MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

October 6, 2003

Thomas Scully, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1476-P

Dear Mr. Scully:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' proposed rule entitled *Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004* Federal Register Vol. 68, No. 158, page 49030-49300 (August 15, 2003). We appreciate the ongoing efforts of the CMS staff to administer and improve payment for physician services, particularly considering the competing demands on the agency. We have comments on two issues within the proposed rule.

Data concerns for the Medicare Economic Index (MEI)

The MEI is a national weighted average of the annual change in prices for the various inputs used to furnish physician services. Inputs are classified in the MEI as practice expense, including professional liability insurance (PLI), and physician earnings. In this rule, CMS proposes to update the MEI weights so they are based on data for 2000, instead of 1996.

While CMS has more timely data on price changes for the various inputs, CMS does not have the data necessary to determine the *weighting* of the price changes beyond the year 2000. Consequently, recent changes in the share of total expenses attributable to each expense category—such as those related to the increase in PLI premiums over the 2001-2003 period—would not be captured in the 2004 MEI weights, though of course they would in the index values. CMS's primary data source for determining MEI input weights is a survey conducted by the American Medical Association (AMA). The most recent AMA survey reported data for the year 2000. In addition to not having more recent data, it is MedPAC's understanding that the AMA does not have specific plans for conducting this survey in future years.

Therefore, CMS will need to find a replacement data source for information on physician earnings and practice expenses for use in future MEI updates.

In our June 2003 report to Congress, MedPAC emphasized the importance of collecting timely data on the expenditures associated with producing physician services. Specifically, MedPAC suggested that CMS could pursue a collaborative approach to finding a new data source, perhaps involving the AMA, physician specialty societies, and other federal agencies. Establishing a new data source could result in more timely access to relevant data.

We made these suggestions in our June 2003 report in the context of payments for practice expense. Concerns about the MEI only increase the need for CMS to secure a timely data source for tracking changes in the cost of producing physician services.

In the interim, CMS should consider using price changes since 2000 to estimate weights for 2004 and subsequent years. These estimated weights would assume no change in input quantities since 2000, which is the assumption implicit in using weights based on data for 2000 from the AMA survey. Using price changes since 2000 with these input quantities would allow updating of the weights and improving their accuracy until a new data source is found to replace the AMA survey.

Further research needs to guide physician payment adjustments for dialysis services

The proposed rule modifies the monthly capitated payment to physicians for providing outpatient services to end-stage renal disease (ESRD) patients needing maintenance dialysis. Under current payment practice, physicians receive the same monthly payment per patient regardless of the number of times the physician sees each patient during the month. CMS proposes to adjust this monthly payment according to the number of face-to-face visits the physician has with the patient during the month—stratified into three payment categories: one visit per month, two or three visits per month, or four or more visits per month.[a] Relative to current payments, physicians would receive higher monthly amounts when they visit four or more times with a given dialysis patient. Conversely, physicians would receive lower monthly payments than they do currently, when they provide fewer than four visits with a given patient.

CMS's rationale for this payment adjustment is to align payments with physician involvement in patient care, and thus make higher payments to physicians when they conduct more face-to-face patient visits. CMS states that the proposed restructured payment will also assist in ensuring that dialysis patients receive high-quality care.

In general, capitated reimbursement may be appropriate for outpatient dialysis-related physician services because it accounts for a collection of physician activities for chronically ill patients. However, capitated payment for these services should include adjustments for patient complexity coupled with incentives for improving the quality of physician care. The per-visit-level approach, proposed by CMS, may not be the best method for achieving these goals.

MedPAC agrees with CMS that the current payment method lacks both accountability and quality incentives, and thus applauds CMS for addressing these issues. However, if a purpose of the proposed payment change is to promote quality and better align payment with physician involvement,

[a] Current and proposed payments also differ based on the patient's age.

it is important to first collect and present baseline data on the type, frequency, and content of physician encounters. Without this data, it is unclear how the agency could determine and measure the impact of the proposed regulation on quality and access. Moreover, MedPAC is concerned about how the proposed change might affect spending, given the lack of information on current visit frequency.

As CMS states in the proposed regulation, the agency is currently exploring several quality-related initiatives to improve outcomes for patients with ESRD. When CMS examines more long-term changes to the physicians' capitated payment for dialysis-related services, MedPAC urges CMS to collect data and report on the type, frequency, and content of physician encounters. CMS should also investigate and incorporate physician clinical practice guidelines into its payment approach, and measure physician quality directly. CMS should also examine whether physician resources vary based on patient complexity. To the extent they do vary, a case-mix adjustment—similar to the one MedPAC recommended for payment to dialysis facilities in its June 2003 report—would be desirable. Additionally, CMS will need to consider how to take into account additional visit payments that are made to physicians when their patients are hospitalized.

Once CMS collects information on physician resource costs and clinical guidelines, the agency should then adjust the monthly capitated payment accordingly. Together with these adjustments, further incentives should be added to the monthly payment to reward and improve the quality and access of dialysis-related physician care, which is consistent with MedPAC's June 2003 recommendations.

MedPAC appreciates the opportunity to comment on policy proposals introduced by the Secretary and CMS. The Commission also values the willingness of CMS staff to provide relevant data and to consult with us concerning technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,

Glenn M. Hackbarth,
Chairman

GH/cbm