MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Wednesday, January 14, 2004
10:19 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Physician services: assessing payment adequacy and updating payments -- Cristina Boccuti, Kevin Hayes

AFTERNOON SESSION [1:23 p.m.]

MR. HACKBARTH: Next on our agenda is the payment update for physician services. Cristina, Kevin whenever you're ready.

MS. BOCCUTI: Thank you. Our presentation will be very quick today and it draws mostly on information that Kevin and I presented to you last month. Since we only have about five slides I'm going to run through all of them but Kevin and I are both here to answer your questions when I'm done.

Before presenting the draft recommendation and as a backup I'm going to first mention some provisions in the new Medicare legislation which affect payments for physician services. Then I'll briefly review the information we presented in last month's meeting on payment adequacy for physician services and expected cost increases for 2005. Finally, the draft recommendation will be presented for your discussion.

So the first question you might have when you see this slide is DIMA. This is what we're using now for the Medicare Prescription Drug Improvement and Modernization Act of 2003. I think that the acronym is still in development but for today were using DIMA. Other terms you might have heard are MPDIMA and MMA for short, just the Medicare Modernization Act. So if you hear them, we're all talking about the same thing.

So as you know, the new Medicare legislation includes an update for physician services of 1.5 percent for 2004 and 2005. This is going to be accomplished by increases in the conversion factor. In addition to this provision there are several others that will increase payments for services furnished by fee-for-service physicians.

The first one I'll talk about is the GPCI floor. This is newly established in the legislation as a floor of 1.0 for the work component of the fee schedule's GPCI. So effectively this floor ends up raising payments for services in areas with below average costs of the work component.

Then the next is the scarcity bonus. Services provided by physicians in newly-established scarcity areas are going to receive a 5 percent bonus payment. These scarcity areas are established separately for primary care physicians and for specialist.

The third bullet there talks about a pre-existing 10 percent bonus payment to physicians that are practicing in health professional shortage areas. Under the new legislation the responsibility for identifying eligibility for the bonus will be shifted from the physician to the Secretary, so that the payments will become more automatic.

Finally, in Alaska all three GPCIs, that's the work, the practice expense and the PLI GPCI will increase to 1.67.

MR. DeBUSK: In the scarcity area bonus of 5 percent for

primary care physicians and specialists, will that include PAs and nurse practitioners as well?

MS. BOCCUTI: It's for the service. I think that determining where it occurs was based on physicians. So the bonus gets attached to the service provided, but the areas are determined -- I think that the determination was based on a ratio between the physician and beneficiaries.

DR. HAYES: That's correct. I'm not 100 percent sure about whether nurse practitioners and physician assistants are eligible for this thing or not. I just don't recall from the legislation. We can get back to you on that.

MR. DeBUSK: I can hardly see how they could exclude them.

MS. BOCCUTI: We'll look at that. I think that the health professional shortage areas might have more latitude, but that's a good question. I'll continue on.

As you know, MedPAC's framework for assessing payment adequacy for physician services
relies on indicators of beneficiary access to physicians and physician willingness to serve Medicare beneficiaries. We draw on these indicators, among others, because physicians don't report their costs to Medicare as do other providers such as hospitals.

So I'll first talk about access. As we talked last month and as we presented then in the last meeting, survey data from 2002 and 2003 indicate that on a national level beneficiaries have good access to physicians and most beneficiaries are able to find a new physician and schedule timely appointments. For example, the largest survey that I presented last time found that 90 percent of beneficiaries reported that they were always or usually able to get doctor appointments as soon as they wanted. But a small share of beneficiaries report that they experience difficulties getting appointments and finding physicians.

In 2003, CMS sponsored a beneficiary targeted particularly in areas where they thought beneficiaries were most likely to have access problems. Unfortunately, the study has not yet been released to the public but we'll try to keep you updated on the results of this study as possible.

The next bullet on the physicians supply up there, the number of physicians practicing in the U.S. has increased faster than both the general population and the Medicare population. As we mentioned in last month's meeting, survey data suggest that most physicians are willing to accept new Medicare beneficiaries but some do not. For example, the National Ambulatory Medical Care Survey found that 93 percent of physicians with at least 10 percent of their practice revenue coming from Medicare accepted new Medicare patients.

As Kevin discussed in last month's meeting, our examination of claims data through 2002 show that the volume of physician services has continued to grow steadily over several years and the steadiness of this increase does not on its own indicated inadequate payments. As you should recall also from last meeting results from research sponsored by MedPAC show that the difference between Medicare and private sector payment rates, those payments widened slightly in 2002, a couple percentage

points. The driving force was likely the 5.4 percent cut in the fee schedule's conversion factor in 2002.

So the second part of our adequacy framework looks at changes in cost for 2005. CMS estimates an increase in input prices of 3.4 percent in 2005, which is 2/10ths of a percentage point higher than its estimate last quarter. The other factor that we consider in our update analysis is productivity growth. Our analysis of trends in multifactor productivity suggests a goal of 0.9 percent.

So with all this in mind here again is the draft recommendation for your consideration. It's the same as we presented in the last meeting. The recommendation would update payments for physician services by 2.5 percent for 2005. This recommendation would maintain current beneficiary access to physician care and current physician supply for Medicare patients. Our estimate indicates that this recommendation would increase Medicare spending by somewhere between $200 million and $600 million relative to current law.

That concludes my presentation so we can discuss it now.

DR. ROWE: On the proportion of the physicians who are involved in the Medicare program you said it was 93 percent of physicians with more than 10 percent of their patient revenues coming from Medicare were not accepting new patients.

MS. BOCCUTI: Are accepting.

DR. ROWE: Were accepting; 7 percent weren't. That could mean that they're too busy to accept any new patients whether they're Medicare or not, or it could mean that they're dissatisfied with the Medicare rates. What percent of physicians do not participate at all in Medicare who used to participate? That is, not the pediatricians or obstetricians but people who actually did participate and have dropped out.

MS. BOCCUTI: Let be clarify. Do you mean the participation rate or actually seeing Medicare patients? Because the participation rate is something where they sign up and officially become a participant which has some other value added to that.

DR. ROWE: Let me tell me why I'm asking and then you can tell me which question to ask.

When there was a 5.4 percent reduction in the physician payments we heard, hell, no, we won't go. That we're going to withdraw from the Medicare program and there's going to be a flight of physicians and there won't be access, et cetera. So I'm trying to understand whether or not there was. So that's my question, and I'm not sure which of your subquestions that --

MS. BOCCUTI: I think I do. There was even an issue when the cuts were scheduled that physicians were saying, we're going to stop participating. CMS is extending the time period when physicians could say whether they're going to participate or not up until February of this year. I think it's all related to the conversion factor which was slated to decrease and now is going to increase.

Now our analysis of the participation rates, those are physicians who sign up to participate with Medicare and thus can have a 5 percent -- their payments per serve are 5 percent higher than those who are non-participating. That rate has increased

every year and it's at about 93 percent I think this year, or 91 percent in 2003 and it has not dropped over the last few years. It's in the draft chapter. I'm going to find it for you.

DR. ROWE: What I'm trying to do and I'm not doing it well is I'm trying to ask a multiple choice question, not an essay question. How about if we pose it this way? Do we have any evidence from the various forms of participation that there has been any significant withdrawal of physicians from the Medicare program?

MS. BOCCUTI: Kevin wants to give it a shot.

DR. HAYES: We confronted that issue.

DR. ROWE: This is a yes/no question.

DR. HAYES: Then the answer is no. But let me elaborate, if I may. I could elaborate a little bit but if no is okay, maybe we'll just --

DR. ROWE: No, I don't want to take everybody's time.

MS. BOCCUTI: Maybe we should just say when we're looking at this on a national level.

DR. ROWE: Thank you.

DR. WOLTER: Just a question, in a table in the body of the report, Table 3.b.3, if I'm interpreting this right, the change in physician services per beneficiary from year to year is basically a dollar number because we're taking the RVUs and multiplying by the conversion factor?

DR. HAYES: That's right.

DR. WOLTER: I'm wondering if it would also have value to look at the change in actual units from year to year, how many echocardiograms, how many CT scans, because obviously some of them weight higher and the dollar changes when it gets converted into a, percentage. That might look differently than if we just looked at the absolute numbers.

DR. HAYES: When we've done this kind of analysis in the past we have often included the units change as well. As you can see from this table it's already got quite a few numbers in it so that's why we chose not to. The other reason we chose not to in this case was because we have found that the units changes tend to be very similar to the changes that you see in this table.

DR. MILLER: But we can put it in if you'd like to see it.

DR. NEWHOUSE: Is it the all-services number in that category that total the increase in RVUs? Does that include the conversion factor change? about.

DR. MILLER: No, Nick is asking for just the unit count, the number of services and what those columns represent.

DR. REISCHAUER: The number of office visits as opposed to the complexity.

MR. SMITH: Kevin, is the answer to Nick's question that the average annual percentage change column is a proxy for the number of units? That it's very close?

DR. HAYES: It's similar to the number of units, but it's weighted. The particular percentages that you see in this table is weighted also by the relative value units from the fee schedule. So it captures not just the change in units but also any change in the intensity of services that's provided.

MR. HACKBARTH: Any other questions or comments?

MS. BURKE: Can I just ask for a clarification on that? Does that suggest in the extreme that you could have had -- showing a 9.4 percent change in echo solely as a result of the intensity and not as a result of the actual volume?

DR. HAYES: In the extreme, that is the case. But as I pointed out to Nick, when we've looked at these kinds of changes in the past we've seen some close similarities between the number of units and the kind of measure that you see here. But there's always the possibility of the extreme case that you're talking about.

MS. BURKE: We have no way to look at this and know where it was largely volume as compared to intensity?

DR. HAYES: The way to do that would be what Mark was suggesting which is to put both numbers on the table so you can do the mental subtraction one from the other and figure out what's the intensity change.

DR. NEWHOUSE: I'm not following this, what the table is then, because I would have thought that, for example, when I look at imaging change 9.4 percent between 2001 and 2002 that that was the increase in RVUs for imaging. Then when we get down to a specific thing like advanced CAT scan of the head 5.3 percent, I would have assumed that was essentially almost all volume because that's so specific. So I'm not sure what we need that isn't in the table.

DR. MILLER: Both of your comments are correct. That's why the actual raw volume count tracks to this very closely because when you get down to this level of disaggregation you are almost on a one-to-one basis. But it really wouldn't kill us, we could put the raw volume counts in with it. Just as long as everybody is tracking this, you could count office visits and that would be a straight measure of volume, or if more complex offices visits were done, longer or whatever the case may be, that could also drive this number up. That's sort of volume and intensity. But they track very closely I think is the point.

MS. BURKE: I understand what you're saying. I'm trying to think of the implications for us in greater clarity. It would seem that the implications would simply be raising the flag if there were disproportionate increases in volume of certain kinds of activities that would then lead us to look at what is it about that activity. Its it that there's something new going on? Is it that it is overpriced? I mean, any number of issues.

So the question is, does the specificity on volume as compared to some suggestion there might be some combined effect here give us more information that would be useful in looking at the adequacy of the payments by type of service? But what I hear you saying is they track so closely disaggregating them may or may not have any benefit to our understanding.

DR. REISCHAUER: I think there's enough here to cause an eyebrow or two to be raised. That office visits for establishment patients weighted by the complexity should rise at 4.3 percent in one year you think, drawn out over a decade what would this imply about health care costs in America? Consultations 6 percent in a year. Some of these numbers seem very, very high in areas that you don't expect there to be huge

procedure-type changes like imaging where imaging is being used for things that it wasn't being used for before.

DR. ROWE: Are these data corrected for any changes in the patient population?

DR. HAYES: No, they're not.

DR. ROWE: Because we have this experience, and I know in one year it's not dramatic, but that the elderly are getting older and that the average age of Medicare beneficiaries is increasing. There's a very steep relationship between age and utilization.

DR. REISCHAUER: It's not increasing, I don't think. As the baby boomers enter, the average age of Medicare will fall.

MS. DePARLE: There are more old-old.

DR. NEWHOUSE: That's also true.

DR. ROWE: But the baby boomers aren't entering yet. I'm the world's oldest baby boomer and I'm 59. So as the baby boomers enter Medicare that will happen, but we're talking about what happened last year not what's going to happen in 2010. So I think that with increases in longevity -- I'm just wondering that's going to discount this number a little bit into if you correct, that's all.

DR. NEWHOUSE: Medicare costs don't go up that sharply because the medical care system isn't that aggressive with the oldest old. They fall out at the end.

DR. ROWE: I'm aware of those data. I was thinking about number of visits. Those data are related to hospitalizations and length of stay and stuff like that, and people don't get hospitalize when they're older. Not number of doctor visits.

MR. MULLER: What was the payment update in '01, '02? Could this be one of those expenditure offset type -- what did we call that, those days?

MS. BOCCUTI: You mean what was the actual or what we recommended?

MR. MULLER: What was the actual payment increase in '01, '02 for physician? Was that a cut year?

DR. HAYES: Yes, minus 5.4 percent.

MR. MULLER: Insofar as there's been speculation on expenditure offsets and so forth this might --

DR. NELSON: But notice that the highest category of those kinds of services was emergency room visits which are largely patient initiated. They're the ones that decide whether to go into --

MR. MULLER: I'm not suggested, Alan, it's across the board because obviously the imaging ones are technology driven, and we discussed this last year, the price of the imaging devices has gone down considerably therefore making the diffusion of them much more possible. These used to be $2 million tickets and now you can get them for $500,000, et cetera, and so forth. So I think there's different explanations for different parts of this but I agree with the point that either Bob or -- these are pretty big numbers if you start compounding them for ten years.

DR. MILLER: I'll just also remind you there's been a couple of other discussions of volume growth here. We went through, Kevin went through things when we were disaggregating volume

growth over a series of years looking at imaging and different services and I think you'll remember that. You were seeing differential volume growth in different service settings, and some of it fairly aggressive. Then we commented on the AHRQ report on volume where they were disaggregating it and trying to track to things like change in demographics and those kinds of things and they were finding that volume was growing in excess of what those factors could explain, if I remember correctly.

MR. MULLER: But one of the themes, Glenn, that we've had cutting through our discussions for a couple years now is looking at utilization and there's all kinds of reasons why utilization is going up, will go up, will probably accelerate. Not just the decline of managed care, the technology, the aging. So obviously a lot of what we think about here are payment rates in our discussions, discourses, recommendations. But I've been arguing for a couple of years now it's utilization that's going to drive this even more than the payment rates. And there's absolutely no break and as I would say and I'm sure a lot of you agree, a lot of accelerators on utilization inside our system and there's nothing in sight to put a brake on that.

DR. HAYES: Just if I may, one more point on that. We will have an opportunity to look more closely at this issue of volume growth. The Medicare legislation has a mandated study in it for us to look at the volume of physician services addressing a number of the issues that you brought up here today. That's due in December of this year.

MR. HACKBARTH: Any other questions or comments?

Okay, I think we're ready to move on to the draft recommendation then. All opposed to the draft recommendation which is on the screen? All in favor? Abstentions?

Okay, thank you.