
Hematology/oncology	639,229	3,149	203
Vascular Surgery	585,504	6,730	87
Otolaryngology	549,810	1,896	290
Physical medicine and rehabilitation	546,734	2,747	199
Neurosurgery	461,806	3,322	139
Cardiac surgery	324,274	9,537	34
Endocrinology	315,236	2,649	119
Infectious disease	309,592	2,120	146
Optometry	292,919	537	545
Radiation oncology	238,053	3,903	61
Rheumatology	232,783	2,060	113

(continued)

Specialty	Bonus payment		Number of physicians
	Total	Average	
Critical Care	232,781	6,651	35
Plastic and reconstructive surgery	173,772	1,687	103
Medical oncology	157,634	3,031	52
Interventional radiology	153,746	7,687	20
Hematology	121,508	1,736	70
Nuclear medicine	116,758	2,848	41
Geriatric medicine	102,098	2,836	36
Chiropractic	86,154	370	233
Peripheral vascular disease	53,876	3,848	14
Allergy/immunology	44,632	930	48
Colorectal surgery	33,191	2,213	15
Surgical oncology	25,459	3,182	8
Oral surgery	23,955	374	64
Osteopathic manipulative therapy	22,805	845	27
Hand surgery	9,370	1,041	9
Neuropsychiatry	8,991	1,499	6
Maxillofacial surgery	6,755	483	14
Preventive medicine	3,410	682	5
Gynecological/oncology	1,493	213	7
Addiction medicine	57	57	1

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 4 1999

Ms. Bernice Steinhardt
Director, Health Services Quality
and Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Steinhardt:

Enclosed are the Department's comments on your draft report entitled, "Physician Shortage Areas: Medicare Incentive Payments Not An Effective Approach To Improve Access." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

June Gibbs Brown
Inspector General

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Physician Shortage Areas: Medicare Incentive Payments
Not An Effective Approach To Improve Access"

The Department appreciates the visibility that the Congress and this General Accounting Office (GAO) report will give to the Department of Health and Human Services' continuing efforts to improve access to health care for Medicare beneficiaries. We share GAO's concerns over this issue, and our commitment to the sound management and oversight of the Medicare program is unwavering. We also note that in order to effectively address the issue of Medicare incentive payments, we face several challenges including the need to more closely integrate efforts in this area Department-wide as well as the need to more closely collaborate with our Medicare contractor community. We look forward to working with GAO, our Medicare contractors, and Congress as we move forward to meet these challenges and strengthen our ability to ensure that Medicare beneficiaries have access to quality health care.

General Comments

The Department concurs with the GAO overall conclusion that the physician incentive program should be redesigned to correct certain problems that have developed in the program. As GAO knows, the Department's Health Care Financing Administration (HCFA) formally stated in response to a Department Inspector General report (June 1994) that making incentive payments to specialists in urban health professional shortage areas (HPSAs) is an unnecessary expenditure for the Medicare trust fund. As this subject GAO report indicates, eligibility for bonus payments is based on an area's designation as a HPSA. HPSA designations are based on the scarcity of primary care physicians, not of specialists. Urban underserved areas with primary care shortages do not necessarily have a shortage of specialists. We continue to believe that these bonus payments should be more appropriately targeted at primary care physicians in underserved urban areas and all physicians in rural underserved areas.

Moreover, we agree that certain structural changes to this program are necessary to target incentive payments to rural areas with the highest degree of physician shortages. Providers in very underserved rural areas are often financially fragile and represent the only source of health care in an area. Therefore, any reduction in reimbursement could be catastrophic for such providers.

Overall Departmental Comments

The statement on page 2 that indicates the relatively small bonus payments that most physicians receive are unlikely to have a significant impact on physician retention and recruitment is misleading for rural physicians, as compared to urban physicians. Since rural physicians receive a greater percentage of their practice revenues from Medicare (33 percent) as compared to urban physicians (27 percent), payments to rural physicians (especially rural primary care physicians) may be clustered at the higher end of the distribution. Also, the Office of Inspector General (OIG) report *"Medicare Incentive Payments in Health Professional Shortage Areas: Do They Promote Access to Primary Care" (OEI-01-93-00050),* issued in June 1994, cites that 52 percent of primary care physicians rated Medicare incentive payments as moderately to extremely important, while only 32 percent of primary care physicians rated the payments as not important.

Page 11 mentions that most (60 percent) of the funds paid out through this program go to specialists rather than primary care physicians, even though there are no recognized shortages of specialists. This is not an accurate statement about program dollars for rural HPSAs. Of total rural bonus payments, 51 percent went to primary care physicians and 49 percent to specialists, with some amount of the payments to specialists for primary care services. The report presents data only on the urban division of payments between primary care physicians and specialists; however, the rural division can be estimated from the marginal totals.

We also note that some information that could have been useful in formulating GAO's conclusions about rural bonus payments was not included in this report. In assessing the importance of the rural bonus payments, it would be useful to know what percentage of all physician payments were for rural HPSA services. The Physician Payment Review Commission (PPRC) estimated that, in 1992, rural HPSA services made up 7 percent of all physician payments in rural areas and 1 percent of urban payments. The PPRC also estimated that about 22 percent of nonmetropolitan area beneficiaries and 5 percent of metropolitan area beneficiaries lived in HPSAs in 1992--a percentage that is unlikely to have changed to any extent.

In understanding the importance of bonus payments to the primary care physicians, it would be useful to know how the bonus payments are distributed among physicians, according to the percent of their time spent on primary care--in particular, for physicians practicing in rural HPSAs. In the above referenced June 1994 OIG report, the OIG calculated that physicians who spent less than 10 percent of their time on primary care received one quarter (26 percent) of the incentive payment amount in 1992. Physicians who spent 90 percent or more of their time on primary care received 44 percent of the incentive payment amount.

The statement on page 13 regarding bonus payments made for treating beneficiaries who do not live in a geographic HPSA gives the impression that there is a rural problem. In fact, there is a pronounced problem in urban areas. The targeting of rural bonus payments to HPSA residents is successful, with less than 10 percent of total rural bonus payments made for treating beneficiaries who live outside of a geographic HPSA, as compared to 50 percent of urban payments spent for treating beneficiaries who do not live in a geographic HPSA.

Departmental Comments on Specific Recommendations

GAO Recommendation #1

To improve management and oversight of the program we recommend that the Secretary of HHS:

-- integrate the program into the Department's overall access to care strategic planning and performance measurement activities.

Department Comment

The Department concurs with GAO's recommendation. We see merit in integrating the program into the Department's overall access to care strategic plan and performance measurement activities. This measure would require HCFA and the Health Resources and Services Administration (HRSA) to work closely in developing objectives for the Medicare incentive payment program.

GAO Recommendation #2

-- direct the Administrator of HCFA to establish more intensive bonus payment review standards for all contractors.

Department Comment

The Department concurs with GAO's recommendation to increase contractor review of the bonus program.

The HCFA's current post-payment review policy is found in operational instructions to the Medicare carriers in the Medicare Carriers Manual, Part 3, Claims Processing, section 3350.7, which provide parameters for review. The carriers are instructed to prepare a list of physicians who received incentive payments for the prior calendar quarter, to array them by the total amount of incentive payments received, and to select 25 percent of

physicians on the list for a review of a sample of 5 claims by each physician. Physicians found to be in compliance need not be reviewed in other quarters within the same calendar year. However, if a carrier finds that a physician received payments in error, the carrier is required to pursue overpayment for the reviewed claims, and to continue monitoring the physician's future claims until compliant. The carrier is not required to review more claims from the initial reviewed quarter.

Technical Comments

In understanding the importance of bonus payments to rural physicians, it would be useful to know how many rural physicians (absolute number and percentage) are receiving bonus payments. Also, what is the 75th percentile in rural bonus payments for a year? About 12,000 physicians receive annual bonus payments as large or larger than $2,130. What percent of these physicians are rural?

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