

SECTION
20

Physician services

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

2C-1 The Congress should repeal the sustainable growth rate system and instead require that the Secretary update payments for physician services based on the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity.

***YES: 16 • NO: 0 • NOT VOTING: 0 • ABSENT: 1**

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2C-2 The Secretary should revise the productivity adjustment for physician services and make it a multifactor instead of labor-only adjustment.

YES: 16 • NO: 0 • NOT VOTING: 0 • ABSENT: 1

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2C-3 The Congress should update payments for physician services by 2.5 percent for 2003.

YES: 16 • NO: 0 • NOT VOTING: 0 • ABSENT: 1

***COMMISSIONERS' VOTING RESULTS**

SECTION 2C

Section 2C: Physician services

Previously, MedPAC recommended that the Congress replace the method for updating payments for physician services—the sustainable growth rate system—because it fails to account for changes in the cost of efficiently producing physician services, tying updates instead to growth in the national economy. It also applies only to physician services, exacerbating Medicare’s problem of paying different amounts for the same service depending on whether the service is furnished in a physician’s office, a hospital outpatient department, or an ambulatory surgical center. The Commission now recommends a new update method for physician services similar to the methods for other services. The Congress would base the update on an estimate of the change in input prices for the coming year and could adjust the estimate using evidence on whether the current level of payments is adequate. We use this method to develop an update recommendation for 2003. We conclude that although Medicare’s payments for physician services were not too low in 1999, payment updates since then have been less than the increase in input prices. We cannot justify an adjustment for payment adequacy, however, until we have further information. In the interim, we recommend an update for 2003 of 2.5 percent.

In this section

- Assessing payment adequacy
 - Accounting for cost changes in the coming year
 - Update recommendation
-

Medicare's payments for physician services are made according to a fee schedule, under which services are given relative weights that reflect resource requirements. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. The sustainable growth rate (SGR) system updates the conversion factor annually.

The Commission is concerned that the SGR system can cause payments to diverge from costs because it does not fully account for factors affecting the cost of providing physician services. Although the system accounts for input price inflation, productivity growth, and other factors affecting costs, it overrides these factors to achieve an expenditure target.

The main problem is two incompatible goals:

- update payments to account for changes in the cost of providing physician services, and
- control spending for physician services by adjusting updates to achieve an expenditure target.

Updates under the SGR system can lead to payments that diverge from costs because actual spending for physician services is unlikely to be the same as the target. When this occurs, payments will either be too low, potentially jeopardizing beneficiaries' access to care, or too high, making spending higher than necessary. This is a particular concern given that the SGR system only applies to services paid for under the physician fee schedule. Because these services can be provided in physicians' offices, hospitals, ambulatory surgical centers, and other settings, updates based on an expenditure target that applies only to one setting could create financial incentives that inappropriately influence clinical decisions about where services are provided.¹

Even if the SGR system's goals were compatible, it is unlikely that such a mechanism would work as the Congress intended. When first enacting an expenditure target for physician services in 1989, it was assumed that the system would provide physicians with a collective incentive to control the volume of services. This goal is unrealistic, however, because an individual physician reducing volume in response to incentives provided by the SGR system would not realize a proportional increase in payments. Instead, the increase in payments would be distributed among all physicians providing services to Medicare beneficiaries. If anything, an individual physician has an incentive to increase volume under such a system.

Recently, another problem has surfaced: the SGR system can produce volatile and unpredictable updates. Updates went from large increases in 2000 and 2001 of 5.4 percent and 4.5 percent, respectively, to an unexpected large reduction in 2002 of 5.4 percent.

To solve these problems, in our March 2001 report we recommended that the Congress replace the SGR system with an annual update based on factors influencing the unit costs of efficiently providing physician services (MedPAC 2001). The Commission's recommendation is based on a belief that getting the price right is important when making update decisions. If spending control is necessary, it should not occur through an update formula with no consideration of payment adequacy. In this report, we go further to describe how the Congress should replace the SGR system.

RECOMMENDATION 2C-1

The Congress should repeal the sustainable growth rate system and instead require that the Secretary update payments for physician services based on the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity.

Replacing the SGR system would solve the fundamental problems of the current system and would allow updates to more fully account for factors affecting costs. The change also would uncouple payment updates from spending control and would make updates for physician services similar to the updates for other services. This would promote the goal of achieving consistent payment policies across ambulatory care settings, including physician offices, hospital outpatient departments, and ambulatory surgical centers.

The proposed update method for physician services differs from the methods for other services in that it includes an adjustment for growth in multifactor productivity. For other services, MedPAC is assuming that decreases in cost due to productivity growth will offset increases in cost due to scientific and technological advances and other factors. For physician services, however, it is unclear whether savings from productivity growth are offset by such cost-increasing factors. The unit of payment is small, which allows new and revised billing codes to account for much of the cost increases due to technological advances and other factors.

To replace the SGR system, the Congress could repeal provisions in current law and replace them with language similar to that for other services. For example, the Social Security Act requires updates for inpatient hospital care that equal the increase in the hospital market basket index except for years in which the Congress chooses to make the update smaller or larger than this increase. The Congress generally makes these choices after considering advice from MedPAC and the Secretary. With a similar update method for physician services, the Commission intends to base its advice to the Congress on assessments of payment adequacy such as the one discussed below, and we believe that the Secretary should also advise the Congress on payment adequacy.

1 Problems with the SGR system are discussed further in Chapter 2 of MedPAC's March 2001 report to the Congress (MedPAC 2001).

For the proposed update method to work appropriately, the Congress and the Secretary should take several steps. The Congress should:

- change current law to replace the SGR system, and
- require the Secretary to change the current measure of input price inflation for physician services—the Medicare Economic Index (MEI)—to make it a forecast of input price growth for the coming year.

The Secretary should:

- remove the productivity adjustment from the MEI so the MEI measures prices only and productivity can be considered separately in update decisions, and
- change the productivity adjustment so it measures growth in the productivity of all inputs, not just labor.

The budgetary consequences of replacing the SGR system are important. The system is designed to control spending for physician services by limiting growth in the quantity and intensity of services per beneficiary to growth in real gross domestic product (GDP) per capita.

Growth in real GDP per capita is estimated at 2.3 percent per year through 2010 (OMB 2001). Projected growth in the quantity and intensity of services is higher: 2.9 percent per year through 2010 (Board of Trustees 2001). Without the SGR system, the difference between these two projected growth rates would not be used to adjust payment rates, so spending would be higher than with the SGR.

Changing the productivity adjustment that the Centers for Medicare & Medicaid Services (CMS) uses to update payments for physician services would also increase

the annual updates, by about 1.1 percentage points.² This increase would be offset slightly if another Commission recommendation were adopted: changing the measure of inflation in input prices from a retrospective measure to a forecast (MedPAC 2001). This change would have a one-time effect on the update. Together, the budgetary impact of all these changes would be an increase in spending of about 1.7 percent per year.

The cost of replacing the SGR system could be higher than the 1.7 percent estimate because recent events suggest a wider difference between growth in real GDP and growth in the quantity and intensity of services. First, the current recession could last longer than projected, which would lead to lower estimates of growth in real GDP per capita and a wider gap between updates based on the SGR system and updates based on MedPAC’s proposed update method. Second, CMS recently reported that it had omitted some of the growth in the quantity of physician services when calculating the 2000 and 2001 updates under the SGR system (CMS 2001). The agency has not yet reported the size of this error, but correcting it would reduce future updates under the SGR system.

Assessing payment adequacy

The first question in applying MedPAC’s approach is whether the current level of Medicare’s payments for physician services is adequate. The information available to answer this question is limited, which suggests caution in answering it. We lack information on the cost of physician services, so we cannot compare Medicare’s payments and costs the way we can for other services, such as inpatient hospital care, post-acute care,

and outpatient dialysis. On the other hand, we have information on several other factors that, when considered together, allows judgments about the adequacy of payments. This information includes data on the number of physicians furnishing services to Medicare beneficiaries, the results of surveys of physicians on their perceptions of the Medicare program and their willingness to furnish services to beneficiaries, and information from surveys of beneficiaries on their ability to obtain care and their satisfaction with the care received.

The data available on payment adequacy are limited for two reasons. First, the most recent data are for 1999. Payment changes since then are important, including the 5.4 percent reduction that occurred in 2002. Second, all the available measures of payment adequacy present formidable challenges of interpretation. Even collectively, the measures do not provide conclusive evidence of the appropriateness of Medicare’s payment rates. Nevertheless, the combined weight of evidence allows reasonable judgments about payment adequacy, as described below.

Available information suggests that, through 1999, payments were not too low. From 1999 onward, we have very limited data; we do know, however, that payments did not keep up with increases in input prices.³ This suggests that payments for 2002 may be too low, raising concerns about beneficiary access to care. We will not know if payments are too low until we have further information on payment adequacy.

Entry and exit of providers

Provider entry and exit data provide information regarding adequacy of the current level of payments. Rapid growth in the number of providers furnishing services to beneficiaries may indicate that

2 This increase is the difference between average growth in labor-only productivity (through 2006) of 1.6 percent and MedPAC’s policy standard for growth in multifactor productivity of 0.5 percent.

3 The updates have averaged 1.7 percent per year, including an update of –5.4 percent for 2002. Over the same period, the change in input prices has averaged 3.6 percent per year. This average change in input prices is based on the MEI, excluding the index’s productivity adjustment. If the productivity adjustment is included in the index, the average change in input prices is 2.4 percent per year, which is still higher than the average update of 1.7 percent. There is evidence that, on average, updates have been less than the change in input prices since 1992 (Maves 2002).

Medicare's payment rates are too high. Conversely, widespread provider withdrawals from Medicare could suggest that the rates are too low.

Counts of physicians billing Medicare shows that the number of physicians furnishing services to beneficiaries has kept pace with growth in the number of beneficiaries (Table 2C-1).⁴ From 1995 to 1999, the number of physicians per 1,000 beneficiaries grew slightly, from 12.9 to 13.1. This is evidence that payment rates were not too low in 1999.

Beneficiaries' access to care

Another way to evaluate the adequacy of payment rates is to evaluate beneficiaries' access to and quality of care. Evidence of widespread access or quality problems for beneficiaries may indicate that Medicare's payment rates are too low. Access and quality measures are often difficult to interpret, however, because they are influenced by many factors. Access to care for specific services, for example, may be influenced by beneficiaries' incomes, secondary (medigap) insurance coverage, preferences, local population increases, or transportation barriers, all of which are unrelated to Medicare's payment policies.

As detailed below, access to care was good in 1999, according to a survey of beneficiaries. Furthermore, MedPAC's 1999 survey of physicians suggests that physicians were willing and able to serve beneficiaries. These results are consistent with the conclusion that payment rates were not too low in 1999.

Beneficiary reports about access

Data from the Medicare Current Beneficiary Survey suggest that access was good in 1999 (Table 2C-2). The percentage of beneficiaries reporting trouble getting care (4 percent) was low and essentially unchanged from previous years. Other access measures were also unchanged: slightly more than 9 percent of beneficiaries reported that they did not have a usual source of care, and about 19

TABLE 2C-1

Physicians billing traditional Medicare

Year	Number of physicians	Part B enrollment	Number of physicians per 1,000 beneficiaries
1995	460,700	35,684,584	12.9
1996	469,915	36,139,608	13.0
1997	476,164	36,460,143	13.1
1998	478,123	36,780,731	13.0
1999	484,576	37,039,848	13.1

Note: The numerator of the ratio of physicians per 1,000 beneficiaries includes allopathic and osteopathic physicians. The denominator is the number of beneficiaries enrolled in Medicare Part B, including traditional Medicare and Medicare+Choice, on the assumption that physicians are providing services to both types of beneficiaries.

Source: Unpublished CMS data.

percent had not had a physician office visit that year. The data also show that beneficiaries were overwhelmingly satisfied with the care they received.

Physician willingness and ability to serve beneficiaries

Findings from a 1999 survey of physicians, sponsored by MedPAC and conducted by Project HOPE and The Gallup Organization (Schoenman and Cheng 1999), show that physicians were willing and able to care for Medicare beneficiaries.

- Only about 10 percent of physicians reported any change since 1997 (before Medicare payment policy changes took place) in the priority given to Medicare patients seeking an appointment. Of those changing their appointment priorities, the percentage that reported giving Medicare patients a higher priority was almost the same as the percentage that assigned Medicare patients a lower priority.
- Only 4 percent of physicians said that it was very difficult to find suitable referrals for their fee-for-service Medicare patients, a finding comparable to the percent who

reported problems referring their privately insured fee-for-service patients.

One of the most important findings of the survey was that, among physicians accepting all or some new patients, more than 95 percent said they were accepting new Medicare fee-for-service patients. This finding is consistent with the results

TABLE 2C-2

Beneficiary access to and satisfaction with care

Characteristics	Percentage
Access	
Had trouble getting care	3.7
No office visit this year	18.9
No usual source of care	9.4
Satisfaction	
Strongly agree/agree	
Physician checks everything	93.9
Great confidence in physician	94.9
Very satisfied/satisfied	
Availability of medical care	93.7
Overall quality of care	96.1

Source: MedPAC analysis of 1999 Medicare Current Beneficiary Survey Access to Care file.

4 These counts include only physicians, and not nurse practitioners, physician assistants, psychologists, chiropractors, podiatrists, or other health care professionals.

of a 1998-1999 survey sponsored by the Robert Wood Johnson Foundation and conducted by the Center for Studying Health System Change, which showed that, among physicians accepting new privately insured patients, more than 98 percent were accepting at least some new Medicare patients (Reed 2002).⁵

While these findings are positive, many doctors participating in MedPAC's survey expressed concerns about payment levels. About 45 percent said that reimbursement levels for their Medicare fee-for-service patients were a very serious problem; 25 percent reported that reimbursement levels for private fee-for-service patients were a very serious problem. Fifty-nine percent reported that reimbursement for fee-for-service Medicaid patients was a very serious problem. Physicians expressed the highest level of concern with the reimbursement by health maintenance organizations (HMOs) and other capitated plans: about 66 percent said that HMO reimbursements were a very serious problem.

Finally, many physicians who responded to MedPAC's survey reported taking steps to reduce their practice costs. More than 50 percent said their practices had reduced staff costs, and two-thirds said their practices had delayed or reduced capital expenditures.

Data from a 1999 survey sponsored by the American Medical Association (AMA) show similar changes in physician practices (Hixson and Thran 2001). For example, 65 percent of physicians said they had reduced the length of visits, increased the number of visits per day, or referred more difficult cases to other physicians.

The relationship between changes in physician practices and Medicare payment policy is unclear, however. MedPAC survey data show no consistent relationship between time physicians

spent furnishing services to Medicare beneficiaries and reductions in staff costs or capital expenditures.⁶ More importantly, such practice changes may not indicate that payments are inadequate. Instead, physicians could be making their practices more efficient, in response to forces in the marketplace, without compromising quality of care. Research on patient outcomes is necessary before policymakers can reach conclusions about whether access to high-quality care has diminished.

Accounting for cost changes in the coming year

Given the information about the adequacy of the current level of payments, the next step in determining payment updates is to ask how much costs will change in the coming year. Several factors will affect the cost of physician services, but the most important one is inflation in input prices. The available measure—the MEI—has two problems, but the Secretary can correct them. Other factors that may increase costs include scientific and technological advances and the regulatory burden of the Medicare program, including the burden of compliance with requirements of the Health Insurance Portability and Accountability Act of 1996. These other factors are likely to have small or unmeasurable effects on costs. The remaining factor—productivity growth—will reduce costs. Here again, a measure is available but the Secretary should change it. Using measures of inflation and productivity growth, it appears that the cost of physician services will increase by 2.5 percent during the coming year.

Measuring input price inflation

The MEI is the SGR system's measure of input price inflation. It is calculated by CMS as a weighted average of price changes for inputs used to provide physician services (Table 2C-3). Those inputs include physician time and effort, or work, and practice expense. Practice expense includes nonphysician employee compensation, office expense, medical materials and supplies, professional liability insurance, medical equipment, and other professional expenses, such as private transportation. In general, the weights used to construct the MEI represent the shares of physicians' practice revenues attributable to each input, based on a survey conducted by the AMA in 1996. Physician work has a weight of 54.5 percent; the remaining 45.5 percent is allocated among categories of practice expense.

The MEI is analogous to the market basket index used to update payments for inpatient hospital care; however, the MEI, as currently calculated by CMS, differs from the market basket index in that it includes an adjustment for productivity growth. This adjustment is intended to prevent double-counting of changes in productivity (Freeland et al. 1991). Such double-counting could occur if the changes in input prices measured by the MEI are partly due to changes in the productivity of the inputs. Failure to account for productivity growth could mean that physicians are paid twice for productivity growth—once in the MEI and once for any increases in the volume and intensity of services they provide that are the result of increased productivity.

Although productivity growth is an important factor, MedPAC believes that it should be considered separately in update decisions. This allows input price indexes to account only for changes in prices, not other changes in cost. Other factors affecting costs often offset each other.

⁵ In addition to this overall finding, the survey showed a small decrease in the number of physicians accepting all new Medicare patients and a small increase in the number of physicians accepting most new Medicare patients. These changes occurred between the first round of the survey (conducted in 1996-1997) and the second round (conducted in 1998-1999).

⁶ The AMA survey shows a relationship between practice changes and Medicare, but physicians were not asked about other payers in this survey.

**TABLE
2C-3**

Medicare Economic Index weights and forecast of input price changes for 2003

Input	Weight (%)		Price changes for 2003 (%)
	Category	Total	
Total		100.0	3.0
Physician work		54.5	3.2
Wages and salaries	44.2		3.1
Nonwage compensation	10.3		3.2
Practice expense		45.5	2.9
Nonphysician employee compensation			3.3
Wages and salaries	12.4		3.3
Nonwage compensation	4.4		3.4
Office expense	11.6		2.3
Medical materials and supplies	4.5		2.1
Professional liability insurance	3.2		4.6
Medical equipment	1.9		2.0
Other professional expense			2.6
Professional car	1.3		1.3
Other	6.3		2.8

Source: Unpublished data from CMS.

Removing the productivity adjustment is not the only change necessary in the MEI. As used in the SGR system, the MEI is not a forecast of the change in input prices for a given year; instead, it measures input price inflation for the previous year. To allow payment updates to anticipate changes in costs during the coming year, MedPAC has recommended that CMS use a forecast of the MEI when making payment updates for physician services (MedPAC 2001).

By removing the productivity adjustment and making it a forecast, the MEI would become a better measure of input price inflation. So modified, the index shows that input prices for physician services are expected to increase by 3.0 percent in 2003.⁷

Other cost-increasing factors

The cost of physician services may increase because of factors other than input price inflation. The effects of some of these factors are likely to be small, however. For instance, costs could go up because of scientific and technological advances or complexity changes within service categories.⁸ These two factors are usually accounted for in the physician fee schedule, however, when new billing codes are created or existing codes are revised.⁹ Many such changes in the codes occur every year (Figure 2C-1). Technological advances and within-service complexity are also accounted for when the fee schedule's relative weights are reviewed and recalibrated every five years. CMS estimated a small spending

impact for the most recent of these five-year reviews: 0.46 percent, or about 0.1 percent per year.¹⁰

Other factors increasing costs are difficult to measure. For example, the regulatory burden of the Medicare program is an important concern of physicians. Nevertheless, estimates of the cost of this burden are not available. Furthermore, the Secretary has appointed an advisory committee on regulatory reform and has taken other steps to reduce regulatory burden. These activities are important but complicate any effort to assess cost impacts. One way to account for any increases in cost due to these factors is to assess payment adequacy, as described earlier, and adjust payments accordingly in the updates for years after 2003.

Productivity growth

Assuming the Secretary removes the productivity adjustment from the MEI as MedPAC recommends, how should the Secretary measure productivity growth for physician services?

Productivity growth is the ratio of growth in outputs to growth in inputs. Measuring productivity growth requires detailed information on the personnel, facilities, and other inputs used and on the quantity, quality, and mix of services (outputs) produced. Because such data are generally not available, MedPAC has adopted a policy standard, or goal, for achievable productivity growth that is based on growth in multifactor productivity in the national economy.¹¹

Why is this policy standard necessary for physician services? If productivity growth is unmeasurable, why don't we assess it after the fact when we assess payment adequacy? Because we do not have cost reports for physician services, our tools

7 This estimate is subject to change as CMS collects better data. Better data are important because of recent instability in the market for professional liability insurance (Albert 2002).

8 Scientific and technological advances include advances that enhance quality of care but also raise costs. Complexity changes within service categories are changes in the average severity of illness or other factors that raise costs.

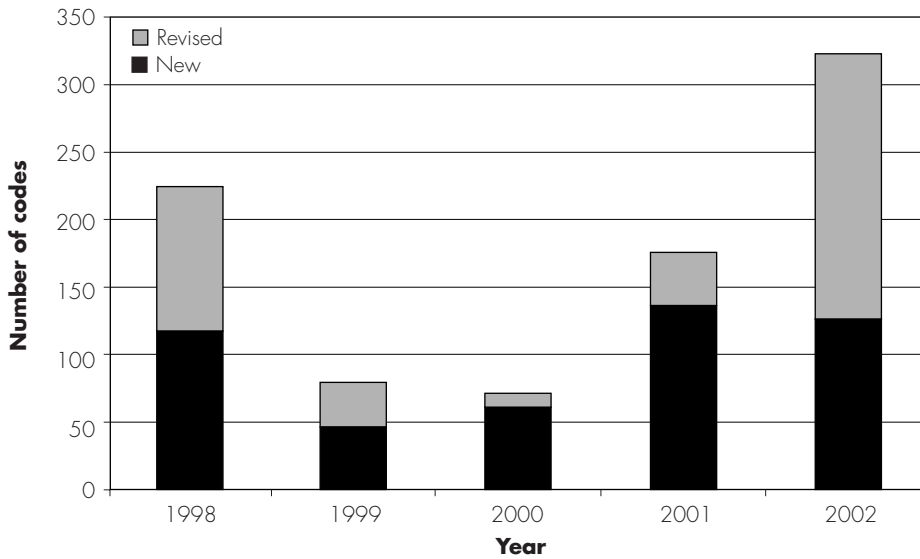
9 Some coding changes are budget neutral, which prevents them from accounting for increases in cost.

10 CMS used this estimate to adjust payment rates so the five-year review would be budget neutral.

11 Multifactor productivity is based on all relevant inputs used to provide goods and services. Those inputs include labor, capital, and other inputs, such as energy and materials.

**FIGURE
2C-1**

New and revised billing codes



Source: CMS, Physician fee schedule final rules, various years.

for assessing payment adequacy are much better at telling us if payments are too low than if payments are too high. Therefore, we cannot use these tools to see if cost-decreasing effects of productivity growth have led to payments that are too high.

The productivity adjustment currently in the MEI is a policy standard like the one proposed here because it is not based on measures of productivity growth for physician services. The current adjustment only accounts for growth in the productivity of labor inputs, however. It does not account for growth in the productivity of capital and other inputs.

RECOMMENDATION 2C-2

The Secretary should revise the productivity adjustment for physician services and make it a multifactor instead of labor-only adjustment.

Revising the productivity adjustment to account for labor and nonlabor factors is consistent with the way physician services are produced. Labor accounts for most of the cost of providing physician services, but other inputs are also important, including office space, medical materials and supplies, and equipment. A labor-only productivity adjustment implies that there is no complementarity between labor and other inputs. The Commission believes that such complementarity exists, however. The production of physician services, like the production of most other goods and services, is a joint effort that requires both labor and non-labor inputs.

Another reason to revise the productivity adjustment is to make it consistent with modern methods of measuring productivity. A labor-only adjustment has been part of the MEI since the index was first used in paying for physician services in 1975, before the Bureau of Labor

Statistics (BLS) began publishing measures of multifactor productivity in 1983 as a way to capture the joint effects of multiple inputs (BLS 2001a).

If the Secretary decides to make the productivity adjustment for physician services a multifactor one, he has two options. He can adopt a policy standard such as MedPAC's, which is 0.5 percent, or he can calculate an adjustment using the same method as the one used for the current, labor-only adjustment, which is a 10-year moving average of productivity growth. Based on current estimates from the BLS on growth in multifactor productivity, the adjustment would be about 0.7 percent (Figure 2C-2).¹² Regardless of the option chosen, the Commission believes that the Secretary should continue to use an adjustment that is stable from year to year. The adjustment should be based on long-run trends in multifactor productivity growth, however.

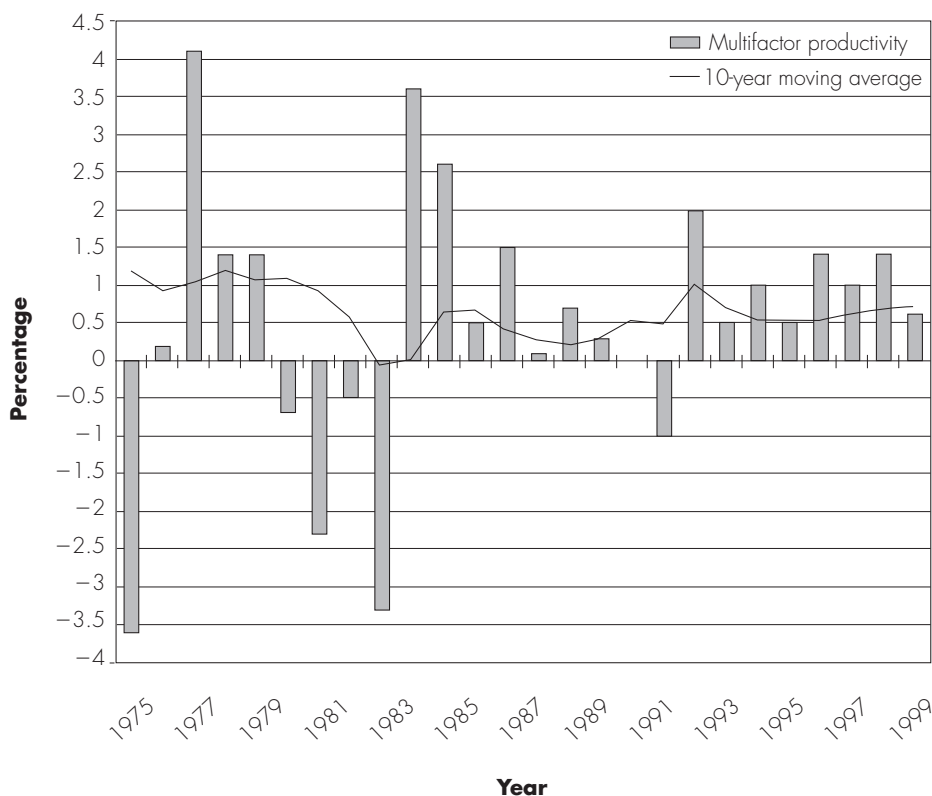
Are such productivity gains achievable for physician services? A number of factors contribute to growth in multifactor productivity, including research and development, new technologies, economies of scale, managerial skill, and changes in the organization of production (BLS 2001a). These factors appear relevant to physician services. Two examples illustrate this:

- Economies of scale. Research has shown that doubling the size of a physician practice (from the current average of about 2.5 physicians to 5 physicians) would increase productivity by 9 percent with no increase in practice expense per physician (Pope and Burge 1996). Physicians apparently perceive the advantages of group practice (Figure 2C-3): in 1990, 52 percent of self-employed physicians were in solo practice, but by 1998, that percentage had dropped to 42 percent.

¹² MedPAC's productivity growth standard of 0.5 percent is lower than the current trend in multifactor productivity because this standard was established before recent increases in productivity growth. Since 1999, MedPAC has used this standard when making update recommendations for services other than physician services.

FIGURE 2C-2

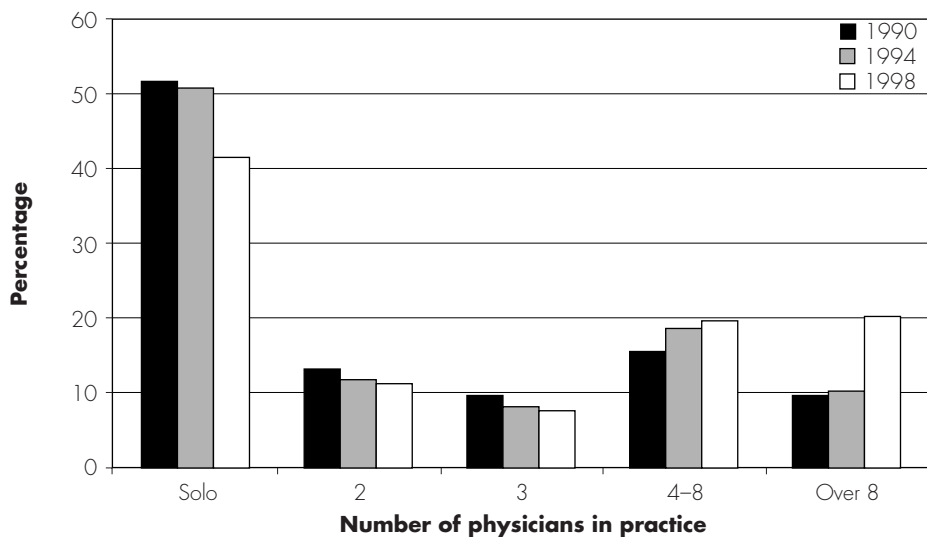
Multifactor productivity growth, 1975–1999



Source: MedPAC analysis of data from the Bureau of Labor Statistics (2001b).

FIGURE 2C-3

Distribution of self-employed physicians by size of practice, 1990, 1994, and 1998



Source: AMA, Physician Marketplace Statistics, Fall 1990; AMA, Physician Marketplace Statistics, 1994; and AMA, Physician Socioeconomic Statistics, 1999–2000.

- New technologies. Physicians are increasing their productivity by using a variety of new technologies, including handheld computers, electronic medical records, and the Internet (Bureau of National Affairs 2001). Of these, the Internet probably has the greatest potential. Physicians currently use it for claims processing, research, and continuing education. Future uses include remote interpretation of radiographic and other medical images in central imaging centers designed for optimal productivity (Kieffer and Drew 2000). New technologies do not always lead to productivity increases, however. For example, e-mail communication between physicians and patients can reduce physician productivity if it diverts them from providing services.

Update recommendation

Under MedPAC’s proposed update method for physician services, updates can include three components: an adjustment for payment adequacy, if appropriate; an estimate of inflation in input prices; and a downward adjustment in the update for growth in multifactor productivity.

RECOMMENDATION 2C-3

The Congress should update payments for physician services by 2.5 percent for 2003.

Payments for physician services may be too low currently because payment updates have not kept pace with the change in input prices since 1999. MedPAC recommends no adjustment for payment adequacy at this time, however, pending collection of further data. The other components of the update are the estimate of the change in input prices for 2003, which is 3.0 percent, and MedPAC’s adjustment for growth in multifactor productivity, which is 0.5 percent. ■

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