MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 4, 2003
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
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

MR. HACKBARTH: Cristina and Kevin, I think we're going to go ahead. We'll have the remainder of the commissioners coming shortly.

MS. BOCCUTI: Good afternoon. Kevin and I will be presenting an assessment of payment adequacy and update considerations for physician services. To help the Commission consider its recommendations for physician payments we will summarize the available evidence on adequacy of current payment. Kevin will present two pieces of this analysis. First an analysis of volume growth and also a comparison of Medicare payment to private insurance payment. Claudia Scherr is with us today and she's going to be available to answer some questions on a new survey which I'll be telling you about in a little bit. We're also going to discuss expected cost changes and a draft recommendation.

To examine beneficiaries access to physician services we consider several information sources. Surveys that ask beneficiaries directly about their access to care, data on physician supply, particularly with respect to physicians who treat Medicare patients, and surveys that ask physicians directly about their willingness to serve Medicare beneficiaries. Overall, from surveys between 2000 and 2003 access is generally good for beneficiaries. A small share of beneficiaries, however, do report some difficulties obtaining access to physicians.

A large survey, the CAHPS fee-for-service survey, provides some insight on beneficiary access to physician services. The details of this survey will be discussed tomorrow morning but I'm going to highlight a couple results specifically dealing with physician access. Those results are on this slide here. Beneficiaries are asked on the survey if they have had problems seeing a specialist and 94 percent of beneficiaries said that they had small or no problems seeing a specialist when necessary. Asked about timeliness of scheduling an appointment for regular or routine care about 90 percent said that they usually or always received care as soon as they wanted. Note that this survey gives us information only up to 2002.

To obtain more timely data MedPAC has begun sponsoring small telephone surveys to beneficiaries. This project is managed by Project HOPE which is where Claudia helped us, and we have received results from an initial round of this survey. We think of these results as giving us some baseline information.

I'm going to take a moment to describe the survey since it's the first time we've used it. I'm going to talk about the goals and limitations, but Claudia Scherr is here to answer some technical questions if they arise.

This survey is an attachment of a set of questions to a larger consumer telephone survey conducted by a survey research company. The survey includes a core set of demographic questions in addition to questions sponsored by other organizations. We sponsored 13 questions. The survey was conducted recently, between September 17th and October 2nd, 2003. It took about three weeks to obtain a little over 1,000 respondents who were Medicare beneficiaries age 65 or over.

The goals of the survey for us were to help us obtain baseline results from its initial implementation and then future rounds to give us an ability to monitor beneficiaries' access to physicians services. But due to sample size and response rate limitations a comparison to other larger government-sponsored surveys with longer field period may not be possible. So our analysis is cautious and we see this mostly as a monitoring tool. The major advantage of this survey is its timeliness and low cost. Additionally, we can use this survey to assess beneficiary response to other Medicare policy issues in the future.

So now I'll share some results from the survey. These results are weighted to be nationally representative with respect to basic demographic variables. So on the slide you can see that we asked about beneficiaries' ability to find a new primary care doctor. Ninety-three percent of beneficiaries who were seeking a new physician reported that they encountered small or no problems and only 7 percent reported that they encountered big problems or were unable to find a doctor. When asked about access to specialists, similarly, 93 percent of beneficiaries who tried to find a new specialist reported having small or no problems finding one, and 5 percent reported big problems or were unable to find a new specialist.

When asked about routine care and whether or not they experienced delays in trying to schedule an appointment, 71 percent of those beneficiaries who tried to schedule an appointment for routine care never experienced a delay, or that's what they reported; 21 percent said sometimes and 8 percent said that they usually or always experience a delay. For illness or injury-related needs, beneficiaries' ability to schedule timely appointments was better. Specifically, 80 percent of beneficiaries who tried to schedule an appointment for an illness or injury never experienced a delay, 16 percent sometimes and 4 percent said they usually or always experienced a delay.

Because we're only interviewing Medicare respondents this survey and all other ones that only interview Medicare respondents, don't offer a comparison to other insured populations across the United States so it's difficult to determine whether or not access concerns for some beneficiaries are unique to their Medicare status. For example, market area trends in physician availability may play a role in Medicare beneficiaries' ability to find doctors and receive timely appointments. On this point, older research from the Center for Studying Health Systems Change found that between 1997 and 2001 both Medicare beneficiaries and privately insured near elderly, -- that's people between the ages of 50 and 64 -- encountered growing rates of access problems. Results from this study were discussed in our report last year.

Next I'm going to talk about some supply issues, looking at supply issues that affect beneficiaries' access to care specifically. Usually we provide you with updates on the number of physicians billing Medicare. However, CMS is in the process of re-examining their data on this so we're unable to give you this information today for 2002.

But in using slightly less direct indicators of the supply of Medicare physicians I've put up a chart here that shows the share of physicians signing participation agreements and the share of allowed charges paid on assignment over time. In 2002, 99 percent of allowed charges for physician services were assigned. That is, for 99 percent of allowed charges physicians agreed to accept the Medicare fee schedule charge as the full charge. This high assignment rate indicates that fee schedule amounts may be adequate, at least when associated with the additional benefits physicians receive when accepting assignment. This high assignment rate may also reflect the high rate of physicians who agree to participate in Medicare, which was 91 percent in 2003. Participating physicians agree to accept assignment on all allowed charges in exchange for a 5 percent higher payment on allowed charges than non-participating physicians.

We also examined physician surveys that provide information on the proportion of physicians who are accepting new Medicare patients into their practice. In general, the most recently available data indicate that most physicians are willing to accept new Medicare beneficiaries, particularly those with a relatively large portion of Medicare patients in their practice.

Smaller share physicians who report a reluctance to serve Medicare beneficiaries may be responding to a variety of factors other than or in addition to payment adequacy. These other factors may include administrative burden of Medicare, local physician supply, demand for physician services, area market

insurance conditions, and the amount of time physicians are willing to devote to patient care. So it's difficult to disentangle these factors given the availability. Consequently, we're often limited to physician responses to simple questions regarding whether or not they are accepting Medicare patients.

The most recent survey information comes from the National Ambulatory Medical Care Survey, or NAMCS as we often call it. This survey is conducted in 52 reporting period during the year, so that ensures that it's capturing an even spread throughout the year. Results from this study show that 93 percent of office-based physicians with at least 10 percent of their practice revenue coming from the Medicare accepted new Medicare patients. This number is not significantly different from those reported on the 2001 NAMCS. We're hoping to get 2003 results in January.

Moreover, this finding is consistent with the results of the MedPAC-sponsored survey of physicians that Kevin talked about last year, and that was conducted in 2002. Ninety-six percent of physicians in that study who were accepting any new patients and who spent at least 10 percent of their time with Medicare patients were accepting new fee-for-service Medicare patients. But a you may recall, the percentage accepting all new Medicare patients was lower at about 70 percent. Earlier research from the Center for Studying Health System Change showed that the proportion of physicians accepting all new Medicare patients fell at about the same rate as that for privately insured patients.

Next is Kevin.

DR. HAYES: One other indicator that we look at of the adequacy of Medicare's payment rates for physician services is changes in the use of services by Medicare beneficiaries, changes in the volume of services. The thought here is that if we see decreases in volume that could be a sign that Medicare's payment rates have become inadequate. As we look at claims data through 2002, however, we do not see decreases in volumes, at least among the broad categories of services shown here. In fact we see some pretty strong increases still in a couple categories of services, as we have seen in the past, and that would be in the categories of imaging and tests. On a per-beneficiary basis the volume of imaging services went up by 9.4 percent in 2002, and for tests the increase was 11.1 percent.

Within these categories we do see some decreases in volume for selected services but it's not clear that the decreases are a sign that payments have become inadequate. In general, the decreases that we see are quite small or they follow rapid increases in previous years. One exception to all this would be a service like coronary artery bypass grafts, however, and there

the decrease was just over 4 percent in 2002. Our interpretation of what's happening there that we're just seeing some substitution of the less-invasive coronary angioplasty procedures for the more invasive open heart surgical procedures.

So bottom line on this indicator would be that we don't see any evidence that the payments have become inadequate.

If we look at our last indicator of payment adequacy, this is something that we looked at last year. if you recall, comparing Medicare's payment rates for physicians services with average private insurers' payment rates. The thought here is that if Medicare's payment rates get too far below those of private insurers that some physicians may choose to limit their practices to private patients and not take Medicare's patients.

For this year we contracted with Chris Hogan at Direct Research to update previous analyses to use claims data through the year 2002. Recall in previous analyses we ad shown that the difference between Medicare's payment rates and those in the private sector had narrowed. This was through 2001 at a time when Medicare's payment rates were growing at a relatively rapid rate.

In 2002, we see some slight widening of the gap between Medicare and private rates. The figure for 2002 is 81 percent. So we're going from 83 percent in 2001 to 81 percent in 2002. The reason for this, a good part of it has to do with the payment reduction that occurred in Medicare's rates in 2002. Recall that the conversion factor fell by 5.4 percent in that year.

The gap would have been wider if not for a few other things that happened. For one thing, Chris found in analysis of the private data some drop in average private insurers' rates. This was primarily due to a shift of private enrollment from more generous-paying indemnity plans toward other lower-paying types of plans.

Other factors at work here include the fact that when we look at physician services we're including in the definition of them not just physician fee schedule services but also Part B drugs and laboratory services, and those services did not experience the decreases that the physician fee schedule services did in '02.

Finally on the Medicare side, there were some offsetting increases in relative value units in the fee schedule which slightly muted the effect of the conversion factor change.

But anyway, putting all this together, we do see some slight widening of the gap between Medicare and private rates, but we're not by any means at the point we were in the mid-1990s. As you can see here, the gap was much wonder where Medicare's rates were more in the range of 60 to 70 percent of

private rates.

MS. BOCCUTI: I'm going to take you into the second part of our adequacy payment framework, which is changes in cost for 2005. There's two factors that are important here, the input price inflation and the productivity growth. The preliminary information on input price inflation from CMS for 2005 shows an increase in input prices of 3.2 percent. Within that total, CMS sorts the specified inputs into two major categories: physician work and physician practice expense.

Physician work includes salaries and fringe benefits allotted for physicians, and that's expected to increase by 3.4 percent. In the physician practice expense category, what's included there are the non-physician employee compensation, office expenses, professional liability insurance, drugs and supplies, and medical equipment. That is expected to increase by 2.9 percent for the whole category. Within that, the PLI is expected to increase by 4.7 percent.

As you know, to calculate these increases, CMS uses weighted averages. Recently CMS rebased its input category weights. These calculations resulted in a decrease in the share of revenues going towards the physician work component and an increase in the practice expense share with an increase in PLI.

The other factor that we consider here is productivity growth. Our analysis of trends in multifactor productivity suggest an increase of 0.9 percent. We'll put these two numbers together, the input price, inflation, and productivity growth numbers in just a moment.

So to recap what we've said so far, we determined that payments in general have been at least adequate though some access problems may exist for some beneficiaries.

Now to discuss a draft recommendation for our report, and this applies to the year 2005. In order to determine payment adequacy in 2005 we need to make some assumptions about payments in 2004. As you know, Congress has acted to prevent a payment cut in 2004 and accordingly payments in 2004 are likely to be adequate.

So the draft recommendation here is similar to the one in the previous March 2003 report. That says that the Congress should update payments for physician services by the projected change in input prices less 0.9 percent in 2005.

To discuss the implications on beneficiaries and providers, increasing payments for physician services would help preserve beneficiary access to care. And increasing payments to physicians would help to maintain the adequacy of those payments and allow physicians to furnish high-quality care.

Having recently received CBO's budget estimates for the new act, we do not feel that we can confidently predict the budget

implication compared to the legislation, so we will present budget implications of the Commission's draft recommendation at the next meeting.

Thank you.

MR. HACKBARTH: Just for context can I ask you to go over briefly the provisions in the reform legislation? In fact let me ask you to just react to this characterization. As I recall it was a 1.5 percent update for each of the two years and then there were a series of changes in some other provisions affecting physicians, many of them directed as rural physicians, increasing payments to rural physicians. Do we have a sense of what the aggregate effect of the update plus the other provisions was in terms of the total increase in payments, and how it would compare to our recommendation?

MS. BOCCUTI: I'm going to turn that over to Kevin who's been investigating some of that right now.

DR. HAYES: Relying on the CBO scoring of those other provisions, they represent a total somewhere in the area of less than 1 percent of total spending. So if we couple the 1.5 percent increase in the conversion factor with those additional more targeted spending increases we're looking at a total increase in spending for physician services somewhere in the 2.3 percent, 2.4 percent area.

MR. HACKBARTH: The aggregate effect of what Congress did would be very similar to the effect of our recommendation in terms of total spending but they've chosen to distribute the dollars differently?

DR. HAYES: Yes.

DR. STOWERS: First I think it was a great chapter. There was one thing or a couple two or three things. One was this assumption that if physicians accept assignment, or participate, or don't balance bill inferred that that meant that they were satisfied with the payment or whatever. I think I would make the case that the majority of them accepting assignment has nothing to do with whether or not the fee schedule is adequate or inadequate. It has more to do with the incentives that are built into whether to accept assignment or not accept assignment. The only docs that do not accept assignment or those that are in affluent enough areas that their patients can pay the bill up front in those practices, because if they don't then the patient has to pay the bill up front in the office because the check is going to come from the Medicare at a much delayed rate, sometimes two to three months later because Medicare is not obligated to get the check out in a certain period of time. Then the physician has to go collect the money then later from the patient, and it's at a reduced rate and you'd have to go through all of this trouble, and in the end the

physician ends up with less money in the end. Just all the collection problems and all the other things that happen. So that's why 98 percent of physicians accept assignment. It has virtually nothing to do with the payment schedule being enough or too little or too much.

So I really think it's an inappropriate confusion of whether or not Medicare is paying enough or too much for services in this chapter, as to whether or not physicians are accepting assignment or not. It's all these other incentives, in other words, that are forcing --

MS. BOCCUTI: Right, the additional benefits.

DR. STOWERS: The incentives have been built in there by Medicare for many years to force docs into accepting assignment. It has nothing to do to with --

MS. BOCCUTI: And I didn't even mention all the additional benefits. I did in the chapter, I tried to. So I will make that very clear, that there are added benefits that may be weighted heavily in a physician's decision to accept assignment.

DR. STOWERS: I really question whether this accepting assignment ought to even be in this chapter at all. Because we're looking here at the adequacy of payment in Medicare and I don't see a place in the chapter for accepting or not accepting assignment.

MR. HACKBARTH: So from your prospective it goes more to the question of beneficiary liability, and it has an effect there, but it doesn't reflect that the Medicare payment rates are adequate.

DR. STOWERS: Right, it has nothing to do with that.

DR. HAYES: If I may, it would just be that we have traditionally used this indicator as a complementary indicator with the information that we don't have yet, admittedly, on the number of physicians billing the Medicare program. So when we put all of this together we have a picture of whether or not physicians are continuing to accept Medicare patients and an indication of what the financial liability is what for the beneficiary, which is an indicator of access, which we do consider access as one of our payment adequacy indicators here.

So in the interest of putting together a complete picture of what it's like for the beneficiary to make use of physicians services we felt like there was some value in putting it in there.

DR. STOWERS: I'm okay with what's in the box that says, it may have something to do with the balance billing part and the access to the patient and that's truly pretty insignificant because it only makes up 1 or 2 percent of the physicians out in the field. But then you turn around and made the statement that because most of the physicians accept assignment than the

payment rates must be okay. That statement I feel is -- that's an inappropriate --

MS. BOCCUTI: The conclusion is what --

DR. STOWERS: That conclusion is inappropriate because there's lots of other things driving the fact that physicians accept assignment versus going the non-assignment, rather than the fact that they're being paid enough by Medicare.

Nick might have other thoughts about that than I do. So I just don't think we can jump to that conclusion.

MS. BOCCUTI: I understand.

MS. ROSENBLATT: I just want to ask a question about the Chris Hogan survey and the graphs that you showed that was about 80 percent. That's based on actual claims data and it's based on comparing Medicare fee schedules to what a private insurers might pay an under-65 population most likely, correct? Refresh my memory, does that include capitated payments? I wouldn't think so. Or does it?

DR. HAYES: Yes, there are HMO claims on the private side.

MS. ROSENBLATT: HMO claims, but not capitation.

DR. HAYES: No.

MR. HACKBARTH: So it's just payment -- fee-for-service claims.

MS. ROSENBLATT: There's no capitation in there?

DR. HAYES: Correct.

MS. ROSENBLATT: So if it's HMO, it's an HMO that's paying on a fee-for-service basis?

DR. HAYES: That's correct.

DR. NELSON: I may have misunderstood what you said but with respect to the 2004 update I think you said that Congress has legislated a small update so we assume that payments were adequate for '04 in projecting for '05?

MS. BOCCUTI: Right, in that what Glenn was bringing up earlier in getting a sense of aggregate payments. But before the act there was a pay cut that was slated to occur.

DR. NELSON: I understand all that. I guess the point that I want to make is that we came up with a recommended update for '04 that was based on inputs less a productivity factor and Congress's actions ought not to necessarily negate that, at least until we have experience that tells us whether that update was adequate or not. The presence of legislation that may redistribute that within various portions, rural versus urban or whatever, doesn't detract from the fact that that indeed may not be an adequate update for large portions of the population receiving services. Until we can develop some data on '04 I wouldn't want to see us assume that that was an adequate update until we know that it is.

Even reflecting on '05, I think we ought to be consistent

with the same process and try and estimate as accurately as we can what the input costs will be, less a productivity factor, which I've never agreed that we use the right metric for that. I wonder if there is a productivity for the service industry as opposed to industry that produces products, in labor statistics. I don't know that, but I'd like to find a way to refine the productivity better than just taking a shot at 0.9. But that's a different issue.

So the point that I want to make is, let's word our recommendation for '05 so that our reference to '04 is consistent with what our recommendation has been and the process that we followed in arriving at it.

MR. HACKBARTH: Maybe we ought to jump ahead and just look at the language --

MS. BOCCUTI: The background that I said on 2004 -- 2004 is not necessarily in the draft recommendation. That's background.

MR. HACKBARTH: Right. So based on the measures of adequacy that we review, we have no data suggesting to us that what was done in '04 was inadequate. On the other hand, we have no information, as you're pointing out, to specifically bless it as adequate. So we're silent on that and the recommendation language is directed only towards '05.

MR. MULLER: If we could go back to the chart that compares the physician -- thank you.

In some of our other provider chapters we often make a comparison of Medicare margins versus total margins and I think as a policy we have basically said that we should not use the Medicare program to support margins that are less than adequate from other payers. I think it might be useful -- this is obviously a provider sector in which the Medicare program pays less than the private market, though I'm sure if we had a Medicaid slide up there it would show it pays more than Medicaid on average.

But I think for the sake of consistency it would be useful to show that in fact this is one area in which, if one could use such a margin calculation -- we don't do it as much with physicians as we do with other providers because of the difficulty of calculating physician margins -- but this is an area in which Medicare in a sense could be said to pay less than the private market. We in a sense have a higher margin elsewhere and one could -- what I'm suggesting is it's the total margin elsewhere that is supporting the Medicare margin being less. I think if we're going to make that point consistently in those areas where the Medicare margin is higher than what is paid by private payers and other providers sectors, I think we might want to suggest the reverse here. That in fact there is some support going on of physician income from the private

payers. I wonder, Kevin, if you want to comment on that.

DR. HAYES: I don't know about support of physician income without knowing the unknowable, which is what their costs are. That's the difficulty that we face in this sector is not having a good measure of costs. So I don't know where Medicare is relative to their costs otherwise. So our goal here with this has been, as you can see with this slide, is to just look at trends over time and see how Medicare compares to the other payers. But implicit in this is a recognition that we can't get at that further issue of the cost comparison.

MR. HACKBARTH: In fact I think I would be uncomfortable with the notion of saying this slide shows some cross-subsidization of one payer by another. I think the relevance of these data are -- we're looking for potential harbingers of access problems for Medicare beneficiaries. The notion is that if these numbers get too far out of whack it could be a harbinger that problems are on the way for beneficiaries. So it's an indicator that we're looking at as opposed to a commentary on the relative subsidization of one payer by another.

DR. REISCHAUER: Let me jump in just because I want to talk about this table here, and some of the things Ralph had said. Kevin, I guess I just didn't focus on the fact that this included, I think you said Part B drugs and lab tests. My guess is, relative to physician services narrowly defined, the fraction over time accounted for by lab and prescription drugs applied in the office have grown. The numbers are pretty small but I wonder if you could do a what-if on the weights.

I'm looking at this table that you have, and I know we discussed this before, and looking at lab tests which is an infinitesimal section of the total, but a 16.9 percent growth in one year. Bells would go off if this were bigger. I just can't imagine what's bringing about a service utilization growth in one year that is that great. We have the drug thing, as I said. This trending upward that we have could really be an artifact.

DR. HAYES: So we need to do some sensitivity analysis I guess and see want to the effect is without those other factors. Hold on one second.

DR. REISCHAUER: Don't tell me you have it.

DR. HAYES: Chris is pretty good and he did this --

DR. HOGAN: Page 5.

MR. HACKBARTH: Chris, why don't you come up?

DR. HOGAN: Good point. I wish I'd thought of it. Page 5 of the report, I took them out and it didn't make any difference in that ratio. It was almost 15 percent of the spending total when I got all the little odds and ends take out. So 85 percent of what you see up there really is the services of physicians,

15 percent is other stuff. But it turns out the pricing differential was not all that different for the other stuff versus the physician services. Put it in, take it out, I get that last bar, that 2002 bar is at the same spot.

MS. RAPHAEL: I just wanted to share with commissioners a conversation that I had with Mark and Kevin and Cristina and some of the things that grew out of that, because I have been approached by a number of people who have been telling me that they believe in their area of the country there are access problems that are being experienced. This is all fairly anecdotal. It's not at all based on any kind of national review of the issue.

But in discussing this with Kevin, Cristina, and Mark and Bob Berenson in a conversation this week there were a number of things that I guess I hadn't been as aware of. One is that there are differences in marketplaces attributable to dependence on Medicare. Because if you're in a particular specialty like ophthalmology that is very dependent on Medicare you're less likely to reject Medicare patients than if you're in specialty where you actually can select from a broader population. I think that is something that we need to take a look at.

Secondly, one of the points that was made based on some recent information which maybe Chris can comment on, was that actually there's a broader gap between private payments for specialists and Medicare payments for specialists than there's for primary care and general practitioners, which I also had not been as aware of. I think, Mark, we agreed that we were going to take some steps to try to get at this beneficiary access issue over the next few years. But you may also want to comment on --

DR. MILLER: Just a couple of comments on this. Last year when we went through this same analysis -- and refresh my memory if I'm wrong, we did disaggregate by specialty and IM, GP types of physicians and did make this point about specialists, that the gap between the specialist payments in private and Medicare is larger than it is between the primary care and IM types. In a conversation with Bob Berenson what was interesting was that what he was finding was, or what he was arguing in some marketplaces is almost counterintuitive. That it's much easier to get access to a specialist -- and some of it is because they are very dependent on Medicare types of patients -- and that the issue, the bottleneck was more among primary care physicians, and that some of what was happening is that the patient presents and the primary care are not spending the time to go and do the evaluation and management. It's just, your leg hurts, you go to the leg specialist. Your head hurts, you go to the head specialist. You can tell how technical I am on all this. That

was the argument.

What we got into was discussions of relative payment within the fee schedule, is the longer run issue. Kevin or anybody like that should comment if there's a piece of the conversation I missed.

DR. HAYES: No, that's it. The interesting thing for me in that conversation was that there's clearly more involved than just payment rates. If it's a matter of a narrow gap between Medicare and private rates for primary care services, yet that seems to be where the beneficiaries, at least from anecdotal reports, is where they're having the most difficulty. Then you figure there's perhaps some other more macro, system level factors at work here having to do with just overall demands on the primary care physicians from all patients, not just Medicare patients. So it's a complex thing.

DR. WOLTER: Kind of a process interpretation question related to something Alan raised, if the new legislation has, what is it, 2.4 percent increase for physicians?

DR. HAYES: 1.5 for physicians.

DR. WOLTER: If the total when you add in the GPCI and other things it's closer to 2.3 or 2.4, and our recommendation comes out at whatever it comes out at, how does that get interpreted, and do we make any comment on that? Because there could be the thought that we're right on with the recommendation coming out of MedPAC in terms of the legislation. Others might say, there was an update recommended and that should be on top of the total that's perhaps in the legislation; this distributional issue that Alan raised. Is that something we just stay silent on, or how do we deal with those questions?

MR. HACKBARTH: The reason I raised it is I think that the explanation is important. On how people will react to it I'm less certain. But I didn't want people to say, MedPAC recommended 2.3, Congress did 1.5; they're at odds. I think it's more complicated than that. Congress did essentially the same thing in terms of increasing aggregate expenditures for physician but chose a different distribution of the payments. I don't think we're -- we could decide to comment on that distribution and say that we think Congress distributed it properly or improperly. That's an option open to us.

But the first order analysis is just that the aggregate dollars are about the same and I wanted people to understand that. I think that is an important statement for us to make.

DR. WOLTER: That was a good point. Of course another option would be that we think the update needs to be whatever it needs to be and that's a separate question from GPCI adjustments or whatever, and those would be additional dollars. There would be several options in the conversation.

MR. MULLER: We've done the physician update based on kind of a marketbasket equivalent.

DR. MILLER: The only thing I was going to say about commenting on the bill, it's happened fairly recently and whether, at least from an analytical perspective of being able to express an opinion about it would have involved a fair amount of work. First understanding it, modeling it, and determining what the distributional impacts are, and then a discussion of whether we agreed with them or not. I can tell you for certain, our ability to do that between now and January is going to be pretty much zero. So it will be hard to make an analytical statement about whether we agree with what they've done.

MR. HACKBARTH: That would not foreclose our, in the future, looking at the GPCI changes and the like and offering an opinion on whether those were a good thing or not. But then the other side of the coin and the one I think Nick is getting at is that, arguably, you're saying that there should be a 2.3 percent increase and then the GPCI and all that stuff on top of it. That would be another way to go.

DR. WOLTER: I was just envisioning the possibility after you raised it and then Alan followed up that those might be conversations that would occur over the course of the year.

MR. HACKBARTH: I guess the way I would like to leave it is keep our recommendation framed in terms of the overall update, and I think the 2.3 percent is about the right to number. If we wish to come back and address some of rural provisions that were added I think we need to do so in a careful and thoughtful way and January isn't sufficient time to do that. We can come back to it later.

DR. REISCHAUER: I guess I sort of have the feeling that if the 1.5 percent is significantly lower than what we suggested for a general update we should make some nod in that direction and not pretend that money that's going to be concentrated on a very small fraction of the physician population really is there to take care of the general problem that's out there. I'm not sure that we do this with sufficient precision so that when the general update is a few tenths of a percentage point below or above where we recommend that we then leap from our chairs and say, good Lord, inadequate payments; we have to do something. I think you can write this in a non-confrontational, non-judgmental way.

MR. MULLER: Glenn, just to go back to the point I was making earlier, this is a provider segment in which we do not do our usual two-part test. Basically we use measures of access as a proxy that the base is adequate. I understand why it's difficult to get a calculation of physician revenue and cost, but basically in the other sectors, whether it's home health,

SNF, hospitals, et cetera, we do make some calculation of adequacy before we do our update, and obviously here we don't. Maybe we should say, we don't do it here because it's too complicated to do, but basically use the access measure as a proxy for adequacy rather than actually calculating it.

MR. HACKBARTH: Access is a part of the framework for all providers so it's not unique to physicians that we look at access. But it is in fact true that we have no data on margins, because we have no information on physician costs. So that's an empty hole in our framework for physicians, which I think maybe makes it even more important that we look at the access number.

I also think the physician market -- I haven't thought this all the way through so bear with me. But I think that the physician market may have a little bit different dynamic than some of the other provider sectors. I think Medicare's market power is less for physicians, at least some specialties of physicians than it is for hospitals. It's very difficult for a hospital to walk away from the Medicare program, except in rare circumstances. But for some physicians and some specialties where Medicare is a very low, or a much lower share of their revenue, walking away or not accepting new Medicare patients is much more of an option. We hear anecdotes that in fact some physicians are exercising that option in particular parts of the country.

So I think paying particular attention to how Medicare rates compare to private rates and any other indicator of access is especially important for physicians. The sensitivity may be even greater there.

DR. REISCHAUER: Kevin, I think you said that to the extent that there appeared to be difficulty in accessing care it was more with primary care physicians than with specialists. I would think that that's what one would expect because specialists have a much higher turnover of patients during a year, so in a sense there's more openings than a primary care physician who might have very low amount of turnover, so the probability of one going and seeking an open slot is always going to be less.

MR. MULLER: It's more clinical, Bob. It's basically that people who need specialists are old. I mean, 35-year-olds by and large don't need specialists. It's more of a clinical indicator -- specialists have more Medicare patients than primary care because they're the ones who need specialists and because 35-year-olds don't need them.

DR. NELSON: They may have a rapid turnover but they may have a longer queue. But to get back, I think it's important for us to retain the distinction between the way we tried to estimate an update that would take into account input prices and

try and keep pace with inflation, on the one hand and Congressional action that was intended to entice people into underserved areas. It has a different motivation and a different reason. It doesn't make sense to commingle those and just say, it all adds up to about the same number, it must be okay, because they have different purposes.

MR. HACKBARTH: So what we want to avoid is implied endorsement of the distributive policy.

We want to make it clear that we think the appropriate update is the 2.3 percent. That's the message, right? Then if we wish to look at the distributive issues later on we can do that as a separate matter when we've got more time and opportunity.

DR. MILLER: I'm really reluctant to do this with this many people in the room, and Kevin, if this is way off base -- I mean, part of the nervousness I had about thinking through the distributional stuff in a short timeframe is I myself, and many other people, I think were carrying around the notion that these physician dollars were targeted to small areas and small groups of physicians. Yet if you look at some of the scoring, there's a fair amount of dollars that are traveling through some of these mechanisms. So exactly how far out they're going to reach is something of a question.

Now if I'm way off base here, Kevin, you need to correct this. But this is part of what we're starting to unpack. I walked into this legislation thinking there was a whole bunch that went to underserved areas. I think that's the general intention, but the definition of the area is at least not clear to me at this point. And like I said, there's a fair amount of dollars traveling through this.

DR. HAYES: One way to add to what Mark said is to think about the new bonus payments, the new 5 percent bonus payments. They apply to areas with the lowest physician to beneficiary ratios such that the cumulative beneficiary enrollment in all such areas that are eligible for this bonus equals 20 percent of Medicare enrollment. That's a pretty large percentage of the beneficiary population.

One observation we had at the staff level was that 25 percent of beneficiaries live in rural areas, so this is a pretty large -- now granted, not all of those beneficiaries stay in those places and receive care there, but it just gives you some idea of breadth of some of these provisions.

DR. STOWERS: On page 23 you got a little bit into the PLI -- and I don't mean to get off into this PLI thing altogether because it's -- but you talk about the projection of 4.7 percent, or 6.6 last year and then it went to 16.9. I only make the point that if we're talking access to beneficiaries, Oklahoma went up 44 percent last year and we got hit with 80

percent this year for the average physician in increased premiums. That's probably going to affect access more than the basic fee schedule in Medicare, especially in a lot of our specialties, neurosurgery and emergency medicine and that kind of thing.

I would like to see you develop this text box maybe a little bit more to show, maybe the word was sensitivity to which Medicare is going to respond to particular specific geographic areas and specialties to carry its part of this crisis that's happening around the country.

In other words, if I'm a specialist providing care to Medicare beneficiaries, what percentage of that increased hit is going to be covered by Medicare in this formula, and in what timeframe is that going to be covered? In other words, is there some assurance, if I read this MedPAC report, that the Medicare fee schedule is going to respond to my problems? I think that plays a big role in whether I'm going to stay a participant as much as what the actual amount I'm getting paid for a particular procedure.

MS. BOCCUTI: I see what you're saying. What's in the text box explains that there is really two mechanisms for dealing with the PLI. You bring up the one that is more sensitive, which is the fee schedule. It's more sensitive to specialists and to geographic areas because its differential in that way. Whereas the MEI's capture of the PLI is not, so that's all over.

But I think the point that you're trying to make, and make sure I understand you correctly because you're talking about addressing this in the chapter, is to draw some conclusions about adequacy and access with relation to the PLI. I see what you're saying in that we didn't really say that this may or may not to affect access and how. But we did show the example of a Detroit neurosurgeon who is in an area that has high PLI.

DR. STOWERS: I'm just trying to quantify it. One of our surgeons jumped from $20,000 a year two years ago to $85,000 in premiums and 50 percent of his practice is Medicare. Is his Medicare reimbursement going to increase that 50 percent in between to cover his --

MS. BOCCUTI: We'll try to make that clear.

DR. STOWERS: Do you see what I'm saying?

MS. BOCCUTI: Yes.

DR. STOWERS: It would be nice if that's explained in here, that the Medicare formula is going to take care of what's happening to him in that particular community in Oklahoma.

MS. BOCCUTI: Or How it does.

MR. HACKBARTH: Of course it won't address it for every individual physician and every circumstance.

DR. STOWERS: I understand that.

MR. HACKBARTH: But I do recall in the November materials there were some examples of the power of the interaction of the two factors, the MEI component plus the specialty-specific geographic --

DR. STOWERS: We could go a little further maybe. Thank you.

MR. DURENBERGER: I really don't intend my comments to change any of the wording in the decision but I've just finished going all over the state of Minnesota and North Dakota because I'm chairing a governor's citizens forum and so forth and there's very little in here, if I took this around Minnesota with me, that would reflect the reality of what's going on in -- I mean, if I sat down with physicians there's very little in the nature of this presentation that would reflect the realities of what's going on in Minnesota today. I don't mean that as a criticism because I know we have a particular way of having to approach the updates.

But I hope between now and the next time we address this that we would spend a little bit more time talking about how the practice of medicine is changing in this country, about how the variation in practice actually leads to variation in the deployment of various kinds of doctors in a wide variety of communities. I'm sure Nick experiences this as we do across our part of the country.

If I asked people in Minnesota today, doctors in Minnesota today, what's the greatest problem with Medicare payment, they would say the disparity between the financial rewards for primary care and the financial rewards for specialty care, because of financial rewards for specialty care are driving subspecialty hospitals, ambulatory surgery, all that sort of thing, driving people out of general hospitals in rural as well as Twin Cities type areas into other parts of the country. I've told you this before, we now have 38 heart hospitals in two states, two relatively low populated states, Minnesota and Wisconsin and only three of them meet HEDIS requirements. That's the tip of the iceberg.

The point simply being that there's more to the payment formula than the annual update across the board. I really think that at some time we need to deal with that.

There are other issues like shortages. We have a lot of health profession shortages in our state. To the extent that it's ancillary health professionals you are loading more work on the primary care doc, whether it's nurses or whatever the case may be, dentist, a whole lot of other people.

There are specialty shortages that are really interesting that relate to what goes in and out of the education pipeline. There was a time I was told the other day, there was a time in

the late '90s in which anesthesiologists in our state were making about -- to come to work for our hospital, were making about what nurse anesthetists were making, just over $100,000. The last anesthesiologist hired by a hospital in Minnesota got paid $400,000-some. It's a reflection on a marketplace.

I don't know that we're all that different from a lot of other places in America. I just think the markets are changing fairly substantially. There's nothing very static about them. All that means is that within the context of a broad-based adjustment for Part B there are a lot of other things going on that affect beneficiary access. So I'm merely saying that I think we owe it at some point to the professions out there to do not just the update but to try our best to describe how and why the payment formula plays some role in either facilitating positive practice changes or as a barrier to the kind of changes that ought to take place.

MR. HACKBARTH: I think a considerable piece of the reform legislation changes in physician payment were directed at the geographic issues and the difficulty of attracting physicians to certain parts of the country. Now whether they did it right, went far enough or too far, again I don't have any opinion on that and I think that's a subject we can come back and look at. But that's certainly one of the pieces of commentary that --

MR. DURENBERGER: But to me that's the old command and control thing, as some of my more conservative friends -- in other words, we have no way of deciding -- the people that decide that are people like Nick Wolter, Roger Gilbertson who runs Merit Care, which is a huge organization up in Fargo. Those are the people that -- they have to g out and pay $400,000 for a subspecialist, or some other people, who may get paid a lot less in the Medicare program. But they're making those decisions today simply because it's important to put certain kinds of combination of primary and specialty services in certain communities.

In our neck of the woods, the nature of practice often addresses shortages better than doubling the payments to public health doctors or something like that. So I'm not arguing with the fact that there wasn't an effort to do that. I'm just saying I think docs do a better job usually of doing that than does the reimbursement system.

MR. HACKBARTH: Bear with us for a second because I want to make sure that I'm understanding what you're saying. There are several factors that influence beneficiary access to physician services, which is ultimately our goal is. Only one of them is the update. In this conversation we're focused principally on the update factor.

A second is the geographic formulas for adjusting payments.

We're not taking that up here, but again, that's something that we very well could delve into and offer some recommendations in that area.

A third is the specialty differentials that you alluded to at the outset. If I understood you correctly you're saying you still think that specialists are paid too much relative to primary care.

MR. DURENBERGER: I'm reflecting what others say.

MR. HACKBARTH: I think we've gone a considerable distance over the last decade in reducing those disparities. I'm agnostic on whether we've gone far enough or too far, but that is a variable that the program has played with substantially over the last decade. So we've not ignored that one by any stretch.

DR. MILLER: Just so you know, this question and the question that we were talking about with Bob Berenson is the same type of question. And just so you know, the staff isn't dead in the water on this. Kevin has been doing some work with Bob Berenson and some of his colleagues. This work is complicated and takes time, but we do have a path to address some of these issues, correct, Kevin?

DR. HAYES: Yes.

DR. MILLER: The review of the impact of the fee schedule and how it's affected the mix of funds between primary care and specialty.

DR. HAYES: Yes.

MR. HACKBARTH: What we could do in the run-up to this discussion which will focus principally on the update, just make sure it's clear that we understand that there are other moving parts in this system that have a bottom-line effect on beneficiary access.

I think we've covered everything there. Anything else, Cristina, Kevin? All done? All right, thank you very much.