

SECTION
2B

Physician services

R E C O M M E N D A T I O N

The Congress should update payments for physician services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

COMMISSIONER VOTES: YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

SECTION 2B

Physician services

Section summary

Our analysis of beneficiary access to physician care, physician supply, comparisons of Medicare and private fee levels, service volume, and quality of ambulatory care finds that most of these indicators are stable and the large majority of beneficiaries are able to obtain physician care. The volume of services used per beneficiary continues to grow significantly. In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that the Congress update payments in 2008 for physician services by the projected change in input prices less the Commission's expectation for growth in productivity.

The Congress should update payments for physician services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

In this section

- Are Medicare payments for physician services adequate?
- How should Medicare payments for physician services change in 2008?
- Update recommendation

Recommendation 2B

COMMISSIONER VOTES:
YES 14 • NO 0 • NOT VOTING 0 • ABSENT 3

Although the recently passed Tax Relief and Health Care Act directs funds to physicians in 2008, the sustainable growth rate (SGR) formula continues to call for substantial negative updates through

2015. Currently we do not see overall access problems, but the Commission is concerned that such future consecutive annual cuts would threaten beneficiary access to physician services, particularly those provided by primary care physicians. As a mechanism for volume control, the current national SGR has several problems, and the Commission has examined alternative approaches in a mandated report to the Congress, *Assessing Alternatives to the Sustainable Growth Rate System*. The report states that, ideally, Medicare's physician payment system would include incentives for physicians to provide better quality of care, to coordinate care (across settings and medical conditions), and to use resources judiciously.

As with other sectors, our approach for recommending updates for 2008 first considers payment adequacy from the most currently available data and then assesses the factors that will affect efficient providers' costs in the coming year. Following is a summary of our findings from this analysis for physician services.

Beneficiary access—Results from several surveys conducted between 2004 and 2006 show that beneficiary access to physicians is generally good with few statistically significant changes in recent years. Most beneficiaries are able to find new doctors and schedule medical appointments in an amount of time they find acceptable, but small subsets of beneficiaries report problems. Researchers have found that other factors, such as developments in local health systems, may be a major influence on beneficiary access (Lake et al. 2005, Trude and Ginsburg 2005).

Supply of physicians treating and accepting Medicare fee-for-service beneficiaries—Our claims analysis shows that the number of physicians providing services to fee-for-service Medicare beneficiaries has kept pace with growth in the beneficiary population. Also, according to a 2006 MedPAC survey of physicians, most physicians (80 percent) accept all or most new Medicare beneficiaries, with 97 percent reporting that they accept at least some. Other national surveys show similar results for 2005.

The Commission notes the importance of monitoring the future supply of physicians and plans to examine workforce issues in forthcoming work.

Private insurer rates compared with Medicare—To assess payment adequacy, we also compare Medicare’s physician fees with private insurer fees. Averaged across all services and areas, the 2005 ratio of Medicare rates to private rates was essentially at the same level as in 2004, with Medicare rates computed as 83 percent of private rates. Within a market area and for a given service, the difference between Medicare and private fees may vary substantially.

Volume growth—Service volume per beneficiary continued to grow aggressively in 2005. Across all physician services, volume (as a function of service units and intensity) grew 5.5 percent per beneficiary, which matches the average annual volume growth seen in recent years. Among broad categories of services—evaluation and management, major procedures, other procedures, imaging, and tests—volume growth rates varied, but all were positive. As in previous years, per beneficiary volume for imaging grew the most, at about 9 percent.

Fee-schedule mispricing may be one factor contributing to disparity in volume growth among services. As certain procedures become increasingly profitable, physicians face financial incentives to favor them over less profitable services—putting less profitable services at risk of being underprovided. For example, work relative value units (RVUs) for rapidly growing services may need revaluation, and practice expense RVUs are subject to distortions due to data lags and assumptions about equipment pricing. The Secretary could play a lead role in identifying misvalued services through detailed analyses of volume growth. CMS or the Relative Value Scale Update Committee could use the results from these analyses to flag services for closer examination of relative work values. Alternatively, the Secretary could automatically correct such misvalued services. Additionally, revisiting the entire resource-based Relative Value Scale may be in order.

Some observers suggest that the pricing of individual services should account not just for input costs, but also for the value of the service and the price needed to ensure an adequate supply.

Ambulatory care quality—Our claims analysis shows small improvements in the quality of ambulatory care. We see increases in the share of beneficiaries receiving necessary ambulatory care and averting potentially avoidable hospitalizations. For some medical conditions, we see improvements in outcome measures concurrent with improvements in process measures. Few measures indicated a worsening of care; however, for 11 measures, fewer than two-thirds of beneficiaries in the sample received specified services indicated for their condition.

The Commission has recommended that the Congress establish a quality incentive payment policy for physicians in Medicare but acknowledges several challenges associated with measurement at the physician level (MedPAC 2005). Because we do not currently have well-established performance measures for all providers of physician services, policymakers might consider prioritizing the implementation of some pay-for-performance measures over others. Focusing measures on high-cost, widespread, chronic conditions to maximize benefits to beneficiaries and to the Medicare program might be a good short-term strategy. Further, measures that reflect coordination between health sectors (e.g., hospitals and physicians) will encourage and reward communication among providers, which may improve patient outcomes and reduce Medicare costs.

Input costs—CMS forecasts that input prices for physician services will increase by 3.0 percent in 2008. This forecast excludes productivity adjustments that are integrated into CMS's publicly released Medicare Economic Index (MEI); thus, it is higher than CMS's publicly released MEI. This input cost forecast is revised on a quarterly basis and may change as we approach 2008. Although professional liability insurance (PLI) continues to be the fastest growing input cost, PLI premium increases have slowed in the past few years. ■

Background

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities, other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Physician services are billed to Medicare Part B. Payments for these services (about \$58 billion in 2005) account for about 17 percent of total Medicare spending. If beneficiary cost sharing were included in physician spending calculations, total annual spending would be about \$70 billion.

Medicare pays for physician services according to a fee schedule that lists services and their associated payment rates. The fee schedule assigns each service a set of three relative weights intended to reflect the resources needed to provide the service. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. In general, Medicare updates payments for physician services by increasing or decreasing the conversion factor. For further information, see MedPAC's Payment Basics publications, available on our website.¹

By law, these updates are determined by a formula called the sustainable growth rate (SGR), which ties physician payment updates to a number of factors, including growth in input costs, growth in Medicare fee-for-service (FFS) enrollment, and growth in the volume of physician services relative to growth in the national economy. Over the last several years, physician fees were slated to decrease in accordance with the SGR formula.

Recent laws, however, overrode cuts for the past four consecutive years and moved the negative updates to later years. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) increased payments for all physician services through a 1.5 percent update to the conversion factor in 2004 and 2005 and instituted additional fee increases to certain physicians, particularly those in rural areas. The Deficit Reduction Act (DRA) again overrode the SGR by averting a cut to the 2006 conversion factor and holding payment rates for physician services at 2005 levels. (Although the conversion factor was not increased for 2006, refinements to the relative value units resulted in an overall update of 0.2 percent in 2006.) Most recently, the Tax Relief and Health Care Act effectively held 2007 payments at 2006 levels through a

conversion factor bonus.² Also, the Act extended through 2007 the work geographic practice cost index (GPCI) floor—originally imposed by the MMA and set to expire at the end of 2006.

The Tax Relief and Health Care Act also directs spending to physicians in 2008 through two other provisions. Physicians are eligible to receive a 1.5 percent bonus on all covered services they furnished to Medicare beneficiaries between July 1 and December 31, 2007, provided they submit to CMS an adequate number of approved quality measures. CMS will pay this quality reporting bonus to physicians as a lump sum in 2008. Another provision in the law establishes a \$1.35 billion fund to be used toward physician payments at the Secretary's discretion in 2008; the law explicitly allows the Secretary to direct the funds toward the 2008 update in the conversion factor.

Together, these four provisions in the Tax Relief and Health Care Act—the conversion factor bonus, the GPCI floor extension, the quality reporting bonus, and the physician fund—account for \$5 billion, which will be directed toward physician payments over the next three years.³ These spending increases will be financed through Medicare's Supplementary Medical Insurance (SMI) program (Part B), which is funded through general revenues (75 percent) and beneficiary premiums (25 percent).

Despite these additional payments, the SGR continues to call for substantial negative updates for 2008—the year for which we are making our recommendation—through at least 2015. The Commission is concerned that such consecutive annual cuts would threaten beneficiary access to physician services over time, particularly those provided by primary care physicians. As a mechanism for volume control, the current national SGR system has several problems, and the Commission has examined alternative approaches to it in a mandated report to the Congress, *Assessing Alternatives to the Sustainable Growth Rate System*, available through the MedPAC website.

In the SGR report, the Commission states that, ideally, Medicare's physician payment system would include incentives for physicians to provide better quality of care, to coordinate care (across settings and medical conditions), and to use resources judiciously. However, Medicare's current FFS payment system does not contain these incentives. It does not reward physicians who provide higher quality care or care coordination, and it offers higher revenues to physicians who furnish the most

services—whether or not the services add value or result from medical errors. These deficiencies must be corrected for the Medicare program to promote high-quality health care and avert unsustainable growth in spending. The Commission discusses steps to improve the payment system in its report to the Congress on the SGR. Under its mandate, the Commission will continue to consider ways to improve value in Medicare.

As with other sectors, our approach for recommending updates for 2008 first considers payment adequacy from the most currently available data and then assesses the factors that will affect efficient providers' costs in the coming year.

Are Medicare payments for physician services adequate?

The Commission's framework for assessing payment adequacy for physician services relies on several indicators. We cannot look at financial performance directly because physicians are not required to report their costs to Medicare, as are other providers such as hospitals. Instead, we consider other available indicators. We analyze information on beneficiary access to physician care, including beneficiary and physician survey information and physician supply data. We also compare Medicare's reimbursement levels with those of the private sector and examine changes in the volume and quality of physician services.

Access to physician services: Beneficiary indicators

Physicians are often the most important link between Medicare beneficiaries and health care. According to national survey data from the Medicare Current Beneficiary Survey (MCBS), 87 percent of noninstitutionalized beneficiaries report that a doctor's office or a doctor's clinic is their usual source of care. Beneficiary access to physicians, therefore, is an important indicator of access to health care generally as well as being an indicator of payment adequacy.

To assess beneficiary access to physician services, this section examines results from beneficiary and physician surveys and reviews data on physician supply. By design, many of the surveys' questions rely on respondents' views. For example, respondents use their own judgment when determining if they are able to

schedule timely appointments. Subjective responses can be useful measures for tracking beneficiary experience and perceptions over time, but perceptions of concepts such as "timeliness" may vary across individuals and subpopulations.

Additionally, it is difficult to determine what the appropriate level of access should be. Beneficiary judgments on access to physicians are made in an environment where most beneficiaries have supplemental insurance against out-of-pocket liability. This coverage effectively lowers their costs for physician visits, thereby diminishing the likelihood that cost will temper demand. Some economists might argue that a payment policy goal of no, or almost no, beneficiaries reporting access problems is inefficient or unattainable. Even so, monitoring for changes in access is crucial for the Medicare program.

We find access measures most useful, therefore, when looking for trends across years. They help us observe changes in beneficiaries' access to physicians over time and supplement our analysis of payment adequacy. However, our access measures do not necessarily inform us about the quality or content of physician-patient encounters.

MedPAC's 2006 beneficiary survey on access to physicians

Results from several surveys conducted from 2003 to 2006 show that beneficiaries appear to have steady access to physicians, with most reporting few or no problems. Most beneficiaries are able to schedule timely medical appointments and find new doctors, but small subsets of beneficiaries report access problems.

To obtain the most current access measures possible, the Commission sponsors a telephone survey. In our last three rounds—2004 to 2006—we surveyed both Medicare beneficiaries and privately insured individuals (age 50 to 64) to assess the extent to which access problems, such as appointment scheduling, are unique to the Medicare population. (Our survey does not distinguish FFS Medicare enrollees from those in Medicare Advantage because of difficulty identifying these individuals in the scope of the survey.) The results from this telephone survey are weighted to be nationally representative with respect to basic demographic variables. We did not survey Medicare beneficiaries younger than age 65 because of limited sample size.

Most Medicare beneficiaries have one or more doctor appointments in a given year. Therefore, one access indicator we examine is their ability to schedule timely appointments. The 2006 survey found that most Medicare beneficiaries and privately insured people age 50 to 64 did not have to delay getting an appointment because of scheduling issues (Table 2B-1, p. 102). Further, Medicare beneficiaries enjoyed lower rates of scheduling delays than their privately insured counterparts. In 2006, among those who tried to schedule a routine-care appointment, 75 percent of Medicare beneficiaries and 69 percent of privately insured individuals reported that they never experienced delays. Three percent of Medicare beneficiaries and 4 percent of privately insured individuals reported always experiencing delays. As expected, for illness or injury, timely appointments were more common. Among those who scheduled an appointment for an illness or injury, 84 percent of Medicare beneficiaries and 79 percent of privately insured individuals said they never experienced a delay.

Among those who indicated they had to wait longer for an appointment than they wanted, most reported that they took the later appointment date, but 8 percent of Medicare beneficiaries and 7 percent of privately insured individuals reported that they went to the emergency room (data not shown). As expected, the rate of emergency room use was higher for illness- and injury-related problems. Recent research on variation in the use of emergency departments found that longer waiting times for physician appointments and a higher number of physician office visits relative to the number of physicians in a community increased the rate of emergency room visits; the effects were greatest for people with low incomes (Cunningham 2006). The author suggests that physicians with full practices are less willing to see low-income patients in their offices and more likely to refer such patients to the emergency department.

Our survey also monitors beneficiaries' ability to find a new physician. Compared with the number who schedule doctor appointments, a considerably smaller number of beneficiaries seek a new physician during the year. Therefore, survey questions about problems finding a new doctor apply only to a small share of respondents (e.g., fewer than 10 percent are looking for a new primary care doctor). With this small subset, the differences we see across years and between privately insured and Medicare respondents are often not statistically significant. In our sample, 76 percent of Medicare beneficiaries and 75 percent of privately insured individuals who were looking for a new primary care physician reported that they

experienced no problems. These rates have been relatively stable over the years of the survey.

Although most individuals appear to have good access to primary care physicians, some concerns are worth noting. Among the subset of people who reported any problems in the last two years of this survey, Medicare beneficiaries were somewhat more likely than their privately insured counterparts to characterize their problem as big (versus small). Also, the share of Medicare beneficiaries indicating that they experienced big problems accessing a primary care physician grew slightly in both the 2005 and the 2006 samples. These trends in our samples, however, may not generalize to the actual population because of the small share of people looking for new doctors and the even smaller share reporting problems. (Specifically, fewer than 10 percent of the beneficiaries in our sample reported that they tried to find a new primary care doctor. Of them, only about one-quarter reported having any problems.) Nevertheless, these trends are important to monitor. Some subpopulations of beneficiaries may be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals. Additional data are needed, however, to draw this conclusion.

Similar to the previous year, we found that access to new specialists in our sample was generally better than access to new primary care physicians; 80 percent of Medicare beneficiaries and 83 percent of privately insured individuals looking for a new specialist reported no problem accessing one. While this difference in our sample between Medicare beneficiaries and privately insured people is not large enough to be considered statistically significant, 2006 is the first year when problem rates were higher for Medicare beneficiaries than for privately insured people. Also, the share of beneficiaries reporting big problems finding a specialist significantly increased between 2004 and 2006. We will continue to monitor this change closely.⁴

Our survey asked a follow-up question to those beneficiaries who indicated they had a problem (big or small) finding a new physician (specialist or primary care physician, or both). This question asked if anyone from the doctor's office told them that their problem finding a doctor was because they were covered by Medicare. Eleven percent of these beneficiaries answered "yes" to this question in 2006. This share amounts to less than 1 percent of our entire Medicare sample and is smaller than it was in 2005. The MCBS also asks this question, and

**TABLE
2B-1**

Access to physicians is similar for Medicare beneficiaries and privately insured people

Survey question	Medicare (Age 65 and older)			Private insurance (Age 50-64)		
	2004	2005	2006	2004	2005	2006
Unwanted delay in getting an appointment:						
Among those who had an appointment, "How often did you have to wait longer than you wanted, to get a doctor's appointment?"						
For routine care						
Never	73%	74%	75% ^{a, b}	66%	67%	69% ^{a, b}
Sometimes	21	21	18 ^b	26	25	21 ^b
Usually	4	3	3 ^b	5	5	5 ^b
Always	2	2	3	3	3	4
For illness or injury						
Never	83	82	84 ^b	77	75	79 ^b
Sometimes	13	15	11 ^b	19	19	15 ^b
Usually	2	1	2	3	3	2
Always	2	1	1 ^b	2	2	2 ^b
Getting a new physician:						
Among those who tried to get an appointment with a new primary care physician or a specialist, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."						
Primary care physician						
No problem	77	75	76	73	75	75
Small problem	11	12	10	15	16	15
Big problem	11	13	14	13	9	10
Specialist						
No problem	89	89	80 ^a	83	86	83
Small problem	5	6	7	8	7	9
Big problem	5	5	11 ^a	8	6	7
Not accessing a doctor for medical reasons:						
"In the past year, do you think you should have seen a doctor for a medical problem, but did not?"						
	6	7	8 ^{a, b}	11	12	11 ^b

Note: Numbers may not sum to 100 percent due to rounding. Missing responses are not presented. For the 2004 survey, n=4,122 (2,087 Medicare, 2,035 privately insured); for the 2005 survey, n=4,021 (2,012 Medicare, 2,009 privately insured); for the 2006 survey, n=4,029 (2,005 Medicare, 2,024 privately insured).

^a Indicates a statistically significant difference between 2006 and 2004 for the same group (Medicare or privately insured), at a 95% confidence level.

^b Indicates a statistically significant difference between the Medicare and privately insured populations in 2006, at a 95% confidence level.

Source: MedPAC-sponsored telephone surveys, conducted August-September 2004, 2005, and 2006.

results from its 2004 survey are very similar to our results. The Commission will continue to track this question closely in future surveys and perhaps develop additional survey questions to gain more insights.

Another set of questions in our survey examines reasons respondents give for not seeing a physician for their

medical problems. As in previous years, Medicare beneficiaries report better access than privately insured people on this measure, and the difference between the two is statistically significant. The 2006 survey found that 8 percent of Medicare beneficiaries and 11 percent of privately insured individuals thought they should have seen

a doctor for a medical problem in the past year but did not. Within this small subset, just 11 percent of the Medicare beneficiaries and 12 percent of the privately insured people listed physician availability issues (appointment time, finding a doctor) as the problem. The remaining reasons they gave included cost, procrastination, and low perceived seriousness of the problem (at the time of the illness).

Earlier beneficiary surveys

Earlier studies by CMS and other organizations also examine beneficiary access to physician services and have similar findings. As reported in our March 2006 report, the Center for Studying Health System Change (HSC) found that approximately 10 percent of Medicare beneficiaries and 17 percent of privately insured individuals reported delaying or not getting care in 2003 (Trude and Ginsburg 2005). Both Medicare and privately insured people waited a little longer for appointments in 2003 than in 2001. The authors state that the parallel movement of these indicators suggests that other factors, such as developments in the local health system, may influence beneficiary access as much as or more than Medicare payment levels.

An even larger beneficiary survey, the Consumer Assessment of Healthcare Providers and Systems® for Medicare FFS (CAHPS–FFS), includes two questions related to beneficiary access to physicians: one on access to specialists and the other on appointment scheduling for routine care. CMS did not sponsor this survey in 2005, but for 2004 nearly 95 percent of beneficiaries reported either no problem or small problems accessing a specialist. Also, most beneficiaries reported always or usually being able to schedule timely appointments for routine care. These rates have remained stable over the last several years. We also found that beneficiaries age 85 and older were least likely to report big problems finding a new specialist or getting an appointment. These patients may be more likely than younger patients to have long-established relationships with physicians.

CMS sponsored another survey—the Targeted Beneficiary Survey (TBS)—devoted specifically to beneficiary access to physicians in 11 market areas suspected of having access problems (Lake et al. 2005).⁵ Conducted in 2003 and 2004, the TBS found that, even in these selected areas, only a small percentage of beneficiaries had access problems attributed to physicians not taking new Medicare patients. The rates of access problems did not change between 2003 and 2004. In fact, in both years, 93 percent of beneficiaries surveyed on the TBS

said the ease of seeing a doctor in the past year had either stayed the same or gotten easier. In both years, the study showed that certain subgroups in these markets were more likely to experience access problems. For example, transitioning beneficiaries—those new to a market area, new to Medicare, or recently disenrolled from a Medicare Advantage plan—had slightly higher rates of reported problems seeing a specialist and “getting a personal doctor they were happy with since joining Medicare.” The rates of reported difficulty getting timely routine appointments or urgent care were similar to those of the other Medicare FFS beneficiaries in the survey. A more detailed discussion of this survey’s findings can be found in Chapter 2B of our March 2006 report.

MedPAC has begun studying ways Medicare may need to respond to changes in the Medicare population. This research will likely examine access issues related specifically to demographic differences. Recent work by the National Academy of Social Insurance calls for strengthening Medicare’s role in reducing racial and ethnic health disparities through improved data reporting and targeted bonus payments (Vladeck et al. 2006).

Access to physician services: Physician indicators

For our payment adequacy analysis, we also consider physician survey information and other physician indicators, such as trends in physician supply. For 2006, we conducted a physician survey that found that most physicians (97 percent) are accepting at least some new Medicare beneficiaries, with 80 percent reporting that they accept all or most new Medicare beneficiaries. Also, Medicare FFS claims data show that the number of physicians providing services to Medicare beneficiaries has more than kept pace with growth in the beneficiary population in recent years.

MedPAC’s 2006 survey of physicians

Findings from a recent MedPAC-sponsored survey of physicians present a mixed picture of physician willingness to accept new Medicare FFS patients. Most physicians (97 percent) accept at least some new Medicare FFS patients, and a smaller share (80 percent) accept all or most. Acceptance of new Medicare FFS patients compares favorably with Medicaid and HMO patients but is a little lower than for private non-HMO patients. Across all insurers, most physicians report that they are “very” or “somewhat concerned” about several aspects of practice, including reimbursement levels,

**TABLE
2B-2**

Most physicians accept new patients, 2006

	Type of patient insurance			
	Private, non-HMO	FFS Medicare	Non-Medicaid HMO	Medicaid (including HMO)
Percent of physicians who are accepting new patients*				
At least some new patients	98.3%	96.7%	86.3%	70.4%
All new patients	72.7	66.6	49.6	38.4
Most new patients	13.3	13.6	15.7	8.4
Some new patients	12.3	16.6	21.1	23.6
No new patients	1.7	3.3	13.7	29.6
Percent of physicians who are accepting at least some new patients				
Urban	98.5	97.2	86.4	68.4**
Rural	96.8	93.1	85.8	84.8**
Proceduralists	99.0	97.9	91.9**	75.4
Surgeons	99.1	99.1**	88.2	74.2**
Nonproceduralists	97.5	94.8**	83.6**	66.4**
Percent of physicians who said finding a referral was 'very difficult' for their patients*				
	3.2	6.8	14.3	50.8

Note: FFS (fee-for-service). Proceduralists include physicians in medical specialties that are procedurally oriented (cardiology, dermatology, gastroenterology, and radiation oncology). Nonproceduralists include physicians in all other nonsurgical specialties.

*The distribution of responses is significantly different from FFS Medicare patients ($p < 0.0001$), chi-square test.

**Responses by type of physician are statistically significant within insurance group, at a 95% confidence level.

Source: MedPAC-sponsored survey of physicians conducted by NORC at the University of Chicago and The Gallup Organization.

billing and paperwork, practice costs, and timeliness of claims payments. More physicians were concerned about reimbursement for Medicare FFS patients than for private non-HMO patients. Many physicians have reported recent changes to their practice to increase revenue. Increasing service volume, for example, may be an important factor, as most physicians report that their own productivity is a “very important” determinant of their individual compensation—to a greater extent than quality and patient satisfaction.

This survey was conducted by NORC at the University of Chicago and The Gallup Organization (Schoenman et al. 2006) and was fielded in the summer of 2006.⁶ The survey included nonfederal physicians who spent at least 10 percent of their patient care time with FFS Medicare patients.⁷ Physicians with closed practices—practices not taking any new patients, regardless of insurance

type—were excluded from survey questions about patient acceptance.

Physician willingness to accept new patients Among the physicians in our survey, 3.3 percent reported that they were not accepting any new Medicare patients (Table 2B-2). These rates are slightly lower for new private non-HMO patients (1.7 percent) but are higher for new HMO and Medicaid patients (13.7 percent and 29.6 percent, respectively). These results are similar to those found in the 2005 National Ambulatory Medical Care Survey (NAMCS), which we discuss later in this section.

Relative to the rates of acceptance of *at least some* new patients, the percentages of physicians reporting that they accept *all or most* new patients are lower across all insurance types. For example, about 97 percent of physicians reported that they accept at least some new Medicare FFS patients, and about 80 percent reported

**TABLE
2B-3**

Most physicians are concerned about several aspects of practice, 2006

Aspect and type of patients	Very concerned	Somewhat concerned	Not very concerned	Not at all concerned
Level of reimbursement				
Private, non-HMO patients	53.2%	38.9%	6.5%	1.4%
Medicare FFS patients	72.0	23.0	3.9	1.1
Non-Medicaid HMO patients	62.2	33.5	3.5	0.8
Medicaid patients	78.2	17.5	3.7	0.7
Billing and paperwork				
Private, non-HMO patients	49.6	40.8	8.8	0.8
Medicare FFS patients	51.5	35.1	10.6	2.7
Non-Medicaid HMO patients	53.5	37.8	7.2	1.5
Medicaid patients	56.4	32.7	9.4	1.5
Timeliness of claims payment				
Private, non-HMO patients	33.8	44.5	18.4	3.3
Medicare FFS patients	34.0	37.2	24.2	4.5
Non-Medicaid HMO patients	37.2	44.6	16.7	1.6
Medicaid patients	43.8	35.6	18.4	2.2

Note: FFS (fee-for-service).

Source: MedPAC-sponsored survey of physicians conducted by NORC at the University of Chicago and The Gallup Organization.

accepting all or most. For new private non-HMO patients, about 98 percent of physicians reported accepting at least some, and 86 percent reported accepting all or most. Acceptance of all or most new HMO patients (about 65 percent) or Medicaid patients (about 47 percent) is lower than for both Medicare FFS and private non-HMO patients.

Acceptance rates of Medicare FFS patients varied by physician characteristics, but this variation generally corresponds with physicians' overall patient acceptance, regardless of insurance type. Compared with urban physicians, a smaller but statistically insignificant share of rural physicians reported accepting at least some Medicare FFS patients (about 97 percent compared to 93 percent). Nonproceduralists (e.g., primary care physicians) were less likely than other types of physicians to accept new patients by each given insurance type (though this difference is not statistically significant for the private, non-HMO group).

Physicians more frequently reported difficulty referring their Medicare FFS patients (about 7 percent) than their private, non-HMO patients (about 3 percent). Conversely, physicians less frequently reported difficulty referring

their Medicare FFS patients than their HMO patients (about 14 percent) or Medicaid patients (about 51 percent). In further survey analysis, two-thirds of physicians reported that the level of difficulty in finding appropriate referrals for their Medicare FFS patients was "the same" or "better" than for their private non-HMO patients.

Not surprisingly, physicians who devoted a larger share of their practice to Medicare FFS patients were generally more likely to accept new Medicare FFS patients. The survey excluded specialties with typically low Medicare caseloads, such as pediatricians. Fewer than 10 percent of the physicians in our sample reported that they prioritized appointment slots by patient insurance. Of this relatively small subset of physicians, about 65 percent reported that their priority level for Medicare patients was unchanged or better than for the previous year.

Concerns about reimbursement and billing issues In our survey, most physicians indicated that they were "very" or "somewhat concerned" about reimbursement levels across patients of all insurance types (Table 2B-3). Specifically, about 53 percent of physicians were "very concerned" about reimbursement levels for their private non-HMO

**TABLE
2B-4**

Physician practice changes may link to compensation factors, 2006

	Percent
Physicians who reported:	
In the last year, their practice had:	
Increased number of patients	70.1%
Changed mix of personnel in practice	38.0
Expanded in-office tests and lab services	26.7
Expanded imaging services	19.2
Expanded equipment and supplies sales	5.9
That the factor below was a 'very important' determinant of compensation:	
Physician's own productivity	80.0
Measures of quality of care provided	32.7
Profiling or benchmarking of practice patterns	21.3
Patient satisfaction surveys	16.0

Source: MedPAC-sponsored survey of physicians conducted by NORC at the University of Chicago and The Gallup Organization.

patients, about 62 percent of physicians were similarly concerned for their non-Medicaid HMO patients, about 72 percent for their Medicare FFS patients, and about 78 percent for their Medicaid patients. A comparison of the relative ratings given for each payer (not shown in this table) reveals that a quarter of physicians reported that they were relatively more concerned about Medicare FFS reimbursement than private non-HMO reimbursement, while 70 percent reported similar levels of concern for these payment sources. For both private non-HMO patients and Medicare FFS patients, surgeons were most likely to report being “very concerned” about reimbursement. Proceduralists were next most likely and nonproceduralists were least likely to report being “very concerned” about reimbursement.

Physicians also reported concern about administrative burdens imposed by insurers. For private non-HMO patients and Medicare FFS patients, about half of all physicians reported being “very concerned” about billing paperwork and administration. Rates for Medicaid and HMOs were a little higher.

Compared with the previously mentioned concerns, physicians were less likely to be anxious about the timeliness of claims payments; this was true across all insurers. About one-third of physicians reported that they were “very concerned” with the timeliness of claims

payment for private non-HMO patients and Medicare FFS patients. Rates for Medicaid and HMO patients were, again, a little higher.

Practice changes Many physicians reported recent changes to their practice to increase revenue. Specifically, about 70 percent of physicians reported that in the last year they have increased the number of patients they see (Table 2B-4).⁸ About 27 percent of physicians reported that they expanded in-office testing and lab services and about 19 percent reported expanding imaging services. Approximately 38 percent reported changes to the mix of personnel they have in their practice (e.g., the share of administrative to clinical staff). Surveys conducted by the Center for Studying Health System Change have found similar results (Pham et al. 2004).

Perhaps related to efforts to increase patient caseloads, almost half of the physicians surveyed reported that, in the past year, they had increased the number of hours they worked per week; 12 percent indicated that they decreased the number of hours worked and 41 percent said their hours did not change.

Compensation factors Our survey also asked physicians about the factors that affect their individual compensation. Most—80 percent—reported that their own productivity (typically measured by their service volume) was a “very important” determinant of compensation (Table 2B-4).⁹ Other factors, including patient satisfaction, quality measures, and resource use, were considerably less likely to be important to their compensation. However, physicians who rely more heavily on capitated payments were more likely to report that these other factors were “very important” to their compensation. Our findings are similar to those found by HSC in their 2004–2005 survey (Reschovsky and Hadley 2006).

About 20 percent of physicians reported that they or their practice experienced pay-for-performance (P4P) incentives from private insurer(s), in the form of bonuses, withholds, or both.

Among these physicians, about 60 percent indicated that such payment incentives were “not very effective” or “not at all effective” in improving patient care. A little more than a third reported that they were “somewhat effective.” Survey limitations prevented us from exploring further the characteristics of programs that physicians found most and least effective.

Although more analysis is needed to draw conclusions about why physicians determined that P4P systems were

or were not effective, results suggest that the pervasive incentive for physicians to increase their income by increasing the quantity and intensity of services they provide may, in fact, be a greater influence on practice styles than current P4P programs. Also, these compensation incentives may help to explain the volume increases we see in Medicare FFS. As discussed later in this section, beneficiaries received, on average, 5.5 percent more services in 2005 than in the previous year, with similar growth seen the year before.

Earlier physician surveys

The NAMCS—a national physician survey conducted annually by the National Center for Health Statistics—also shows that a large majority of physicians accept some or all new Medicare patients. For 2005, this survey found that, among physicians with at least 10 percent of their practice revenue coming from Medicare, 92 percent accepted at least some Medicare patients (Cherry 2006). NAMCS also found that more physicians accepted new Medicare patients than privately insured patients in capitated and noncapitated health plans. Importantly, both the overall patient acceptance rate and the Medicare acceptance rate remained relatively steady compared with results from the 2003 and 2004 NAMCS.

HSC reported that only 3 percent of physicians with practices open to private patients completely closed their practices to new Medicare patients in 2004 and 2005 (Cunningham et al. 2006). In contrast, 73 percent of physicians with practices open to private patients reported that they accepted all new Medicare patients, 13 percent said they accepted most new Medicare patients, and 10 percent said they accepted some new Medicare patients. Cunningham and colleagues suggest that while there was a dip in acceptance of Medicare patients between the 1996–1997 survey and the 2000–2001 survey, some increases occurred in the 2004–2005 survey, which suggests stabilization.

Similar to the MedPAC-sponsored surveys, the HSC survey found that physician acceptance of new Medicare patients follows a trend similar to acceptance of new privately insured patients. The HSC study authors suggest, therefore, that overall health system dynamics have played a larger role in physician decisions about accepting Medicare patients than have Medicare payment policies. For example, compared with 2000, the study authors say that physician capacity constraints may have eased somewhat, decreasing physician pressures to limit the number of new patients—of any type—in their practices.

All rounds of HSC’s survey show that acceptance of new Medicare patients continues to be lower for primary care physicians than it is for both medical and surgical specialists, but the most recent survey round found a statistical increase in the share of primary care physicians accepting new Medicare patients. Rates for specialists in the most recent survey were statistically unchanged from the previous round.

Among the 3 percent of physicians in the HSC survey who reported that they did not accept new Medicare patients, the top reasons were inadequate reimbursement, billing and paperwork, high clinical burden, and already full practice. This study did not explore reasons physicians gave for not accepting private patients, which occurred at a similar rate.

Some local market analyses reveal that physician surveys and patient surveys produce seemingly contradictory results. HSC found that, in some local markets, patients’ assessments of access to physician care do not necessarily track with physicians’ willingness to accept patients. In Boston, for example, HSC found relatively high rates of appointment delays reported by Medicare and privately insured near-elderly patients but relatively low rates of physician unwillingness to accept these patients. The reverse effects were reported in the Seattle area (Hargraves et al. 2003).

The small share of physicians who leave the Medicare market, or who report 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 relate to local conditions such as physician supply, demand for physician services, and insurance market conditions. Also factoring into physicians’ decisions to accept Medicare patients may be their dependence on referrals, the size of their Medicare patient caseload, the amount of time they are willing to devote to patient care, and their personal retirement decisions. Disentangling these other factors from Medicare payment adequacy is difficult. To some extent, comparing physicians’ willingness to accept Medicare patients with their willingness to accept all patients helps to control for non-Medicare factors.

Changes in the supply of physicians

Our analysis of Medicare FFS claims data shows that the number of physicians providing services to Medicare beneficiaries has more than kept pace with growth in the beneficiary population in recent years. Comparing growth

**TABLE
2B-5****Number of physicians billing Medicare is increasing steadily**

	Number of Medicare patients in physician caseload				
	≥1	≥15	≥50	≥100	≥200
Number of physicians					
2000	514,419	444,187	398,905	351,012	274,059
2001	535,834	457,292	411,424	364,023	286,862
2002	544,615	466,299	419,269	370,144	291,593
2003	544,922	470,213	424,684	374,721	292,183
2004	561,514	483,945	440,462	393,730	315,398
2005	566,629	492,131	449,524	402,451	322,643
Percent growth, 2000–2005	10.1%	10.8%	12.7%	14.7%	17.7%
Physicians per 1,000 beneficiaries					
2000	13.8	11.9	10.7	9.4	7.3
2001	14.2	12.1	10.9	9.7	7.6
2002	14.3	12.3	11.0	9.7	7.7
2003	14.1	12.2	11.0	9.7	7.6
2004	14.4	12.4	11.3	10.1	8.1
2005	14.3	12.4	11.4	10.2	8.1

Note: Calculations include physicians (allopathic and osteopathic). Nurse practitioners, physician assistants, psychologists, and other health care professionals are not included in these calculations. Medicare enrollment includes beneficiaries in fee-for-service Medicare and Medicare Advantage, on the assumption that physicians are providing services to both types of beneficiaries. Physicians are identified by their Unique Physician Identification Number (UPIN). UPINs with extraordinarily large caseload sizes (in the top 1 percent) are excluded because they may represent multiple providers billing under the same UPIN.

Source: MedPAC analysis of Health Care Information System from CMS.

in the number of physicians with growth in the Medicare population, we see that, from 2000 to 2005, the number of physicians who billed Medicare grew faster than Medicare Part B enrollment. During this time, Part B enrollment grew 6.0 percent. In comparison, the number of physicians with at least 15 Medicare patients grew 10.8 percent (Table 2B-5).¹⁰ The number of physicians with 200 or more Medicare patients grew even faster at 17.7 percent. Therefore, the ratio of physicians per 1,000 beneficiaries grew more rapidly for physicians with higher Medicare caseloads. This growth reflects increases in the share of physicians seeing more Medicare patients. In 2005, a little more than half of all physicians billing Medicare saw at least 200 different Medicare patients.

Our claims analysis also shows that a large share of the 2005 physicians (80 percent) stayed active in the Medicare market during all six study years (2000 through 2005). Despite the overall increase in physicians who

regularly saw Medicare FFS beneficiaries, the supply of physicians was still somewhat dynamic, with small shares of physicians either starting or stopping their regular Medicare practice. These changes affect existing patient–physician relationships and could contribute to the small, but persistent, share of beneficiary complaints about access problems.

Traditionally, MedPAC has not examined workforce issues in the context of our update analyses. However, the Commission plans to study this issue, especially with respect to the supply of primary care providers. Although currently we do not see overall problems with physician supply, the aging of the baby boomers prompts us to examine the issue. Not only do we expect them to use more services as they age over the next several decades, but baby-boomer physicians will begin to retire. Thus, we plan to examine research and analysis on future workforce projections for both physicians and nonphysician

practitioners. Among the workforce issues to consider will be the factors that influence the choices medical students and residents make about their career specialty.

Assignment and participation rates To supplement our data on the supply of physicians treating Medicare patients and patients' access to physician care, we examine assignment rates (the share of allowed charges for which physicians accept assignment) and physician participation rates (the share of physicians signing Medicare participation agreements). Claims data show that 99.3 percent of allowed charges for physician services were assigned in 2005 (Figure 2B-1). That is, for almost all allowed services, physicians agreed to accept the Medicare fee schedule charge as the service's full charge.

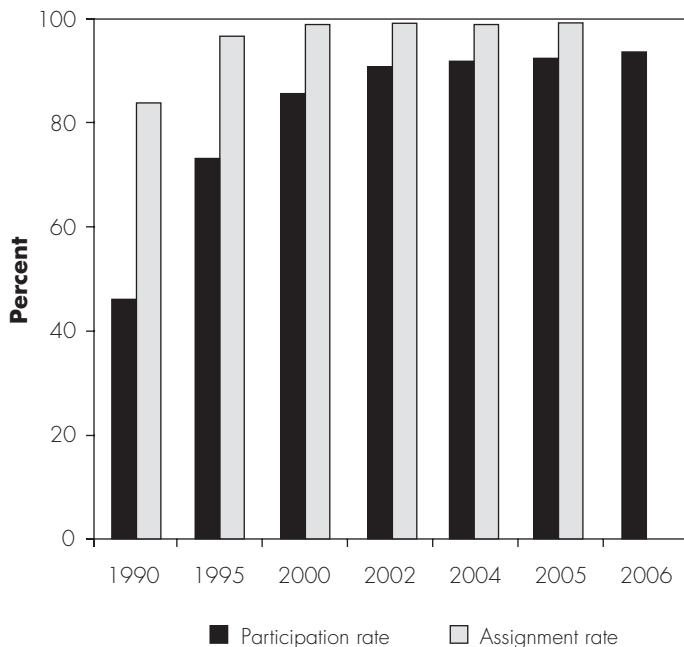
The number of participating physicians as well as the participation rate increased in 2005 and 2006. Participating physicians agree to accept assignment on all allowed claims in exchange for a 5 percent higher payment on allowed charges. Participating physicians receive other valuable benefits, including having their name and contact information listed on Medicare's website and being given the ability to verify a patient's Medicare eligibility and medigap status. Medicare's physician participation agreement does not require physicians to take Medicare patients.

While 96.2 percent of allowed charges were for services provided by participating physicians, 3.1 percent were for services provided by nonparticipating physicians who decided to accept assignment. Only 0.67 percent of allowed charges were for services provided by nonparticipating physicians who did not accept assignment.

For this small amount of nonassigned charges, physicians likely billed higher amounts, making the beneficiary liable for added coinsurance. This practice is called balance billing. Medicare limits the amount physicians may balance bill a patient. The total nonassigned charges for a service may not exceed the fee schedule amount by more than 9.25 percent. (This amount is equal to 115 percent of the nonparticipating physicians' allowed charge, which is 95 percent of the fee schedule amount.) In general, physicians do not consider the additional payment from balance billing to be worth forgoing the nonmonetary benefits associated with accepting assignment. A chief nonmonetary benefit, for example, is that when physicians accept assignment, they can receive payments directly from Medicare (less the beneficiary cost-sharing

FIGURE 2B-1

Participation and assignment rates have grown to high levels, 1990-2006



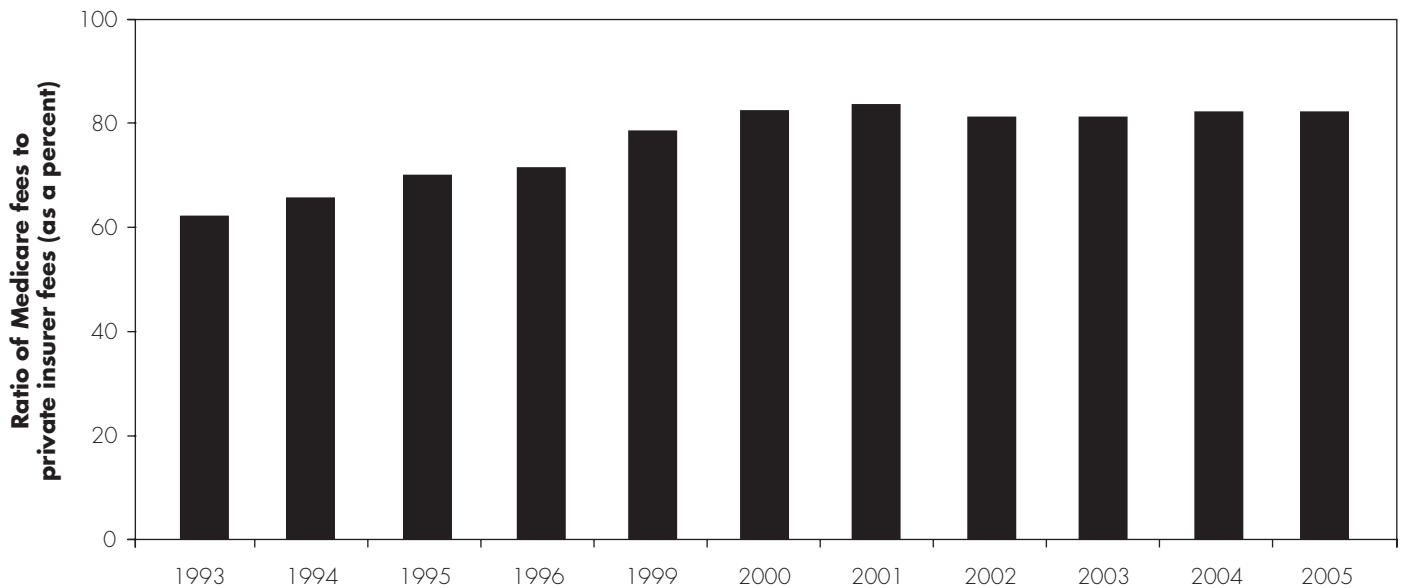
Note: Participation rate is the percentage of physicians and nonphysician providers signing Medicare participation agreements. Assignment rate is the percentage of allowed charges paid on assignment. The assignment rate for 2006 is not shown; it requires calculations from claims not yet available.

Source: Ways and Means Greenbook 2004, unpublished CMS data, and MedPAC analysis of Medicare claims for a 5 percent random sample of Medicare beneficiaries.

portion) rather than collecting from the beneficiary. This arrangement is a major convenience for many physicians. The high rate of assigned charges also reflects the fact that most physicians and nonphysician providers who bill Medicare agree to participate in Medicare—93.3 percent in 2006.

Private payer payment rates for physician services

As another means of gauging the adequacy of Medicare payments, we compare trends in Medicare's physician fees with payment rates of private insurers for physician services. Historically, Medicare payment rates for physician services were below private insurer rates, with Medicare averaging about two-thirds of private payment rates in the early 1990s. The difference between the two narrowed by the late 1990s and has essentially remained

**FIGURE
2B-2****Ratio of Medicare to private reimbursement rates for physician services is stable**

Note: Data are not available for 1997 and 1998.

Source: Direct Research, LLC, for MedPAC for 1993–2004 data. MedPAC analysis for 2005 data.

steady in recent years (Figure 2B-2). Averaged across all services and areas, 2005 Medicare rates were 82.6 percent of extrapolated private rates. In 2004, we found a similar ratio, 83.4 percent. Looking specifically at evaluation and management services, there is less of a difference between Medicare and private payers. In 2005, Medicare rates for such services were about 89 percent of private payer rates, and in 2004 Medicare paid rates that were about 90 percent of private payer rates for evaluation and management services.

The comparison of Medicare to private rates is based on an analysis of private claims for two large national insurers.¹¹ In addition to physician fee comparisons, the analysis estimates average annual fees based on private enrollment trends for different types of plans, including HMOs, preferred provider organizations (PPOs), point-of-service (POS) plans, and traditional indemnity insurance. Analyses from earlier years showed that Medicare payment rates were substantially lower than commercial rates until the late 1990s.

Although in the early to mid-1990s Medicare rates were about two-thirds of commercial payment rates for

physician services, beginning with 1999, Medicare rates consistently have been in the range of 80 percent of commercial rates. Enrollment shifts in the private market from higher paying indemnity plans to lower paying HMOs accounted for much of the narrowing between Medicare and private insurance rates from the mid-1990s to 2001.

Since 2001, the types of health plans that have had the highest rates of enrollment growth in the private sector are network plans with looser structures than HMOs—that is, PPOs and POS plans. The data show a slight increase in payment levels among private POS plans and among HMO plans, compared to Medicare between 2004 and 2005. The relationship between commercial PPO rates and indemnity plan rates compared with Medicare rates remained the same, and there was continued decline in indemnity plan enrollment. The combination of enrollment shifts and slight changes in payment differences did not result in a material change in the aggregate relationship across all payers when comparing private rates with Medicare rates.

While our research averages payments across all areas, some research by HSC has compared access rates by geographic area, with particular attention to the difference between Medicare and private insurer fees in each area (Trude and Ginsburg 2005).¹² This research has found that, despite differences in Medicare and commercial payment rates across markets, the proportion of Medicare beneficiaries reporting problems with access to care in markets with the widest payment rate gaps did not vary significantly from the proportion reporting problems in markets with more comparable payment rates. In addition, privately insured people age 50 to 64 did not appear to gain better access to care relative to Medicare beneficiaries in markets with higher commercial payment rates. These findings suggest that developments in local and national health systems may be more important influences on both Medicare beneficiary and privately insured access. Indeed, these conditions may affect beneficiary access as much as or more than Medicare payment levels.

Changes in the volume of physician services used

Changes in the volume and intensity of services may be another indicator of the adequacy of Medicare's payments for services. However, data on growth in the volume of physician services must be interpreted cautiously; there is evidence that volume goes up for some services when payment rates go down, the so-called volume offset (Codespote et al. 1998). Such a volume offset makes it difficult to interpret volume increases as a payment adequacy indicator. Nevertheless, analyzing service volume can give us some important information on trends in service use.

Using claims data from 2000 through 2005, we calculated per beneficiary growth in the units of services beneficiaries used. We then weighted the units of services used by each service's relative value units (RVUs) from the physician fee schedule. The result is a measure of growth—or volume—that accounts for changes in both the number of services and the complexity, or intensity, of those services (Table 2B-6, p. 112). We thus distinguish growth in volume from growth in units of service: Volume growth includes an adjustment for change in intensity; unit-of-service growth does not. Compared with an analysis of growth in spending, measuring growth in RVU volume removes the effects of price inflation.

The volume of physician services beneficiaries received continued to grow in 2005. Across all services, volume

grew 5.5 percent per beneficiary. This growth rate matches the average annual growth in volume seen in the five previous years. Among broad categories of services—evaluation and management, major procedures, other procedures, imaging, and tests—volume growth rates varied (from about 3 percent to about 9 percent), but all were positive. As we have seen before, per capita volume for imaging grew the most. From 2004 to 2005, imaging volume grew at a rate of 8.7 percent. The volume of other procedures (which includes nonmajor procedures and outpatient therapies) grew at a similar rate—8.5 percent.¹³ The categories with the lowest growth rates are major procedures (3.5 percent) and evaluation and management services (2.9 percent).

The imaging category includes several services with double-digit volume increases in 2005, including certain MRI and computed tomography procedures. Chapter 3 of MedPAC's March 2005 report discusses volume increases in imaging and explores a variety of policy options and recommendations to address volume and expenditure growth in imaging services, some of which were included in regulations for the 2007 Medicare physician fee schedule.

The other procedures category includes a subcategory called minor procedures, which had a volume growth of 15.6 percent per beneficiary. This subcategory includes drug administration and outpatient rehabilitation. Much of the growth is attributable to physical therapy services; we also find growth in drug administration, some of which may be due to payment changes included in the MMA.¹⁴ The volume of cystoscopy services also increased substantially.

Although all broad categories of service increased in volume in 2005, some individual services decreased. The largest decrease (8.6 percent) was for coronary artery bypass graft, which likely represents substitution of less invasive services and has been declining steadily over the last several years. We also see a small decline in coronary angioplasty, which is likely related to coding changes in 2005 that prohibit physicians from billing for both angioplasty and stent insertion (meant to include angioplasty procedures) for the same vessel or artery at the same time.

Overall volume increases translate directly to growth in Part B spending and are largely responsible for the negative updates required by the SGR formula. In fact,

**TABLE
2B-6**
Use of physician services per fee-for-service beneficiary continues to increase

Type of service	Change in units of service per beneficiary		Change in volume per beneficiary*		Percent of total volume*
	Average annual 2000-2004	2004-2005	Average annual 2000-2004	2004-2005	
All services	4.3%	5.7%	5.5%	5.5%	100.0%
Evaluation and management	2.2	1.5	3.6	2.9	40.0
Office visit—established patient	2.3	1.4	3.4	2.5	17.1
Hospital visit—subsequent	1.7	1.3	2.9	2.4	7.8
Consultation	3.9	2.1	5.5	3.6	5.7
Emergency room visit	2.5	2.6	5.5	5.0	2.7
Hospital visit—initial	0.7	1.0	1.3	1.2	1.9
Office visit—new patient	0.4	1.9	0.4	1.9	1.8
Nursing home visit	1.0	0.5	2.8	1.3	1.8
Imaging	5.5	6.5	10.3	8.7	16.3
Standard—nuclear medicine	11.3	5.4	15.7	7.1	2.4
Echography—heart	8.0	7.8	10.5	8.2	2.2
Advanced—CT: other	13.2	11.2	16.1	14.7	2.2
Advanced—MRI: other	17.0	14.7	18.3	14.2	1.9
Standard—musculoskeletal	3.7	5.9	5.0	4.9	1.2
Advanced—MRI: brain	17.4	6.4	17.0	7.1	1.1
Echography—other	8.6	12.4	12.6	12.5	0.8
Standard—chest	0.5	3.8	0.0	3.0	0.7
Standard—breast	9.5	10.2	-5.2	4.3	0.7
Imaging/procedure—other	11.1	15.4	10.6	12.8	0.6
Echography—carotid arteries	5.5	7.2	9.6	9.6	0.6
Advanced—CT: head	6.3	7.3	7.5	9.0	0.5
Major procedures	2.2	1.7	3.8	3.5	8.9
Cardiovascular—other	-0.2	-2.1	2.8	0.4	2.0
Orthopedic—other	7.4	7.2	7.7	7.7	1.1
Knee replacement	11.9	11.2	11.5	11.1	0.7
Coronary artery bypass graft	-4.3	-8.0	-5.3	-8.6	0.6
Coronary angioplasty	6.6	-0.6	6.5	-0.8	0.5
Explore, decompress, or excise disc	7.8	4.4	8.8	4.3	0.4
Hip fracture repair	-1.0	-0.8	-0.2	0.5	0.4
Hip replacement	6.2	2.0	6.2	2.0	0.4
Cardiovascular—pacemaker insertion	7.9	12.6	9.5	11.7	0.3
Other procedures	6.8	15.8	6.4	8.5	22.3
Minor—other, including outpatient rehab	14.6	27.8	14.4	15.6	4.8
Ambulatory procedures—skin	5.0	4.1	4.8	4.9	2.1
Oncology—radiation therapy	1.9	2.9	9.8	10.5	2.1
Minor procedures—skin	2.2	4.1	3.9	6.0	1.9
Cataract removal/lens insertion	1.2	6.9	1.5	7.8	1.8
Minor procedures—musculoskeletal	7.0	10.2	10.2	12.9	1.4
Colonoscopy	6.3	3.0	6.3	2.9	1.1
Oncology—other	4.3	13.5	4.0	12.8	0.9
Upper gastrointestinal endoscopy	3.7	1.1	3.4	1.2	0.6
Cystoscopy	3.1	3.6	4.2	13.9	0.5
Tests	7.1	3.0	8.2	6.2	5.2
Other tests	14.4	3.7	14.4	11.1	2.1
Electrocardiogram	2.0	4.2	2.2	0.8	0.7
Cardiovascular stress test	7.4	6.7	9.8	4.7	0.6
Electrocardiogram monitoring	2.7	7.3	3.9	1.0	0.2

Note: CT (computed tomography). To put service use in each year on a common scale, we used the relative weights for 2005. For billing codes not used in 2005, we imputed relative weights based on the average change in weights for each type of service. Some low-volume categories and services are not shown in the table but are included in the summary calculations. Services without relative value units (RVUs) are excluded from analysis (e.g., labs and Part B drugs).

*Volume is measured as units of service multiplied by each service's relative weight (measured by RVUs) from the physician fee schedule.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries from all 12 months of each year.

the SGR target provides allowances for growth in three factors:

- inflation in physicians' practice costs,
- changes in enrollment in FFS Medicare, and
- changes in spending due to law and regulation.

It then allows for growth above those factors based on growth in real gross domestic product (GDP) per capita. GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much growth in spending the U.S. can afford. The spending target in the SGR system combines all these factors. The basic SGR mechanism lowers the update when cumulative actual spending exceeds target spending. For 2005, for example, the cumulative impact of actual spending was estimated at about \$31.7 billion higher than the SGR target (i.e., allowed expenses) for that year (Office of the Actuary 2006). The disparity in actual spending relative to the target has grown mostly because of volume and legislated fee increases. Further, by statute, the SGR target was not increased to offset the fee increases enacted by the MMA and the DRA. As a mechanism for volume control, the current national SGR system has several problems, and the Commission has examined alternative approaches to it in a mandated report to the Congress, *Assessing Alternatives to the Sustainable Growth Rate System*.

Some observers have hypothesized that growth in volume of physician services is spurred by new technology, demographic changes, and shifts in site of service. Changes in medical protocols and a rise in the prevalence of certain conditions may also play a role. Volume growth of some services may be desirable, but analyses by MedPAC and others have found that much of the rise in volume is unexplained (Beeuwkes Buntin et al. 2004; Fisher et al. 2003a, 2003b). Moreover, it is difficult to determine whether growth in volume is improving the health and well-being of Medicare beneficiaries; indeed, unnecessary services can harm rather than help beneficiaries. In addition, rapid growth in volume and expenditures directly affects beneficiaries' out-of-pocket costs by driving up Part B cost sharing and premiums as well as increasing supplemental insurance premiums.

Our analysis of volume growth for this payment adequacy analysis shows that per capita service use is increasing for the vast majority of services, suggesting that beneficiaries are able to access Medicare-covered services. In a recent report, the Government Accountability Office (GAO)

also found growth in both the share of beneficiaries using services and the volume of services they used (GAO 2006b). GAO concluded that increases in utilization and complexity of services demonstrate that beneficiaries are able to access physician services. GAO also stated that the implications of these utilization trends for the long-term fiscal sustainability of the Medicare program require careful examination.

Volume growth as a signal for mispriced fee-schedule services

Fee-schedule mispricing may be one factor contributing to disparity in volume growth among services. In previous work, MedPAC has made recommendations on the importance of ensuring that fee-schedule payments are accurate to prevent market distortions for physician services (see text box, p. 114). For example, work RVUs for rapidly growing services may need revaluation, and practice expense RVUs are subject to distortions due to data lags and equipment pricing assumption issues.

Rapid volume growth for specific services may signal that Medicare's payment for those services is too high relative to the cost of furnishing them. Specifically, the physician work component of a given procedure may be overvalued if physicians (or their staff) are able to perform the procedure considerably more quickly than they did when it was first introduced. Consequently, physicians can increase their volume of these procedures with little change in the number of hours they work. As these procedures become increasingly profitable, physicians face clear financial incentives to favor them over services that may be less profitable.

Beneficiary access to undervalued services may be threatened if providers are confronted with incentives to avoid furnishing them relative to more profitable services. Evaluation and management services, for example, may have less opportunity for productivity gains because the clinician's face-to-face time with the patient is a major component of the service. It is, therefore, difficult for the physician to perform the office visit faster or fit more into a day's schedule, in contrast to some procedure-based services. Facing these incentives, new physicians may be less willing to choose specialties that frequently provide undervalued services, resulting in reduced access to certain physicians and certain services.

In the future, the Secretary could play a lead role in identifying misvalued services by conducting analyses that calculate changes in the productivity of individual

MedPAC's previous analysis of fee-schedule relative values

Given the importance of accurate payment, the Commission concluded in our March 2006 report to the Congress that CMS's process for reviewing the relative values of physician services must be improved (MedPAC 2006). The three five-year reviews, completed in 1996, 2001, and 2006, led to substantially more recommendations for increases than decreases in the relative values of services, even though many services are likely to become overvalued. We noted that physician specialty societies have a financial stake in the process and therefore have little incentive to identify overvalued services. We recognized the valuable contribution made by the Relative Value Scale Update Committee (RUC), but we concluded that CMS relies too heavily on physician specialty societies, which tend to identify undervalued services without identifying overvalued ones. We found that CMS also relies too heavily on the societies for supporting evidence.

To maintain the integrity of the physician fee schedule, the Commission recommended that CMS play a lead role in identifying overvalued services so that they are not ignored in the process of revising the fee schedule's relative weights; we also recommended that CMS establish a group of experts, separate from the RUC, to help the agency conduct these and other activities. This recommendation was intended not to supplant the RUC but to augment it. To that end, the panel should include members who do not directly benefit from changes to Medicare's payment rates, such as experts in medical

economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers.

MedPAC's public discussions on the importance of reviewing the work relative values of physician services coincided with meetings by the RUC. Consistent with the RUC's recommendations, CMS substantially increased the work values for evaluation and management services for 2007. Because these changes must be budget neutral, work values for other services declined somewhat. The RUC has since formed a committee to identify overvalued services and procedures.

The Commission also recommended that the Secretary, in consultation with an expert panel, initiate reviews of services that have experienced substantial changes in volume, length of stay, site of service, practice expense, and other factors that may indicate changes in physician work. The Secretary also could go further to institute automatic revisions for services that have experienced such changes.

Ensuring the accuracy of payments to other providers—including hospitals and post-acute care providers—is also important. To this end, the Commission has recommended refinements to the diagnosis related groups used in Medicare's hospital inpatient prospective payment system and to the case-mix systems used in Medicare's payment systems for post-acute care services. ■

services. Such analyses could begin by examining specialties that show rapid volume increases per physician over a given time period. Volume calculations would need to take into account changes in the number of physicians furnishing the service to Medicare beneficiaries and the hours those physicians worked. Analyses would also need to consider how changes in practice expenses (e.g., nonphysician staff and equipment) may increase the output of physician services.

CMS could use the results from these analyses to flag services for closer examination (by CMS or by the

Relative Value Scale Update Committee (RUC)) of their relative work values. The RUC could also conduct such volume analyses when making its work value recommendations to CMS, but the RUC's current review schedule (every five years) may not be timely enough to capture services that enjoy rapid productivity gains. Alternatively, the Secretary could automatically correct such misvalued services and the RUC would review the changes during its regular five-year review process. Last year, MedPAC made several recommendations to improve the RUC process (see text box).

Corrections to the practice expense values may also be in order. MedPAC is currently studying the impact of CMS's recent changes to the fee schedule practice expense calculation, including the use of newer practice cost data from some, but not all, specialties. We are also analyzing equipment pricing assumptions that are used to derive the practice expense values, particularly for imaging services. Ensuring that practice expense values are accurately priced reduces market distortions that make some services considerably more profitable than others, thus creating financial incentives to provide some services more than others.

Finally, revisiting the entire resource-based Relative Value Scale (RBRVS) system may be in order. Some observers suggest that the pricing of individual services should account not just for input costs, but also for the value of the service and the price needed to assure an adequate supply.

Changes in quality of ambulatory care

Our physician payment adequacy analysis also examines the quality of ambulatory care through Medicare claims data. Using a set of indicators, the Medicare Ambulatory Care Indicators for the Elderly (MACIEs), we measure the provision of necessary care and rates of potentially avoidable hospitalizations over time.¹⁵ Our analysis shows mostly small improvements and stability in these measures, but despite these improvements, for many measures, fewer than two-thirds of beneficiaries received the service(s) indicated for their condition.

Comparing 2003 with 2005, we find that most of the indicators we measured remained steady or showed small improvements (Table 2B-7). Specifically, among 38 measures, 22 showed improvement and 13 did not change statistically. This finding suggests that, in 2005, beneficiaries with selected conditions were a little more likely to receive certain indicated services for their condition and avert potentially avoidable hospitalizations related to their condition. Further, we see improvements on outcome measures concurrent with improvements on process measures for the same conditions.

We found a decline in quality, as defined by our measures, in only 3 of 38 measures. All three of these measures were related to breast cancer. We found small declines (2 percentage points to 3 percentage points) in general mammography screenings for females and clinically indicated imaging for women with a history or new diagnosis of breast cancer. Recent findings from the National Committee for Quality Assurance (NCQA)

**TABLE
2B-7**

Most ambulatory care indicators improved or were stable, 2003-2005

Indicators	Number of indicators			
	Improved	Stable	Worsened	Total
All	22	13	3	38
Anemia & GI bleed	2	2	0	4
CAD	3	1	0	4
Cancer	1	3	3	7
CHF	6	2	0	8
COPD	2	0	0	2
Depression	0	1	0	1
Diabetes	6	1	0	7
Hypertension	1	0	0	1
Stroke	1	3	0	4

Note: GI (gastrointestinal), CAD (coronary artery disease), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of Medicare Ambulatory Care Indicators for the Elderly (MACIE) from the Medicare 5 percent Standard Analytic Files.

also show slight declines in breast cancer screening for applicable women in commercial plans (NCQA 2006, 2005). NCQA notes that some public debate on the effectiveness of mammography may contribute to confusion about how often—and whether—women should be screened for breast cancer. NCQA's findings suggest that factors for this decline may not necessarily be related to payment adequacy. GAO reported recently that the current nationwide capacity for mammography remains adequate, but closures of certified mammography facilities outpaced openings between 2001 and 2004 (GAO 2006a). Some have suggested that physicians may be less willing to interpret mammograms because of malpractice concerns. However, reports that mammography rates for staff-model HMO patients have declined over the last several years suggest that broader factors may play a role.

Among the 38 indicators, 6 measured the occurrence of potentially avoidable hospitalizations or emergency department visits for selected chronic conditions. All these measures improved between 2003 and 2005. For example, in 2005, a smaller share of beneficiaries with chronic obstructive pulmonary disease (COPD) had COPD-related inpatient hospitalizations, and a smaller share of beneficiaries with diabetes were hospitalized for

serious short-term (e.g., diabetic coma) or long-term (e.g., nontraumatic amputations) complications.

We found that, for several conditions, declines in potentially avoidable hospitalizations occur concurrently with increases in the use of clinically necessary services for the same condition. For example, for diabetes we found decreases in the rate of diabetes-related hospitalizations over the same time period when we found increases in the use of diagnostic testing and follow-up. Therefore, we see improvements in outcome measures (lower rates of short-term and long-term complications) concurrent with improvements in process measures (higher rates of necessary care, such as lipid and hemoglobin testing).

In addition to measuring change from 2003 to 2005, we evaluated the underlying percentages of beneficiaries receiving the indicated care for their conditions. Indicators with the highest rates were generally for condition-specific follow-up visits. Among the lowest rates was the indicator for gastrointestinal work-up near the time of initial diagnosis of iron deficiency anemia. For 2005, we found that, for 21 of the 32 process measures, at least two-thirds of beneficiaries received the indicated care for their condition. At the same time, for 11 measures, fewer than two-thirds of beneficiaries received the specified care for their condition. Among these low-performing indicators, five improved since 2003, two worsened, and four did not change statistically. Further research is needed to analyze whether increased use of these affects *overall* volume, and to what extent.

Quality incentives for physicians

The Commission recognizes the importance of implementing P4P initiatives in Medicare but acknowledges the challenges associated with measurement at the physician level. Compared with the data infrastructure available in other areas—namely Medicare Advantage plans, dialysis facilities, home health agencies, and hospitals—physician offices lack sufficient data collection and reporting systems. Before P4P can be implemented for all physicians serving Medicare patients, a transition strategy may be needed. The Commission has recommended that the Congress establish a quality incentive payment policy for physicians in Medicare (MedPAC 2005). In previous work, we have stated that P4P policies should first focus on measuring quality-enhancing functions and outcomes associated with information technology use, such as if a physician office tracks whether its patients receive appropriate follow-up

visits. Claims-based measures are also important and should include prescription and lab values as soon as possible.

In August of 2007, CMS will publish proposed quality measures for 2008 reporting. By law, these measures must be adopted or endorsed through a consensus-based process by an organization such as the National Quality Forum or the AQA. The Institute of Medicine (IOM) and MedPAC have stated that, ideally, measures should be developed and used for all physician service providers to create incentives to provide better quality care. However, currently we do not have well-established measures for all providers of physician services. Thus, initially, policymakers might consider prioritizing the implementation of some P4P measures over others. Focusing measures on high-cost, widespread, chronic conditions to maximize benefits to the Medicare program and to beneficiaries might be a good short-term strategy.¹⁶

Although under this strategy some specialties may have more P4P measures than others, a targeted approach for measure selection would maximize benefits to the Medicare program and to beneficiaries. Further, measures that reflect coordination between health sectors (e.g., hospitals and physicians) will encourage and reward communication between providers, which may improve patient outcomes and reduce Medicare costs. For example, P4P incentives associated with congestive heart failure could reduce hospital admissions through better ambulatory care or lower readmission rates through improved communication between physicians, patients, and hospitals upon patient discharge. The Commission will continue to examine P4P initiatives in future work.

A discussion of how P4P initiatives fit into our update framework is included in Chapter 2.

How should Medicare payments for physician services change in 2008?

After considering current payment adequacy, we also analyze changes in input costs projected for the coming year. For physicians, we examine two factors to forecast input costs: change in input prices and the Commission's policy goal of increased productivity.

Input price increases

To measure input price inflation for physician services, we use information that CMS collects from various data sets and surveys. CMS uses this information in its calculation of the Medicare Economic Index (MEI), which provides a weighted average of price changes for inputs used to provide physician services. The text box, p. 119, discusses CMS's input cost calculations in more detail. For 2008, CMS forecasts that input prices for physician services will increase by 3.0 percent (Table 2B-8). This forecast excludes productivity adjustments that are integrated into CMS's publicly released MEI; thus, it is higher than CMS's publicly released MEI. Our update framework requires an examination of input costs for each sector—separate from productivity adjustments, which may be used across all provider sectors.

CMS's latest forecast of a 3.0 percent increase in overall input costs for physician services in 2008 is based on increases of 2.8 percent in wages and salaries and 3.7 percent in nonwage compensation. Practice expenses are projected to increase by 3.1 percent.¹⁷

Productivity growth

In making our update recommendation, the Commission has adopted a productivity objective, or goal, to encourage provider efficiency. Chapter 2 discusses the source of our productivity estimates and our rationale for incorporating productivity goals into our payment update analyses. We currently estimate productivity growth to be 1.3 percent for 2008. CMS also uses this methodology for adjusting input costs within the MEI.

Update recommendation

The Tax Relief and Health Care Act effectively held 2007 payments at 2006 levels by allowing the 2007 conversion factor to be cut by 5 percent (as directed by the SGR), but then offset by a 5 percent bonus to the 2007 conversion factor. Thus, compared with the conversion factor that physicians actually experienced in 2007 (inclusive of the 5 percent bonus), the Commission recommends that the Congress increase the conversion factor in 2008 by the projected change in input prices less the Commission's expectation for productivity growth. The latest forecast suggests that this update would be approximately 1.7 percent.

Considering our recommendation to increase payments to physicians in 2008, it is the Commission's view that

**TABLE
2B-8**

Forecasted input price increases and weights for physician services for 2008

Input component	Price increases for 2008	Category weight
Total	3.0%	100.0%
Physician work	3.0	52.5
Wages and salaries	2.8	42.7
Fringe benefits (nonwage compensation)	3.7	9.7
Physician practice expense	3.1	47.5
Nonphysician employee compensation	3.0	18.7
Wages and salaries	2.8	13.8
Fringe benefits (nonwage compensation)	3.4	4.8
Office expense	3.0	12.2
Professional liability insurance	5.2	3.9
Medical equipment	0.6	2.1
Drugs and supplies	2.9	4.3
Pharmaceuticals	3.7	2.3
Medical materials and supplies	1.8	2.0
Other professional expense	2.0	6.4

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight (as listed in the Medicare Economic Index) by its price proxy. Forecasted price changes are not adjusted for productivity. Numbers may not sum to total due to rounding.

Source: Unpublished estimates from CMS, dated December 7, 2006.

the \$1.35 billion fund—established by the Tax Relief and Health Care Act—be directed entirely toward a conversion factor update for 2008.

IOM and MedPAC have stated that, ideally, P4P measures should be developed and used for all physician service providers to create incentives to provide better quality care. However, currently we do not have well-established measures for all providers of physician services. Thus, initially, policymakers might consider prioritizing the implementation of some P4P measures over others. Focusing measures on high-cost, widespread, chronic conditions to maximize benefits to the Medicare program and to beneficiaries might be a good short-term strategy. Further, measures that reflect coordination between health sectors (e.g., hospitals and physicians) will encourage and reward communication between providers, which may improve patient outcomes and reduce Medicare costs. The Commission considers that P4P initiatives would be implemented in a budget neutral manner.

RECOMMENDATION 2B

The Congress should update payments for physician services in 2008 by the projected change in input prices less the Commission's expectation for productivity growth.

RATIONALE 2B

Access, supply, and volume measures suggest that most Medicare beneficiaries are able to obtain physician services with few or no problems. Ambulatory quality measures are generally stable and improving. Our analysis of the most recently available data finds that Medicare payments for physician services are adequate.

IMPLICATIONS 2B

Spending

- Our estimates indicate that this recommendation for 2008 would increase federal program spending by more than \$2 billion in the first year and \$5 billion to \$10 billion over five years, relative to current law. Note that any positive update would increase spending relative to current law because current statute calls for substantial negative updates from 2008 to 2015, under the SGR system. If the Secretary directs the \$1.35 billion fund (established by the Tax Relief and Health Care Act and discussed in the background section of this chapter) toward a conversion factor update for 2008, the spending implication of our recommendation would decrease, particularly for the one-year estimate.

Beneficiary and provider

- This recommendation would increase premiums and beneficiary liability for cost sharing. Coinsurance liability for Part B services would increase directly with the increase in the conversion factor. Part B premiums and the deductible would increase subject to statutory formulas and actuarial projections to ensure that the Medicare program has sufficient revenue to cover costs.

Additional comments

The Commission is concerned that differences in the profitability across physician services create financial incentives for physicians to favor furnishing some procedures and services over other, less profitable ones. In this environment, beneficiary access to relatively undervalued services—and to the providers that generally perform them—may be threatened. Misvalued services should be identified and payments corrected. For example, work RVUs for rapidly growing services may need revaluation, and practice expense RVUs are subject to distortions due to data lags and equipment pricing assumptions. Also, revisiting the RBRVS may be needed to explore the possibility of including other factors—in addition to input costs—in the pricing of individual services.

The Secretary could play a lead role in identifying misvalued services by measuring volume growth for specific services, taking into account changes in the number of physicians performing the service, and other factors. CMS or the RUC could use the results from these analyses to flag services for closer examination of their relative work values. Alternatively, the Secretary could automatically correct such misvalued services and the RUC would review the changes during its regular five-year review process.

With recent passage of the Tax Relief and Health Care Act, physicians did not experience a cut to their 2007 conversion factor. Further, additional payments were directed to physicians in 2008. Nevertheless, the consecutive annual cuts currently called for by the SGR system threaten beneficiary access to physician services over time, particularly those provided by primary care physicians. As a mechanism for volume control, the current national SGR has several problems, and the Commission examines alternative approaches to it and steps to improve the overall Medicare payment system in a mandated report to the Congress, *Assessing Alternatives to the Sustainable Growth Rate System*. ■

Input cost forecasts from CMS

To measure input price inflation for physician services, CMS first estimates the share, or weight, of physicians' practice revenues attributable to each input, based primarily on data supplied by the American Medical Association (AMA). CMS attributes 52.5 percent of physician revenues to physician work and 47.5 percent to practice expense, which includes a professional liability insurance weight of 3.9 percent. In 2004, CMS updated its input category weights based on 2000 survey data from the AMA. Rebasings these weights resulted in a decrease in the share of revenues going toward physician work and an increase in the share of revenues going toward practice expense. AMA is constructing a new survey that can help CMS update the Medicare Economic Index (MEI) category weights. The field dates of the survey have not yet been determined, however. CMS uses more timely data to forecast input price changes.

Although costs for professional liability insurance (PLI) continue to be the fastest growing input cost, PLI premium increases have slowed a little in the past few years. CMS shows that average increases for 2005 were 9.9 percent, compared with 18.7 percent in 2004 and 30.3 percent in 2003. Historically, changes in premiums for PLI have generally followed a cyclical pattern. From past experience, one would have predicted a slowdown in 2001 and 2002; in fact, premium increases did not slow until more recently (MedPAC 2003).

Some physicians—especially in certain geographic areas and with specialties that include high-risk procedures—report PLI premium increases that are much higher and thus take up a significantly larger percentage of their revenues than forecasted in the MEI. The MEI, however, is not designed to reflect price changes for individual physicians; instead, it accounts for an average price change for all physicians. The fee schedule, on the other hand, is the primary tool that reimburses services differentially to account for PLI premium variation by service and geographic area. For example, the fee schedule's PLI relative value units designate higher payments for services furnished by neurosurgeons and cardiothoracic surgeons because they pay higher PLI premiums. Similarly, the fee schedule's PLI geographic practice cost indexes adjust payments to physicians who practice in geographic areas with high PLI premiums, such as Detroit, Michigan. Given both of these factors, more than 20 percent of Medicare's payments to a Detroit neurosurgeon (under the fee schedule) can be attributable to PLI if a fairly high proportion of the neurosurgeon's practice consists of major procedures (MedPAC 2003). ■

Endnotes

- 1 http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_Physician.pdf.
- 2 The Act allows the 2007 conversion factor to be cut by 5 percent as directed by the SGR but then funds a 5 percent bonus to the 2007 conversion factor through Medicare's Supplementary Medical Insurance (Part B).
- 3 Combining the conversion factor bonus and the quality reporting bonus, the Congressional Budget Office estimates that these two provisions will cost \$3.1 billion, the GPCI floor extension will cost \$500 million, and the physician fund will cost \$1.35 billion.
- 4 Although our survey is unable to distinguish between beneficiaries in FFS and those in Medicare Advantage (MA) plans, if we compare our results with the Medicare Advantage Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS) survey, 82 percent of MA beneficiaries reported having “big problems” finding a specialist in the 2003–2004 round and 84 percent reported the same in the 2005–2006 round. The two rounds of the MA CAHPS survey are not comparable to each other because different methodologies were used in data collection, so it is difficult to compare this trend over the survey years with trends we see in the MedPAC survey.
- 5 These 11 selected areas were chosen based on relatively high rates of physician access problems reported on the 2001 CAHPS–FFS and in other CMS monitoring activities on physician access. CMS combined the 2001 CAHPS–FFS measures with state-level information taken from CMS monitoring activities, including environmental scanning reports by CMS regional offices and telephone calls to 1-800-Medicare and Medicare carriers in 2002. Areas designated as eligible for site selection generally met two criteria: (1) they had high rates of 2001 access problems reported on CAHPS–FFS, and (2) they were located in states where CMS monitoring efforts in 2002 indicated emerging physician access issues related to Medicare payment or Medicare physician participation. The 11 areas that met these criteria were Phoenix, AZ; San Diego, CA; San Francisco, CA; Denver, CO; Tampa, FL; Springfield, MO; Las Vegas, NV; Brooklyn, NY; Ft. Worth, TX; Seattle, WA; and Alaska (entire state).
- 6 With 934 physicians participating in the survey, the response rate was 56 percent.
- 7 Physicians in the following specialties were excluded: anesthesiology, radiology, pathology, nephrology, and pediatrics as well as smaller specialties unlikely to meet the other screening criteria (e.g., undersea medicine).
- 8 When asked about increasing the number of patients seen, physicians were not asked to distinguish between Medicare and non-Medicare patients.
- 9 About 72 percent of employee physicians reported that their own productivity was a “very important” determinant of compensation. The percentage of full or part practice owners was higher (83 percent) and could reflect the direct relationship between service volume and practice revenue in a FFS environment.
- 10 We conservatively categorized physicians who saw fewer than 15 patients under the assumption that they did not regularly serve FFS beneficiaries and provided services to beneficiaries for only a short time during a year or only on an emergency or temporary basis while covering for colleagues.
- 11 The methodology used for the comparison involves a calculation of a price index for each type of private plan (HMO, point-of-service, preferred provider organization, and indemnity). Each price index is a weighted average of service-level price comparisons between Medicare and private payment rates, using Medicare's volume in each service as the weights. The plan-specific estimates were then weighted based on the Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) yearly estimates of private enrollment in each type of plan for 2005 (Kaiser Family Foundation/HRET Employer Health Benefits 2006 Annual Survey). For 2006, the Kaiser/HRET survey is beginning to report enrollment in high-deductible health plans with savings options, such as health savings accounts. This would be a new plan type for which we would develop a separate index for comparing Medicare and private insurance.
- 12 Our analysis relies on data from two national insurers, but—like all insurers—they face different market conditions in different areas. In a particular area, for example, there may be one dominant insurer that is better able to negotiate lower prices with providers, while other insurers have to pay higher rates. Although the data we use for our analysis from the two national insurers have a wide and diverse geographic distribution, we may not be fully able to capture the variation in private payment rates in different areas that results from local competitive circumstances. Our estimate of the ratio of Medicare to private payment levels may be lower or higher than the actual ratio across the nation.

- 13 These estimates include only services paid for under the physician fee schedule. The estimates would be higher if they included the volume of other services in CMS's broader definition of physician services, such as Medicare Part B drugs and laboratory services. The Commission has found, for example, that volume of chemotherapy drugs increased 12 percent from 2003 to 2004 and volume of erythropoietin (for patients without end-stage renal disease) grew 36 percent (Hogan 2005).
- 14 Prior to 2004, oncologists were allowed to bill for the administration of only one chemotherapy drug per day by injection, referred to as "push technique," regardless of the actual number of drugs administered. Starting in 2004, CMS allows oncologists to bill for each additional drug administered by push technique on the same day. The MMA also increased payments for drug administration services, but this payment increase is held constant in our volume analysis.
- 15 The text box (p. 96) of our March 2006 report describes the development of the MACIEs in more detail. We updated our analysis from last year's report with 2005 claims, but because our model makes comparisons between cohorts that span two years, we do not expect large differences from our findings in the previous report.
- 16 CMS is currently sponsoring a demonstration project that includes comprehensive performance measures for large medical groups. Many of the measures focus on high-cost widespread diseases, such as congestive heart failure and diabetes.
- 17 CMS also examines service-level changes in practice expenses in the physician fee schedule. MedPAC is currently examining the impact of CMS's recent changes to the fee-schedule practice expense calculation, including the use of newer practice cost data from some, but not all, specialties.

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