

# SECTION 2B

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## **Physician services**

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

The Congress should update payments for physician services in 2009 by the projected change in input prices less the Commission's adjustment for productivity growth. The Congress should enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.

**COMMISSIONER VOTES: YES 13 • NO 2 • NOT VOTING 1 • ABSENT 1**

# SECTION 2B

## Physician services

### Section summary

Our analysis of payment adequacy finds that most of our indicators are positive and stable; thus most beneficiaries obtain quality physician care on a timely basis. The volume of physician services provided per beneficiary continues to grow significantly. The Commission recommends that the Congress update payments in 2009 for physician services by the projected change in input prices less the Commission's adjustment for productivity growth. Based on current estimates of input cost changes and the Commission's productivity adjustment, this recommendation would result in a 2009 update of 1.1 percent. However, CMS revises the input cost projections on a quarterly basis, so the actual update percentage may change.

The Commission also recommends that the Congress enact legislation requiring CMS to measure and report physician resource use confidentially for two years. Using results for physician education would provide CMS with experience applying the measurement tool and allow the agency to work with physicians and other stakeholders on any refinements. After experience is gained, Medicare could use the results

### In this section

- Are Medicare payments for physician services adequate in 2008?
- How should Medicare payments for physician services change in 2009?
- Update recommendation
- Additional comments

for payment—for example, as a component of a pay-for-performance program or to create other financial incentives to improve efficiency and quality.

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## Recommendation 2B

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**COMMISSIONER VOTES:**

**YES 13 • NO 2 • NOT VOTING 1 • ABSENT 1**

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*The Congress should update payments for physician services in 2009 by the projected change in input prices less the Commission's adjustment for productivity growth. The Congress should enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.*

The Commission is not satisfied with the current physician payment update mechanism. The existing sustainable growth rate formula is flawed and continues to call for substantial consecutive negative updates through 2016. We are concerned that repeated annual reductions in physician payment rates would threaten beneficiaries' access to physician services. We are especially concerned about the impact repeated negative updates would have on access to primary care services. Medicare should be actively encouraging, not hindering, access to these services given their potential to improve the quality and efficiency of health care delivery. Our concerns are discussed in detail in *Assessing Alternatives to the Sustainable Growth Rate System* (MedPAC 2007b).

The Commission is also concerned that the distribution of Medicare physician payments is distorted by incentives that encourage the overuse of some services and underuse of others. Medicare's fee-for-service payment system does not systematically reward physicians who provide higher quality care or care coordination, and it offers higher revenues to physicians who furnish the most services—regardless of whether they add value.

The Commission has said that Medicare's physician payment system should include incentives for physicians to provide better quality of care, to coordinate care across settings and medical conditions, and to use resources judiciously. The Commission's recommendations in past reports and the physician resource use measurement and reporting recommendation in this report are intended to keep Medicare moving toward those goals. Providing physicians with information on their practice patterns is one way to engage

the physician community in a dialog to change the negative incentives in the payment system.

As with other provider sectors, our approach for recommending updates for 2009 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 a MedPAC-sponsored survey of beneficiaries conducted in August and September 2007 indicate that beneficiary access to physicians is generally good, with no statistically significant changes from last year's survey. Most beneficiaries reported that they never had to wait for an appointment to see their doctor (75 percent reported never waiting for a routine care appointment; 82 percent reported never waiting for an appointment to treat an illness or injury). However, as in past years, the survey results also show that small percentages of beneficiaries report difficulty with access to physician services. Among the 10 percent of beneficiaries who reported that they looked for a new primary care physician, 70 percent reported no problem finding one who would treat them. About 30 percent of this group reported having at least some difficulty finding a new primary care physician. Among the 15 percent of beneficiaries who reported seeking a new specialist in the previous year, 85 percent reported no problem finding one. About 15 percent of this group reported having at least some difficulty finding one.

***Supply of physicians accepting and providing services to Medicare beneficiaries***—We also analyze whether physicians are accepting new Medicare patients and treating Medicare patients. Newly available results from the 2006 National Ambulatory Medical Care Survey show that 93 percent of office-based physicians who receive 10 percent or more of their practice revenue from Medicare were accepting new Medicare patients in 2006. Our analysis of 2006 Medicare claims data, the most recent available, shows that

the number of physicians providing services to fee-for-service Medicare beneficiaries has kept pace with growth in the total beneficiary population.

***Private insurer rates compared with Medicare***—We also compare the trend in Medicare’s physician fees relative to private insurer fees. If Medicare’s payment rates fall relative to the rates paid by private payers, some physicians may decide to stop accepting Medicare patients and instead focus their practices on privately insured patients. Averaged across all services and areas, the ratio of Medicare fees to private payers’ fees was 81 percent in 2006, the most recent year for which these data are available. The 2006 ratio is lower than the 83 percent ratio in 2005, which may be at least partially attributable to the zero percent fee schedule conversion factor update in 2006. The ratio of Medicare to private fees varies substantially by geographic area and by type of physician service (e.g., primary care services vs. specialty care services).

***Ambulatory care quality***—We analyze trends in 38 claims-based ambulatory care quality indicators to assess changes in the quality of care for Medicare beneficiaries. Most of the quality indicators improved or were stable from 2004 to 2006, the most recent year for which detailed claims data are available. A few indicators showed a statistically significant decline, and for 9 of the 38 measures, fewer than two-thirds of beneficiaries received services that are indicated as a standard of care for their diagnosed condition.

***Volume growth***—We analyze changes in the growth per beneficiary of the volume and intensity of physician services, both in total and by major service types. Service volume per beneficiary continued to grow in 2006, albeit at a slower rate of growth than in the previous year. Overall volume (reflecting both service units and intensity) grew 3.6 percent per beneficiary. Volume growth rates varied among broad categories of services—evaluation and management (2.8 percent), imaging (6.2 percent), major procedures (2.7 percent), other procedures (2.5 percent), and tests (6.9 percent)—but all were positive. ■

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## Background

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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. Medicare fee-for-service (FFS) payments for physician services were \$58.4 billion in 2006 and \$57.7 billion in 2005, accounting for about 15 percent of total Medicare spending (MedPAC 2007a). Per beneficiary enrolled in FFS Medicare, incurred expenditures for physician services were \$1,765 in 2006, an increase of 4.4 percent from the 2005 amount of \$1,691 (Boards of Trustees 2007). Aggregate spending grew more slowly from 2005 to 2006 due to a significant shift in enrollment from FFS Medicare to Medicare Advantage (MA) plans in 2006. Medicare also pays for physician services provided to Medicare beneficiaries enrolled in MA plans through its payments to those plans. Medicare beneficiaries also pay a portion of total payments received by physicians, through beneficiary cost-sharing liabilities.

In the FFS program, 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 (physician work, practice expense, and professional liability insurance) intended to reflect the typical 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 payment basics: Physician services payment system* at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_07\\_Physician.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_Physician.pdf).

By law, the physician fee schedule conversion factor update is determined by a formula—called the sustainable growth rate (SGR)—set forth in the Balanced Budget Act of 1997. It ties physician payment updates to a number of factors, including growth in input costs, growth in Medicare 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,

and in 2002 the fee schedule conversion factor was reduced by 5.4 percent.

Since 2003, however, the Congress has passed and the President has signed laws that have prevented further reductions in the conversion factor from occurring. In most cases, the new laws did not completely eliminate the negative updates but deferred them to later years. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required a 1.5 percent update to the conversion factor in 2004 and 2005. The Deficit Reduction Act of 2005 (DRA) held 2006 payment rates at 2005 levels (technical refinements to the fee schedule resulted in an actual overall update of 0.2 percent in 2006).

The Tax Relief and Health Care Act of 2006 (TRHCA) effectively held 2007 payments at 2006 levels through a conversion factor bonus. TRHCA also prevented the elimination of a floor on the work geographic practice cost index (GPCI) that was originally imposed by the MMA (the elimination of the floor would reduce payments to geographic areas, primarily rural areas, where physician practice costs are relatively lower).<sup>1</sup> TRHCA also directed additional spending to physicians in 2007 and 2008 through the Physician Quality Reporting Initiative, through which physicians are eligible for a 1.5 percent bonus on all their allowed charges if they meet specified quality reporting requirements.

At the end of December 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) replaced what would have been a 10.1 percent reduction in the physician fee schedule conversion factor with a 0.5 percent increase, effective January 1 through June 30, 2008. The MMSEA also extended the GPCI floor through June 30, 2008, and extended through June 30, 2008, a provision of the current system that makes 5 percent bonus payments to physicians practicing in designated physician shortage areas.

Notwithstanding all the update adjustments and other payment enhancements enacted since 2003, the SGR mechanism remains in current law and it is projected by the Medicare actuaries to result in substantially negative conversion factor updates from 2009 through at least 2016. For 2009, CMS estimates that the conversion factor update will be -5.0 percent under the SGR mechanism, absent a change in current law. This reduction would follow a conversion factor reduction of about 10.6 percent

scheduled to take place on July 1, 2008, unless the Congress takes further action to change current law.

The Commission is not satisfied with the current physician payment update mechanism. The existing SGR formula is flawed and the Commission is concerned that repeated annual reductions in physician payment rates could threaten beneficiaries' access to physician services. We are especially concerned about the impact repeated negative updates would have on access to primary care services, the increased use of which Medicare should be actively encouraging, not hindering, given the potential of primary care to improve the quality and efficiency of health care delivery.

The Commission is also concerned that the current distribution of Medicare physician payments is distorted by incentives that encourage the overuse of some services and underuse of others. Medicare's FFS payment system does not systematically reward physicians who provide higher quality care or care coordination, and it offers higher revenues to physicians who furnish the most services—regardless of whether they add value.

The Commission examined several alternative approaches to improving the current physician payment system in a March 2007 report to the Congress, *Assessing Alternatives to the Sustainable Growth Rate System* (MedPAC 2007b). In addition to presenting alternatives for reforming the SGR itself, that report provides suggestions for other physician payment policy approaches that would change the current system to improve the accuracy of Medicare's payments, create incentives for physicians to provide better quality of care and coordinate care across settings and medical conditions, and use resources judiciously. The Commission's recommendations in past reports and the physician resource use measurement and reporting recommendation in this report are intended to keep Medicare moving toward those goals. Providing physicians with information on their practice patterns is one way to engage the physician community in a dialog to change the negative incentives in the current payment system.

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## **Are Medicare payments for physician services adequate in 2008?**

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The Commission's framework for assessing payment adequacy for physician services relies on several indicators.

We cannot look at financial performance of physicians directly because they are not required to report their costs to Medicare, as is required of other providers such as hospitals and home health agencies. 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 the health care delivery system. According to national survey data from the 2003 Medicare Current Beneficiary Survey, about 85 percent of noninstitutionalized beneficiaries report that a doctor's office or a doctor's clinic is their usual source of care (CMS 2003). Beneficiary access to physicians, therefore, is an important indicator of access to health care generally as well as of Medicare 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 whether 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 among individuals and subpopulations.

Additionally, it is difficult to determine what the appropriate level of access should be. Beneficiaries judge access to physicians in an environment where most of them have supplemental insurance against out-of-pocket costs. This coverage effectively lowers their out-of-pocket 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. We use a separate set of quality measures to assess the quality of physician care delivered to Medicare beneficiaries (see discussion on p. 90).

### **MedPAC's 2007 beneficiary survey on access to physicians**

To obtain the most current access measures possible, the Commission sponsors a telephone survey each year of a nationally representative, random sample of about 2,000 Medicare beneficiaries age 65 or older, and about 2,000 individuals age 50 to 64 who have private health insurance. By surveying both groups, we can assess the extent to which access problems, such as delays in scheduling an appointment or difficulty in finding a new physician, are unique to the Medicare population. Our survey does not distinguish Medicare FFS enrollees from those in MA plans, because of the technical difficulty in obtaining reliable self-identification of FFS or MA enrollment from surveyed individuals. The results from this telephone survey are weighted to be nationally representative with respect to basic demographic variables. We do not survey Medicare beneficiaries younger than age 65 because of limited sample size.<sup>2</sup>

### **Most beneficiaries report few or no access problems in 2007**

Results from our 2007 survey indicate that most beneficiaries have reliable access to physician services, with most reporting few or no access problems. Most beneficiaries are able to schedule timely medical appointments and find a new primary care or specialist physician when needed, but small subsets of beneficiaries report problems in making appointments with their physician or finding a new physician. The 2007 survey results are consistent with what we found in our 2005 and 2006 surveys, indicating that access to physician services is stable. However, in light of a possible negative payment update in the second half of 2008 and in 2009, the Commission plans to closely monitor trends in beneficiary access over the next year.

### **Getting timely appointments**

Most Medicare beneficiaries have one or more doctor appointments in a given year. Therefore, one access indicator we examine each year is their ability to schedule timely appointments. In the 2007 survey, most Medicare beneficiaries (75 percent) and most privately insured individuals age 50 to 64 (67 percent) reported never having

to wait longer than they wanted to get an appointment for routine care (Table 2B-1, p. 84). Another 18 percent of Medicare beneficiaries reported that they sometimes had to wait longer than they wanted for a routine appointment, compared with 24 percent of privately insured individuals. The differences between the Medicare and privately insured populations in their “never” and “sometimes” response rates were statistically significant, suggesting that Medicare beneficiaries on average are more satisfied with the timeliness of their appointments.<sup>3</sup> Only 6 percent to 7 percent of either group reported that they usually or always had to wait longer than they wanted to get a routine care appointment.

As expected, reported rates of getting appointments without delay in cases of illness or injury were more common for both groups, but Medicare beneficiaries reported fewer difficulties getting timely appointments in these cases, too. Among those who scheduled an appointment for an illness or injury, 82 percent of Medicare beneficiaries and 76 percent of privately insured individuals said they never experienced a delay, while 13 percent of Medicare beneficiaries reported sometimes having to wait longer than they wanted, compared with 17 percent for privately insured individuals. These differences are statistically significant.

### **After-hours care for urgent medical conditions**

In addition to monitoring access to doctors' appointments for routine care and illness or injury, this year's survey included a series of questions about beneficiaries' access to their doctors for an urgent medical condition during nonregular working hours. The survey found little difference by insurance type in the percentage of beneficiaries reporting that their physician gave them instructions about what to do if they needed care for an urgent medical condition during nonregular working hours. In both groups, slightly more than one-third reported being told to go to the emergency room if this situation arose, roughly another third reported being told to call their doctor's office or answering service, and 25 percent said they were not given any instructions for this circumstance (the remainder did not know).

We also wanted to find out what respondents actually did when they thought they needed care for an urgent medical condition during nonregular working hours. Among the 12 percent of the sample who faced such circumstances, Medicare beneficiaries were more likely to go to the emergency room without first trying to contact their doctor (38 vs. 28 percent) and less likely to call their

**TABLE  
2B-1**

**Access to physicians remains stable for Medicare beneficiaries age 65 and older and privately insured persons age 50 to 64, 2005-2007**

Survey question	Medicare (Age 65 and older)			Private insurance (Age 50-64)		
	2005	2006	2007	2005	2006	2007
<b>Unwanted delay in getting an appointment:</b>						
Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
<b>For routine care</b>						
Never	74%	75%	75%	67%	69%	67%
Sometimes	21	18	18*	25	21	24*
Usually	3	3	3	5	5	4
Always	2	3	3	3	4	3
<b>For illness or injury</b>						
Never	82	84	82*	75	79	76*
Sometimes	15	11	13*	19	15	17*
Usually	1	2	3	3	2	3
Always	1	1	2	2	2	3
<b>Getting a new physician:</b> Among those who tried to get an appointment with a new primary care physician or a new specialist, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."						
<b>Primary care physician</b>						
No problem	75	76	70*	75	75	82*
Small problem	12	10	12	16	15	7
Big problem	13	14	17	9	10	10
<b>Specialist</b>						
No problem	89	80	85	86	83	79
Small problem	6	7	6	7	9	11
Big problem	5	11	9	6	7	10
<b>Not accessing a doctor for medical problems:</b>						
"During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")						
	7	8	10*	12	11	12*

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. For "Unwanted delay in getting an appointment," 2007 survey n=4,061 (2,036 Medicare; 2,025 privately insured), 2006 survey n=4,029 (2,005 Medicare; 2,024 privately insured), and 2005 survey n=4,021 (2,012 Medicare; 2,009 privately insured). For "Getting a new physician," 2007 survey primary care physician n=353 (165 Medicare and 188 privately insured) and specialist n=626 (304 Medicare and 322 privately insured), 2006 survey primary care physician n=394 (197 Medicare and 197 privately insured) and specialist n=699 (309 Medicare and 390 privately insured), and 2005 survey primary care physician n=329 (155 Medicare and 174 privately insured) and specialist n=769 (353 Medicare and 416 privately insured). All samples include fee-for-service and managed care enrollees.  
\* Indicates a statistically significant difference between the Medicare and privately insured populations in 2007 at a 95% confidence level.

Source: MedPAC-sponsored telephone surveys, conducted August-September 2005, 2006, and 2007.

doctor's office or answering service (45 vs. 54 percent) than privately insured individuals. It is possible that the differences in these response rates reflect differences in health status or the urgency of the medical conditions experienced by individuals in the two groups. While the number of respondents is too small to show statistically significant differences, we found that when Medicare beneficiaries did call their doctors first, they were more likely than the privately insured to be told to go to the emergency room. In addition, when they went directly to the emergency room, they were slightly more likely to be met there by their doctor.

### **Finding a new physician**

Our survey also monitors Medicare beneficiaries' and 50- to 64-year-old privately insured individuals' ability to find a new physician. In both cases, the survey results are based on the experiences of a relatively small number of individuals, which means the differences we see across years and between privately insured and Medicare respondents often are not statistically significant. In the 2007 survey, about 10 percent of Medicare beneficiaries and privately insured individuals reported having tried to find a new primary care physician in the preceding year; a higher percentage (about 15 percent) reported seeking a new specialist.

Of the 10 percent of Medicare beneficiaries who looked for a new primary care physician in 2007, 70 percent reported no problem in finding one, compared with 76 percent in the 2006 survey. The difference in these percentages is not statistically significant because of the small number of beneficiaries surveyed in this part of the sample. However, the percentage of privately insured individuals who reported no problem finding a new primary care physician (82 percent) was significantly higher than the percentage of Medicare beneficiaries reporting no problem in finding a new primary care physician (70 percent).

As in the previous two years, we found that beneficiaries seeking a new specialist reported problems finding one less frequently than those seeking access to a new primary care physician. Eighty-five percent of the Medicare beneficiaries and 79 percent of the privately insured individuals who said they were looking for a new specialist reported no problem finding one. In contrast to the results for primary care physicians, a slightly greater percentage of Medicare beneficiaries reported no problem finding a new specialist in 2007 compared with 2006,

and the rates of those with a small or big problem finding a specialist were lower (but not statistically different) for Medicare beneficiaries than for privately insured individuals. This result in 2007 is the opposite of the findings in the 2006 survey, underscoring the year-to-year volatility in these figures based on small sample sizes.

It is important to understand that the results of our surveys of beneficiaries' experiences in finding a new physician may not be representative of the experience of the entire Medicare population because of the small numbers of respondents in this part of the survey. The survey results are based on the experiences of about 200 Medicare beneficiaries who reported seeking a new primary care physician (about 10 percent of the total sample) and about 300 beneficiaries who reported seeking a new specialist (about 15 percent of the total sample) from a sample that was randomly selected from across the United States. Experiences of beneficiaries in particular geographic areas may vary significantly from the reported national survey results. Also, the reported rates of difficulty may reflect experiences of beneficiaries in the FFS program or in MA plans, because the survey does not distinguish between those two types of Medicare beneficiaries. Nevertheless, it is important to monitor the trends in survey responses over time, especially if there are significant year-to-year changes in the percentage of beneficiaries reporting difficulty finding a new physician or reporting problems at a higher rate than the privately insured comparison group.

Research published by the Center for Studying Health System Change (HSC), although based on information that is somewhat dated, 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). This research 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—for example, if there is an overall shortage of primary care physicians or certain types of specialists in areas of the country where the total population is growing rapidly—may be more important

influences on access for both Medicare beneficiaries and the privately insured. These conditions may affect beneficiary access as much as or more than Medicare payment levels.

Within the Medicare physician payment system, the Commission remains concerned about how the current distribution of payments undervalues primary care services, which may be contributing to some of the access problems for primary care physicians being reported by a small number of beneficiaries in MedPAC's annual beneficiary access survey. Another paper published recently by HSC researchers noted that the "flip side of physicians' responsiveness to financial incentives is their avoidance of providing services they perceive as undervalued," including favoring more highly valued procedures over cognitive primary care services (Pham and Ginsburg 2007). In a later section of this chapter, we discuss the Commission's ongoing work to improve how Medicare values physician services under the Medicare fee schedule, which, along with pay for performance and other quality improvement incentives, is part of the Commission's effort to align payment incentives to create a high-quality, efficient, and patient-centered health care delivery system for Medicare beneficiaries.

### **Few beneficiaries report access delays attributed to Medicare coverage status**

To get specifically at the question of whether a beneficiary's Medicare coverage was cited as a reason for difficulty in accessing physician care, our 2005, 2006, and 2007 surveys 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. Fourteen percent of these beneficiaries answered "yes" to this question in 2007, compared with 11 percent in 2006 and 27 percent in 2005. None of these year-to-year differences is statistically significant, primarily because the share of our sample answering "yes" to this question amounts to less than 1 percent of the entire Medicare sample.

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 2007 survey found

that 10 percent of Medicare beneficiaries and 12 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 8 percent of the Medicare beneficiaries, compared with 15 percent of the privately insured people, listed physician availability issues (getting an appointment time or finding a doctor) as the problem. The remaining reasons they gave included low perceived seriousness of the problem at the time of the illness, procrastination, and cost concerns.

### **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. Due to data collection limitations, our physician survey and supply indicators usually lag one year behind the results from our beneficiary access survey, but they still provide useful information about the direction and magnitude of changes in physicians' willingness and availability to treat Medicare patients. Most of the data presented in this section capture physician indicators as they stood in 2006, the most recent year for which these data are available. As of that year, MedPAC's physician survey and indicators from other sources both found that most physicians accepted all or most new Medicare beneficiaries. Our analysis of 2006 Medicare claims data shows that the number of physicians providing services to FFS Medicare beneficiaries has kept pace with growth in the total beneficiary population.

### **Physician surveys report high rates of Medicare patient acceptance**

The most recent available results from the National Ambulatory Medical Care Survey (NAMCS)—a national survey of office-based physicians in clinical practice, 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 2006, the NAMCS found that, among physicians with at least 10 percent of their practice revenue coming from Medicare, 93 percent accepted at least some new Medicare patients (Cherry 2007). The NAMCS also found that a greater percentage of physicians accepted new Medicare patients than privately insured patients in capitated and non-capitated health plans. Importantly, both the overall and Medicare patient acceptance rates remained relatively steady in the 2003, 2004, and 2005 surveys. We also analyzed Medicare acceptance rates separately for

physicians in primary care and all other specialties (also among physicians with at least 10 percent of their practice revenue coming from Medicare), and found that just over 90 percent of primary care physicians and about 95 percent of physicians in all other specialties accepted at least some new Medicare patients in 2006.<sup>4</sup>

MedPAC sponsored its own large survey of physicians in 2006, and its results presented a mostly positive but somewhat mixed picture of physician willingness to accept new Medicare FFS patients (MedPAC 2007d, Schoenman et al. 2006).<sup>5</sup> Most physicians (97 percent) were accepting at least some new Medicare FFS patients, with a smaller share (80 percent) accepting all or most. Acceptance of new Medicare FFS patients compared favorably with Medicaid and HMO patients but was a little lower than for private non-HMO patients. More physicians were concerned about reimbursement for Medicare FFS patients than for private non-HMO patients. Many physicians 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.

A 2007 study by researchers at HSC, based on somewhat older data, found two trends in the composition of the physician workforce that may underlie the relative stability of these observed access indicators: 1) a growing proportion of female physicians, who disproportionately choose primary care, and 2) continued reliance on international medical graduates, who now account for nearly a quarter of all U.S. primary care physicians. The authors found that between 1996–1997 and 2004–2005, a 40 percent increase in the female primary care physician supply helped to offset a 16 percent decline in the male primary care physician supply relative to the U.S. population. In addition, nearly one-fourth of the primary care physician workforce in 2004–2005 consisted of international medical graduates, whose share of the primary care workforce remained stable at just above 24 percent since 2000–2001, after increasing from just under 21 percent in the late 1990s (Tu and O’Malley 2007).

### **Number of physicians billing Medicare has kept pace with enrollment growth**

Our analysis of Medicare FFS claims data shows that the number of physicians providing services to Medicare beneficiaries has kept pace with growth in the beneficiary

population in recent years. In this analysis, Unique Physician Identification Numbers are used as a proxy for individual physicians; identification numbers with extraordinarily large caseload sizes (in the top 1 percent) are excluded from the analysis because they may represent multiple providers billing under one identification number.

Comparing growth in the number of physicians with growth in the Medicare population, we see that, from 2001 to 2006, the number of physicians who billed Medicare grew faster than Medicare Part B enrollment. During this time, Part B enrollment grew 6.9 percent. In comparison, the number of physicians with 15 or more Medicare patients grew 8.7 percent (Table 2B-2, p. 88).<sup>6</sup> The number of physicians with 200 or more Medicare patients grew even faster at 12.9 percent, indicating the ratio of physicians per 1,000 beneficiaries grew more rapidly for physicians with larger Medicare caseloads. This growth reflects increases in the share of physicians seeing more Medicare patients. The number of unique physicians billing Medicare for FFS beneficiaries actually grew faster between 2005 and 2006 than indicated in Table 2B-2, since enrollment growth in FFS Medicare was negative from 2005 to 2006 because of the rapid growth of MA enrollment in 2006.

Despite the overall increase in physicians who regularly saw Medicare FFS beneficiaries, the supply of physicians was somewhat dynamic, with small shares of them 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.

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.

**TABLE  
2B-2**

**Number of physicians billing Medicare has kept pace with enrollment growth, 2001–2006**

	Number of Medicare patients in caseload				
	>1	>15	>50	>100	>200
<b>Number of physicians</b>					
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
2006	569,461	497,072	453,822	405,504	323,877
Percent growth, 2001–2006	6.3%	8.7%	10.3%	11.4%	12.9%
<b>Number of physicians per 1,000 beneficiaries</b>					
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	11.3	10.1	8.1
2006	14.1	12.3	11.3	10.1	8.0

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 2001–2006 CMS Health Care Information System data.

**Claims assignment and physician participation rates are stable at high levels** To supplement our data on the supply of physicians treating Medicare patients and beneficiaries’ reported 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). Our analysis of Medicare paid claims data shows that 99.4 percent of allowed charges for physician services were assigned in 2006 (Figure 2B-1). That is, for almost all allowed services last year, physicians agreed to accept the Medicare fee schedule amount as payment in full for the service. The assignment rate has held steady at more than 99 percent since 2000.

The high rate of assigned charges reflects the fact that most physicians and nonphysician providers who bill Medicare agree to participate in Medicare—93.3 percent

in 2007, the same percentage as in 2006. Participating physicians agree to accept assignment on all allowed claims in exchange for a 5 percent higher payment on allowed charges. Participating physicians also receive nonmonetary benefits, such as being able to receive payments directly from Medicare (less the beneficiary cost-sharing portion) rather than having to collect the total amount from the beneficiary. This arrangement is a major convenience for many physicians. Participating physicians also have their name and contact information listed on Medicare’s website and they have the ability to electronically verify a patient’s Medicare eligibility and supplemental insurance (medigap) status. Medicare’s physician participation agreement does not require physicians to take Medicare patients. While 96.7 percent of allowed charges in 2006 were for services provided by participating physicians, another 2.7 percent were for

services provided by nonparticipating physicians who decided to accept assignment. Only 0.6 percent of allowed charges were for services provided by nonparticipating physicians who also did not accept assignment.

### Physician workforce and access to primary care

While the Commission traditionally has not examined workforce issues in the context of our update analyses, we indicated in our March 2007 report that we plan 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 will increase the demand for physician services over the next several decades, while baby boomer physicians will begin to retire. As noted above, other researchers have found that significant changes in the composition of the primary care and specialist physician workforces have already occurred since the mid-1990s, changes that raise concerns about the longer term implications for access to primary care and specialty services (Tu and O'Malley 2007). We plan to continue examining 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.

### Private payer payment rates for physician services

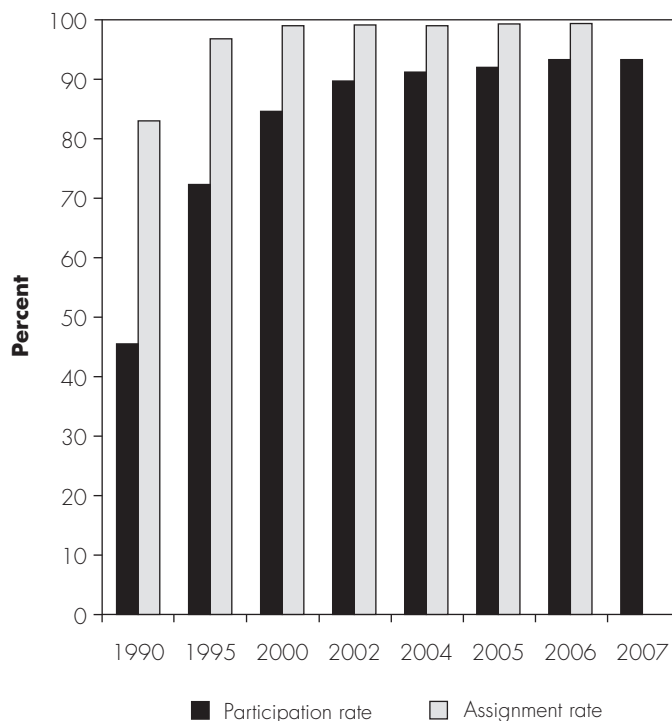
Another measure of Medicare payment adequacy that we use is a comparison of the trend in Medicare's physician fees relative to private insurer fees. If Medicare's payment rates fall relative to the rates paid by private payers, some physicians may decide to stop accepting Medicare patients and instead focus their practices on privately insured patients. The comparison of Medicare and private rates is based on an analysis of paid claims for two large national private insurers.<sup>7</sup> 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 plans, high-deductible health plans (HDHPs), and traditional indemnity insurance.

### Ratio of Medicare to private payer rates was lower in 2006 than in 2005

Averaged across all services and areas, 2006 Medicare rates were 81.3 percent of extrapolated private rates. In 2005, we found a slightly higher ratio, 82.6 percent. Looking specifically at evaluation and management (E&M) services, Medicare's payment rates are closer to the private

**FIGURE 2B-1**

**Physician participation and claims assignment rates are stable at high levels**



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 2007 is not shown; it requires calculations from claims not yet available.

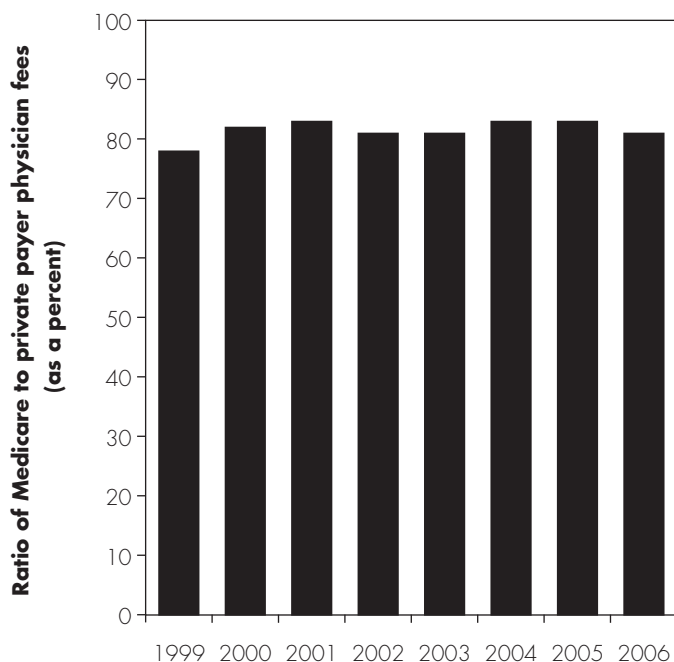
Source: U.S. House of Representatives, Committee on Ways and Means Green Book (2004), unpublished CMS data, and MedPAC analysis of Medicare claims for a 5 percent random sample of Medicare beneficiaries.

payers' rates—about 86 percent on average in 2006—but not as close as they were in 2005, when Medicare's rates were about 89 percent of the private payers' rates for E&M services.<sup>8</sup> These declines in the ratios may be at least partially attributable to the zero percent conversion factor update that occurred in 2006. (Although the conversion factor was not increased for 2006, refinements to the fee schedule relative value units (RVUs) resulted in an overall update of 0.2 percent in 2006.)

In the early to mid-1990s, Medicare payment rates on average were about two-thirds of commercial payment rates for physician services, but since 1999, Medicare rates consistently have been in the range of 80 percent of

**FIGURE  
2B-2**

**Ratio of Medicare to private payer physician fees is stable**



Source: Direct Research, LLC, for MedPAC for 1999–2004 data. MedPAC analysis for 2005–2006 data.

commercial rates (Figure 2B-2). This year’s analysis of 2006 data (the most recent available) showed that some types of private plans increased their physician payment rates between 2005 and 2006, while Medicare’s payment rates increased only slightly. Continuing a trend begun in the early 2000s, there also was a small shift in the distribution of enrollees in each plan type, from plan types with lower payment rates, such as HMOs, to those with higher payment rates, such as PPOs and HDHPs (Kaiser Family Foundation HRET 2007). The combination of enrollment shifts and changes in payment differences resulted in the change observed in the aggregate relationship between private plan and Medicare rates.

**Changes in the 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 (see text box for a discussion of quality-related payment incentives

for physicians).<sup>9</sup> Our analysis shows mostly small improvements and stability in these measures, yet, for several measures, fewer than two-thirds of beneficiaries received the services indicated as the basic standard of care for their condition.

**Most quality-of-care indicators improved or were stable from 2004 to 2006**

Comparing 2006 with 2004, we find that most of the indicators we measured remained steady or showed improvements (Table 2B-3). Specifically, among 38 measures, 21 showed improvement and 11 were stable. This finding suggests that beneficiaries with the selected conditions were either more likely or at least not less likely in 2006 than in 2004 to receive the indicated services for their condition and avert potentially avoidable hospitalizations related to their condition. Further, we see improvements on the MACIEs outcome measures that are correlated with improvements in the process measures for the same conditions.

We found a decline in quality in 6 of the 38 quality measures between 2004 and 2006:

- There were statistically significant declines in two measures of clinically indicated imaging for patients with an initial diagnosis of breast cancer. We are

**TABLE  
2B-3**

**Most ambulatory care quality indicators improved or were stable, 2004–2006**

Indicators	Number of indicators			Total
	Improved	Stable	Worsened	
All	21	11	6	38
Anemia	2	2	0	4
CAD	2	2	0	4
Cancer	3	1	3	7
CHF	5	2	1	8
COPD	0	1	1	2
Depression	0	1	0	1
Diabetes	5	1	1	7
Hypertension	1	0	0	1
Stroke	3	1	0	4

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

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



## Quality-related payment incentives for physicians

In past reports to the Congress and public testimony, the Commission has recognized the importance of implementing pay-for-performance (P4P) initiatives in Medicare but also acknowledged the challenges associated with performance measurement at the physician level. The Institute of Medicine (IOM) and MedPAC have stated that, ideally, measures should be developed and applied to all physicians to create equitable incentives to provide better quality care (IOM 2007, MedPAC 2005). However, we do not have well-established measures for all providers of physician services.

Given the state of the art in performance measurement, the Commission has noted that, at least initially, policymakers might consider prioritizing the implementation of some physician 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.<sup>10</sup> Performance measures for which success requires communication and coordination between parts of the health care delivery system (e.g., hospitals and physicians) may improve patient outcomes and reduce Medicare costs. For example, P4P incentives associated with congestive heart failure may reduce hospital admissions through better ambulatory care before an admission would otherwise occur. They may also lower readmission rates through improved post-discharge communication between physicians, patients, and hospitals (MedPAC 2007d). The Commission intends for any P4P initiatives to be implemented in a budget-neutral manner. ■

evaluating whether these declines may be related to a shift in providers' use of imaging modalities that are not captured in our current indicators or to a drop in the rates for any imaging.

- There was a decline in a measure of the rate for colonoscopy or barium enema within one month before or three months after an initial diagnosis of iron deficiency anemia, which may be a symptom of colon cancer. The overall rate at which the clinically indicated procedure is performed remained less than 30 percent.
- There were slight declines in two measures of clinical assessments for beneficiaries with diabetes or chronic obstructive pulmonary disease. In both of these cases the declines were very small (although statistically significant) and occurred in measures where there was a very high rate of performance (more than 96 percent).
- There was a decline in a measure of the use of X-ray imaging for beneficiaries with a diagnosis of heart failure. The observed decline in this rate could be the result of a shift among imaging technologies (e.g., greater use of computed tomography scans instead of X-ray imaging), a decline in the use of any imaging in these cases, or a combination of factors.

### Measures of potentially avoidable hospitalizations improved or were stable

Six of the MACIEs measure the occurrence of potentially avoidable hospitalizations or emergency department visits for selected chronic conditions. Five of these measures improved and one remained stable between 2004 and 2006. For example, in 2006, a smaller share of beneficiaries with congestive heart failure (CHF) had CHF-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., non-traumatic 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).

## **Many beneficiaries not receiving care indicated for their conditions**

In addition to measuring change from 2004 to 2006, we evaluated the underlying percentages of beneficiaries receiving the indicated care for their conditions. For 2006, we found that, for 23 of the 32 process measures, at least two-thirds of beneficiaries received the indicated care for their condition. For the other nine measures, fewer than two-thirds of beneficiaries received the specified care for their condition. Among these low-performing indicators, four improved between 2004 and 2006, one remained stable, and four worsened. The four indicators that worsened are the ones described above: two indicators of imaging rates after an initial breast cancer diagnosis, an indicator for rate of gastrointestinal diagnostic testing after a first-time diagnosis of anemia, and an indicator of the rate of use of X-ray imaging for beneficiaries with a diagnosis of heart failure.

## **Changes in the volume of physician services used**

Changes in the volume of services are another indicator of the adequacy of Medicare's payments for physician services. Increases in service volume could indicate that payments are at least adequate. Nonetheless, such data 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), which makes it difficult to interpret volume increases alone as a payment adequacy indicator.

The volume of services also has implications for the value of Medicare. First, rapid growth in volume may be a signal that some services in the physician fee schedule are mispriced. Second, the volume of services includes new diagnostic and therapeutic services that have disseminated into medical practice without physicians or other providers knowing whether they outperform existing services. Third, research comparing geographic areas has shown that the volume of services varies widely and that more care is not necessarily better care. We address each of these issues after the following discussion of volume growth and payment adequacy.

## **Volume growth as an indicator of payment adequacy**

Using claims data from 2001 through 2006, we calculated per beneficiary growth in the units of service beneficiaries used as furnished by physicians and other professionals billing under Medicare's physician fee

schedule. We then weighted the units of services used by each service's 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. 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 analyzing growth in spending, measuring growth in volume removes the effects of price changes (see text box, p. 94).

The volume of physician services beneficiaries received continued to grow in 2006 (Table 2B-4). There are two implications of this volume growth. First, physicians can realize increased revenues from Medicare even when fees per service are restrained. Second, however, the ability to generate volume (and thus revenue) varies significantly based on the types of services a physician provides. For example, physicians who predominantly provide office visits and major procedures have less ability to increase the volume of those services than physicians who predominantly provide imaging and diagnostic tests.

Across all services, volume grew 3.6 percent per beneficiary. Excluding a drop in the volume of outpatient rehabilitation, all-services volume grew by 4.1 percent. Among broad categories of services—E&M, imaging, major procedures, other procedures (nonmajor procedures and outpatient therapies), and tests—volume growth rates varied (from about 2.5 percent to 6.9 percent), but all were positive.<sup>11</sup> Per capita volume for tests grew the most. From 2005 to 2006, the volume of tests grew at a rate of 6.9 percent. The growth rate for imaging was next highest, at 6.2 percent. The categories with the lowest growth rates are E&M (2.8 percent), major procedures (2.7 percent), and other procedures (2.5 percent). However, excluding the drop in outpatient rehabilitation volume, the growth rate for other procedures was 4.6 percent.

The 6.2 percent rate of growth in the volume of imaging services, while higher than the all-services average, is not as high as the growth in previous years (from 2001 to 2005, imaging volume grew at an average annual rate of 9.1 percent). CMS also has reported that imaging growth declined in 2006 after the agency and the Congress took steps to control spending on imaging services (Kuhn 2007). Starting on January 1, 2006, payments for certain imaging services were reduced for second and subsequent studies when performed during the same session on contiguous body parts. These reductions were required

**TABLE  
2B-4**

**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 2001-2005	2005-2006	Average annual 2001-2005	2005-2006	
<b>All services</b>	<b>4.5%</b>	<b>0.9%</b>	<b>5.2%</b>	<b>3.6%</b>	<b>100.0%</b>
All services excluding outpatient rehab	3.4	2.1	4.9	4.1	97.8
<b>Evaluation and management</b>	<b>1.7</b>	<b>1.1</b>	<b>3.3</b>	<b>2.8</b>	<b>39.5</b>
Office visit—established patient	1.7	1.5	3.1	2.8	16.9
Hospital visit—subsequent	1.3	2.1	2.6	3.0	7.7
Consultation	3.1	-6.7	4.7	-0.7	5.5
Emergency room visit	1.9	-0.7	4.8	1.6	2.6
Nursing home visit	1.1	3.9	2.8	15.5	2.0
Hospital visit—initial	0.6	-0.3	1.2	0.1	1.8
Office visit—new patient	0.4	1.2	0.6	1.4	1.8
<b>Imaging</b>	<b>5.5</b>	<b>3.2</b>	<b>9.1</b>	<b>6.2</b>	<b>16.6</b>
Advanced—CT: other	12.1	10.0	15.3	11.6	2.4
Standard—nuclear medicine	8.9	2.1	12.6	3.8	2.4
Echography—heart	7.5	4.6	9.5	5.5	2.3
Advanced—MRI: other	14.6	8.0	15.7	8.5	2.0
Standard—musculoskeletal	4.0	1.8	4.6	2.3	1.2
Advanced—MRI: brain	8.8	4.3	10.1	4.0	1.1
Echography—other	7.0	7.4	11.1	7.7	0.8
Imaging/procedure—other	12.4	2.3	10.8	13.5	0.7
Standard—breast	11.2	6.9	-5.2	5.2	0.7
Standard—chest	1.1	-0.6	0.5	-1.4	0.6
Echography—carotid arteries	5.6	3.5	9.5	6.4	0.6
Advanced—CT: head	6.3	6.8	7.8	8.3	0.6
<b>Major procedures</b>	<b>0.4</b>	<b>2.4</b>	<b>2.9</b>	<b>2.7</b>	<b>9.1</b>
Cardiovascular—other	-3.3	1.4	0.8	3.7	2.1
Orthopedic—other	6.6	5.9	7.4	6.2	1.2
Knee replacement	10.0	2.5	11.0	3.3	0.7
Coronary artery bypass graft	-6.5	-7.5	-7.2	-8.1	0.5
Coronary angioplasty	3.9	2.1	3.9	1.5	0.5
Explore, decompress, or excise disc	5.7	3.4	6.2	3.9	0.4
Hip replacement	2.7	0.8	3.8	1.8	0.4
Hip fracture repair	-1.4	0.0	0.0	1.5	0.4
Cardiovascular—pacemaker insertion	8.7	-3.5	9.9	-3.7	0.3
<b>Other procedures</b>	<b>8.9</b>	<b>-2.2</b>	<b>6.9</b>	<b>2.5</b>	<b>22.1</b>
Other procedures excluding outpatient rehab	3.5	4.7	5.5	4.6	19.9
Minor—other, including outpatient rehab	19.0	-8.3	15.4	-5.3	4.3
Without outpatient rehab	15.9	5.1	10.1	3.7	2.1
Outpatient rehab only	20.4	-13.7	21.1	-13.0	2.2
Oncology—radiation therapy	0.4	3.9	9.6	10.9	2.3
Ambulatory procedures—skin	4.0	5.0	4.5	4.0	2.1
Minor procedures—skin	2.3	4.7	4.2	6.0	2.0
Cataract removal/lens insertion	2.5	-2.2	2.7	-1.9	1.8
Minor procedures—musculoskeletal	7.4	8.2	10.6	11.1	1.5
Colonoscopy	5.2	0.3	5.1	0.1	1.1
Oncology—other	6.6	2.2	6.0	3.9	0.9
Cystoscopy	2.4	2.1	5.6	6.9	0.6
Upper gastrointestinal endoscopy	2.6	4.0	2.5	3.9	0.6
<b>Tests</b>	<b>6.1</b>	<b>-0.9</b>	<b>7.6</b>	<b>6.9</b>	<b>5.4</b>
Other tests	12.1	-7.9	13.4	8.0	2.3
Without allergy tests	10.1	7.1	13.3	10.1	2.2
Allergy tests only	16.4	-35.7	15.8	-35.9	0.1
Electrocardiogram	2.2	1.3	1.6	2.4	0.7
Cardiovascular stress tests	6.8	3.3	8.2	4.8	0.6
Electrocardiogram monitoring	4.0	4.5	2.9	3.0	0.2

Note: CT (computed tomography). To put service use in each year on a common scale, we used the relative weights for 2006. For billing codes not used in 2006, 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 on the table but are included in the summary calculations. One such category includes all positron emission tomography services that would otherwise appear in disparate other categories.

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

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

## Measuring changes in use of physician services

**M**edPAC measures changes in use of physician services as changes in the volume of services. Volume in this context is the sum of units of service billed and paid for under the physician fee schedule multiplied by the fee schedule's relative value unit (RVU) for each service.

Because there are so many discrete services billable under the physician fee schedule—about 6,700—we group similar services into categories using CMS's Berenson-Eggers Type of Service (BETOS) classification system. For each type of service in BETOS, volume is equal to two numbers multiplied together: total units of service and the weighted average of RVUs for each of the services in the category. Thus, volume changes for a type of service when units of service change. Volume can also change if the weighted average of RVUs per service changes. A change in RVUs per service is often called a change in service mix or complexity or a change in the intensity of services.

With changes in intensity, services can exhibit changes in units of service and changes in volume that differ markedly. The service category called "Other tests—other" provides an example. Here, units of service per beneficiary from 2005 to 2006 fell by 7.9 percent, but volume per beneficiary went up by 8.0 percent. The

difference—an increase in intensity of 17.3 percent—is due in part to a large drop (–35.7 percent) in the number of relatively low-RVU allergy tests billed and paid for in 2006. Meanwhile, units of service for other, higher RVU services in this type of service, such as nerve conduction tests and sleep tests, continued to grow. One explanation for the decrease in allergy skin tests may be that CMS instituted a set of coding edits that limited the number of such tests that are payable when furnished during a single patient encounter.

Changes in the volume of physician visits in nursing homes provide another example. From 2005 to 2006, units of service went up by 3.9 percent, and volume went up by 15.5 percent, for an 11.2 percent increase in intensity. One explanation for the increase in intensity may be that payment policy for a related type of service—consultation—changed in 2006. As discussed elsewhere in this chapter, some consultation billing codes were deleted in 2006 because other codes are available to more accurately bill for the services involved. Some of those codes, in turn, are for nursing home visits. Thus, a change in billing—from consultations to nursing home visits—could have led to an increase in intensity for the nursing home visit type of service. In addition, the increase in intensity accompanied implementation of new billing codes—and service definitions—for nursing home visits in 2006. ■

by the DRA and recommended by the Commission (MedPAC 2005).

Although all broad categories of service increased in volume in 2006, some individual services decreased. For instance, the largest volume decrease (8.1 percent) was for coronary artery bypass graft (CABG). We have seen decreases in CABG volume previously, and they likely represent continued substitution of less invasive services for this procedure. There was also a 5.3 percent decline in volume in the "minor other procedures" category that includes outpatient rehabilitation. Annual spending limits on outpatient rehabilitation—referred to as the "therapy caps"—went into effect on January 1, 2006, and volume for these services decreased 13.0 percent.<sup>12</sup> Consultation

is another noteworthy type of service. While the decrease in consultation volume was small (0.7 percent), units of service went down by 6.7 percent. The decrease is primarily due to deletion of certain billing codes in this category, which were deleted because they were often used incorrectly and because other codes are available for billing the services involved (McKenzie and Baker 2006).

### **Volume growth and policies to improve the value of physician services**

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 2006). 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.

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 by factors such as the demographic characteristics of the beneficiary population and new technology (Beeuwkes Buntin et al. 2004; MedPAC 2004a; Fisher et al. 2003a, 2003b). Moreover, it is difficult to determine whether broad-based growth in volume is improving the health and well-being of Medicare beneficiaries; greater use of evidence-based services can improve the quality of care, but 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.

To help ensure that Medicare spending is giving good value, the Commission has addressed several issues related to the volume of physician services. First, rapid volume growth may be a sign that some prices in the physician fee schedule are inaccurate. To improve the accuracy of those prices, the Commission has recommended steps the Secretary can take, such as establishing an expert panel that would help CMS identify potentially overvalued services. Second, the volume of services includes many new diagnostic and therapeutic services that have disseminated quickly into medical care without providers knowing whether they outperform existing services. The Commission has recommended that the Congress charge an independent entity with sponsoring credible research on the comparative effectiveness of health care services and disseminating this information to patients, providers, and public and private payers. Third, research comparing geographic areas has shown that the volume of services varies widely and that more care is not necessarily better care. Here, the Commission has recommended that CMS

measure physicians' resource use and share the results with physicians.

### **Volume growth as a signal for mispriced fee schedule services**

Fee-schedule mispricing may be one factor contributing to the disparity in volume growth among services. In previous work, MedPAC has made recommendations on improving the accuracy of fee schedule payments to prevent market distortions for physician services (discussed in more detail in the text box on p. 97). For example, work RVUs for rapidly growing services may need to be revalued if physicians' increased proficiency in performing a service means that less work effort is required to perform it. Practice expense RVUs may be subject to distortions over time 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. E&M 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 difficult for a physician to perform an office visit faster or fit more of them 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 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

**TABLE  
2B-5**

**Physician services with high spending growth, 2001–2006**

HCPCS	Description	First year in fee schedule	Most recent review of work RVUs		Allowed charges	
			Year	Change in work RVUs	2006 (in millions)	Average annual percent change 2001–2006
53850	Prostatic microwave thermotherapy	1998	—	—	\$136.8	55%
64483	Injection, anesthetic agent and/or steroid	2000	—	—	100.2	43
64475	Injection, anesthetic agent and/or steroid	2000	—	—	83.3	41
95811	Sleep testing, polysomnography	1998	—	—	123.4	37
66982	Cataract surgery, complex	2001	—	—	81.4	36
35476	Angioplasty, therapeutic component	1992	1997	0	129.0	35
27245	Repair thigh fracture	1993	—	—	82.4	34
76005	Fluoroscopic guidance for spinal injection	2000	—	—	88.5	34
72194	CT, pelvis	1992	1997	0	64.8	31
74183	MRI, abdomen	2001	—	—	81.9	30

Note: HCPCS (Healthcare Common Procedure Coding System), RVU (relative value unit), CT (computed tomography). Eligible codes had allowed charges of at least \$10 million in 2001. If no year is listed for review, service has not been reviewed.

Source: CMS proposed and final rules for 1992, 1997, 2002, and 2007 and MedPAC analysis of claims data for 100 percent of beneficiaries.

furnishing the service to Medicare beneficiaries and the hours those physicians work. Analyses would also need to consider how changes in practice inputs (e.g., nonphysician staff and equipment) may change the output of physician services.

CMS could use the results from these analyses to flag services for closer examination by CMS, specialty societies, or the American Medical Association Relative Value Scale Update Committee (RUC). 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 adjust the RVUs for such potentially misvalued services and the RUC would review the changes during its regular five-year review process.

To illustrate, we analyzed data for 2001 to 2006 and identified the physician services growing most rapidly (Table 2B-5). While spending for all physician services grew at an average annual rate of 6 percent, spending growth for the top 10 services ranged from 30 percent to 55 percent annually. Checking the history of the RUC’s review of RVUs for these services, we see that either they

have never been reviewed or they have not been reviewed in the last 10 years—since 1997. Such services are examples of those that could be considered during a more timely review process for adjustment by the Secretary or as part of an automatic adjustment policy.

Corrections to the practice expense (PE) values may also be in order. In its June 2007 report, the Commission examined how CMS determines PE payment rates in the physician fee schedule; PE payments accounted for close to half of the \$58 billion Medicare spent under the fee schedule in 2005 (MedPAC 2007). Beginning in 2007, CMS is using new methods to calculate direct and indirect PE RVUs, using the same approach to calculate PE RVUs for services that do and do not involve physician work, and using more current practice cost data to calculate indirect PE RVUs for eight specialty groups. Effects of these new PE methods and data are a reminder that changes in payment policy often redistribute payments across services. When CMS fully implements the PE changes in 2010, PE RVUs will increase by 7 percent for E&M services and by 3 percent for other (nonmajor) procedures and tests. By contrast, PE RVUs will decrease by 8 percent for major procedures and by 9 percent for imaging services.

## 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 RUC meetings. 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, site of service, practice expense, and other factors that may indicate changes in physician work. The Secretary could go further to institute automatic revisions for services that have experienced such changes. ■

Making payments for PE more accurate could include changing the fee schedule's adjustment of payments to account for geographic differences in practice costs. As discussed in the Commission's June 2007 report, payments for PE would be more accurate if the adjustment excluded costs that do not vary geographically, such as equipment and supplies (MedPAC 2007). In addition, the Commission discussed reasons why CMS should revisit how it estimates the per service price of equipment, in particular the assumption that all equipment is operated half the time that practices are open for business.

### **Producing comparative-effectiveness information about physician services**

With a resource-based payment system such as Medicare's physician fee schedule, physicians and other providers

have an incentive to adopt new services into their practices—particularly those that are profitable—without knowing whether they outperform existing diagnostic and therapeutic services. The payment system accounts for only the number of billable services furnished to Medicare beneficiaries and the resources consumed in furnishing those services. The result is that more resources are consumed with no assurance that they improve value.

To counter these forces, comparative-effectiveness information can help health care providers and patients make informed decisions about alternative services for diagnosing and treating most common conditions. It can also reveal services that are needed but underused. As we discuss on p. 98, options exist for using comparative-effectiveness information in payment policy as a way to improve value.

With little available information that compares the effectiveness of a service with its alternatives, the Commission has recommended that the Congress charge an independent entity with producing credible, empirically based information on comparative effectiveness, information that would help providers and patients make informed decisions about alternative services for diagnosing and treating common clinical conditions. The entity would:

- be independent and have a secure and sufficient source of funding;
- produce objective information and operate under a transparent process;
- seek input on agenda items from patients, providers, and payers;
- re-examine the comparative effectiveness of interventions over time;
- disseminate information to providers, patients, and public and private payers; and
- have no role in making or recommending coverage or payment decisions for payers.

Such an investment could lead to future use of comparative-effectiveness information in Medicare's payment policies. Options for doing so include:

- creating a tiered cost-sharing structure that costs patients less for services that show more value to the program;
- not paying the additional cost of a more expensive service if evidence shows that it is clinically comparable to its alternatives; and
- requiring manufacturers to enter into a risk-sharing agreement, which links actual beneficiary outcomes to the payment of a service based on its comparative effectiveness.

In addition, comparative-effectiveness information could inform the level of payment. For instance, a new set of budget-neutral RVUs could be established in the fee schedule. These RVUs would go beyond the current RVUs, which only account for differences among services in resource costs. The new RVUs would be value-based RVUs that would be greater than zero if evidence shows that a service is more effective relative to available alternatives, and zero otherwise.

Some uncertainty would accompany development of such a new set of RVUs. Very little information on comparative effectiveness is currently available. Developing this information would be a significant undertaking, and the number of services for which such RVUs could be developed may turn out to be small. In addition, many services—for example, office visits—are used in diagnosing and treating a broad range of conditions. Developing comparative-effectiveness information for discrete physician services may be very difficult, if not impossible.

### **Measuring and providing feedback on physician resource use**

Medicare beneficiaries in regions of the country where physicians and hospitals deliver many more health care services do not experience better quality of care or outcomes, nor do they report greater satisfaction with their care (Fisher et al. 2003a, 2003b). Thus, the nation could potentially spend less on health care, without sacrificing quality, if physicians whose practice styles are more resource intensive reduced the intensity of their practice.

In the March 2005 Report to the Congress, the Commission recommended that CMS measure physicians' resource use over time and share the results with physicians (MedPAC 2005). Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (when available) recommends, and revise their practice styles as appropriate.<sup>13</sup> Moreover, when physicians are able to use this information in tandem with information on their quality of care, they will have a foundation for improving the value of care beneficiaries receive.

Private insurers increasingly measure resource use to contain costs and improve quality (MedPAC 2004b).<sup>14</sup> Evidence on measuring the effectiveness of resource use in containing private sector costs is mixed and varies depending on how the results are used. Providing feedback on use patterns to physicians alone has been shown to have a statistically significant, but small, downward effect on resource use (Balas et al. 1996, Schoenbaum and Murray 1992), but, when paired with additional incentives, the effect on physician behavior can be considerably larger (Eisenberg 2002).

Medicare's feedback on resource use may be more successful than previous experience in the private sector. As Medicare is the single largest purchaser of health care, its reports should command greater attention. In



addition, because Medicare's reports would be based on more patients than private plan reports, they might have greater statistical validity and acceptance from physicians. Confidential feedback of the results to physicians might be sufficient to induce some change. Many physicians are highly motivated individuals who strive for excellence and peer approval (Tompkins et al. 1996). If identified by CMS as having an unusually resource-intensive style of practice, some physicians may respond by reducing the intensity of their practice. However, confidential information alone may not be sufficient to have a sustained, large-scale impact on physician behavior.

Using results for physician education would provide CMS with experience using the measurement tool and allow the agency to explore the need for refinements. Similarly, physicians could review the results, make changes to their practice as they deem appropriate, and help shape the measurement tool. Once greater experience and confidence were gained, Medicare could use the results for payment—for example, as a component of a pay-for-performance program (which rewards both quality and efficiency). Alternatively, the results could be used as a method allowing Medicare to create other financial incentives for greater efficiency or to enable beneficiaries to identify physicians with high-quality care and more conservative practice styles. Collaboration between the program and private plans could speed development of a standard report card, which is likely to be more useful than multiple report cards. At the same time, CMS could use the measurement tool to flag unusual patterns of care that might indicate misuse, fraud, or abuse.

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## **How should Medicare payments for physician services change in 2009?**

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Our payment adequacy analysis shows that beneficiaries' overall access to physician services is good but that pockets of access difficulties exist, especially for the small percentage of beneficiaries who look for a new primary care physician. Our analysis also indicates that the quality of most services provided by physicians for screening, diagnosing, or treating the most prevalent medical conditions among elderly Medicare beneficiaries is either stable or improving. While our analysis of service volume growth in 2006 found that the rate of growth was somewhat slower than in previous years, we remain concerned about the continual growth in the volume of and

spending on physician services as well as the implications of that growth for the sustainability of the Medicare program overall.

In addition to analyzing overall payment adequacy, we also consider changes in input costs for physician services projected for the coming year and a productivity adjustment.

### **Input price increases**

To measure input price inflation for physician services, we use information that CMS collects from various data sets and surveys. CMS provides a weighted average of price changes for inputs used to provide physician services. For 2009, CMS forecasts that input prices for physician services will increase by 2.6 percent. This forecast includes an estimated 2.7 percent increase in physician work compensation (2.4 percent for wages and salaries and 3.5 percent for nonwage compensation) and practice expense cost increases of 2.4 percent (Table 2B-6, p. 100).<sup>15</sup> This forecast excludes productivity adjustments that are calculated by CMS and integrated into the publicly released Medicare Economic Index (MEI); thus, it is higher than CMS's publicly released MEI.

### **Productivity adjustment**

The productivity adjustment reflects the Commission's policy principle that Medicare's payment systems should encourage efficiency in the provision of Medicare services. The Commission's approach links the adjustment for improving efficiency to the productivity gains achieved by the firms and workers who pay the taxes and premiums that fund Medicare benefits. Our productivity adjustment is set equal to the Bureau of Labor Statistics' estimate of the 10-year average growth rate of multifactor productivity in the general economy, which is currently 1.5 percent. CMS uses a similar method for adjusting input costs when calculating the MEI.

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### **Update recommendation**

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The Commission's recommendation is that for 2009 the Congress should increase the physician fee schedule conversion factor by the projected change in input prices less the Commission's adjustment for productivity growth. With the current estimate of input cost changes in 2009 of 2.6 percent and the Commission's productivity adjustment of 1.5 percent, the Commission's recommended 2009

**TABLE  
2B-6**

**Forecasted input price increases and weights for physician services for 2009**

<b>Input component</b>	<b>Price increases for 2009</b>	<b>Category weight</b>
<b>Total</b>	<b>2.6%</b>	<b>100.0%</b>
<b>Physician work</b>	<b>2.7</b>	<b>52.5</b>
Wages and salaries	2.4	42.7
Fringe benefits (nonwage compensation)	3.5	9.7
<b>Physician practice expense</b>	<b>2.4</b>	<b>47.5</b>
Nonphysician employee compensation	2.9	18.7
Wages and salaries	2.9	13.8
Fringe benefits (nonwage compensation)	2.8	4.8
Office expense	2.1	12.2
Professional liability insurance	2.3	3.9
Medical equipment	0.7	2.1
Drugs and supplies	3.0	4.3
Pharmaceuticals	1.7	2.3
Medical materials and supplies	3.9	2.0
Other professional expense	2.1	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 total exactly due to rounding.

Source: Unpublished estimates from CMS, dated December 4, 2007.

update would be 1.1 percent. CMS revises the input cost projections on a quarterly basis, so the actual update percentage may change.

The Commission is not satisfied with the current physician payment update mechanism, for reasons we discussed in our March 2007 report, *Assessing Alternatives to the Sustainable Growth Rate System* (MedPAC 2007b). The existing SGR formula continues to call for substantial consecutive negative updates through 2016, and the Commission continues to be concerned that repeated annual reductions in physician payment rates would threaten beneficiaries' access to physician services. We are especially concerned about the impact that repeated negative updates would have on access to primary care services, the increased use of which Medicare should be actively encouraging, not hindering, given the potential of primary care to improve the quality and efficiency of health care delivery.

The Commission is also concerned about how the distribution of Medicare physician payments is distorted by incentives that encourage the overuse of some services and underuse of others. Medicare's FFS payment system

does not systematically 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.

The Commission examined several alternative approaches to improving the current physician payment system in *Assessing Alternatives to the Sustainable Growth Rate System* and said that Medicare's physician payment system should include incentives for physicians to provide better quality of care, to coordinate care across settings and medical conditions, and to use resources judiciously. The Commission has made specific recommendations in its past reports to move the payment system toward these goals, and the second part of our payment policy recommendations in this chapter is intended to keep Medicare moving toward those goals.

Specifically, the Commission recommends that the Congress enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis starting in 2009 for a period of two years, after which data on physician resource use should be made public. The Congress should also direct

that, at the end of this two-year period, CMS should be positioned to implement physician payment rate adjustments based on physician resource use information. The Congress should allocate sufficient administrative resources to CMS to achieve this policy goal within the recommended two-year time frame.

## RECOMMENDATION 2B

**The Congress should update payments for physician services in 2009 by the projected change in input prices less the Commission's adjustment for productivity growth. The Congress should enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.**

## 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. However, the negative fee schedule update in 2009 required under current law could reduce access to physician services for Medicare beneficiaries. Thus, we recommend that the Congress change current law to update the physician fee schedule conversion factor for 2009 by the projected change in input prices in 2009 less the Commission's adjustment for productivity growth.

The second part of our recommendation is intended to improve the value of physician services purchased by Medicare, by directing CMS to measure and report Medicare resource use attributable to physicians for two years on a confidential basis. It will take time for CMS to develop the infrastructure and work constructively with stakeholders to implement accurate and actionable resource use measurement and reporting systems. CMS should begin the operational development process now to be prepared to use it for public reporting and for payment policy if and when authorized to do so by the Congress.

## IMPLICATIONS 2B

### Spending

- Our estimates indicate that the update recommendation for 2009 would increase federal program spending by more than \$2 billion in the first year and by more than \$10 billion over five years, relative to current law. Enactment of any positive

update for 2009 would increase spending relative to current law, because current law calls for substantial negative updates from 2009 through 2016 under the current SGR system.

### Beneficiary and provider

- Relative to current law, the update recommendation would increase the monthly Part B premium and per service coinsurance amounts paid by Medicare beneficiaries (or paid on their behalf by state Medicaid programs, in the case of dual eligibles).

## Additional comments

In this chapter, we have discussed three opportunities for improving the value of Medicare—using volume growth as an indicator of services that may be misvalued, producing information on comparative effectiveness, and measuring physician resource use. In future reports, the Commission will pursue other ways to use physician payment policy to improve value. The Commission intends to continue its consultations with physicians and other important stakeholders as it analyzes and discusses these policy options, and CMS also should continue to engage the physician community in its initiatives. One option that both the Commission and CMS are exploring are “medical home” programs, which, if designed carefully, may be a way to improve the value of physician and other health care services. Important design issues remain if Medicare is to implement a medical home program. Our next step will be to explore these design issues, moving forward from the Commission's previous work on care coordination (MedPAC 2006).

Another concern is that Medicare FFS payment reinforces a fragmented health care delivery system that discourages coordination of care between physicians and hospitals and does not hold providers accountable for quality and resource use. Bundling payments—for care provided around a hospitalization, for example—could improve incentives and foster greater “systemness.” The Commission is considering ways to implement bundling in Medicare and may make recommendations to the Congress in this area later this year. ■

## Endnotes

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- 1 TRHCA allowed the 2007 conversion factor to be cut by 5 percent as directed by the SGR but then funded a 5 percent bonus to the 2007 conversion factor through Medicare's Supplementary Medical Insurance (Part B).
- 2 In past years, our physician payment adequacy analysis has included data from other surveys of beneficiaries, such as the Consumer Assessment of Healthcare Providers and Systems for Medicare FFS (CAHPS®–FFS) and the Targeted Beneficiary Survey (TBS), both sponsored by CMS. Data from the 2006 CAHPS–FFS were not available in time for inclusion in this report, and the most recent TBS was conducted in 2003 and 2004 so the results were deemed out of date for purposes of the payment adequacy analysis in this report.
- 3 Statistical significance is measured at a 95 percent confidence interval ( $p \leq 0.05$ ) by a two-tailed *t*-test.
- 4 For this analysis, we excluded certain types of specialties that do not typically serve most Medicare beneficiaries, such as all pediatric specialties, obstetrics/gynecology, and medical genetics. Physicians with specialties of anesthesiology, radiology, and pathology are excluded by the NAMCS sampling frame.
- 5 More information on the results of MedPAC's 2006 survey of physicians is available in Chapter 2B of our March 2007 Report to the Congress (MedPAC 2007d).
- 6 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 the year or only on an emergency or temporary basis while covering for colleagues.
- 7 The method used for the comparison involves calculating a price index for each type of private plan (HMO, point of service, preferred provider organization (PPO), 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 weight. The plan-specific estimates are then weighted based on the Kaiser Family Foundation and Health Research and Educational Trust yearly estimates of private enrollment in each type of plan for 2006 (Kaiser Family Foundation HRET 2007). To address enrollment in high-deductible health plans (HDHPs), we classified them as PPOs for enrollment distribution and payment rate purposes, because health plan industry sources indicate that 90 percent of HDHP enrollees are offered these options off of a PPO "platform."
- 8 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 able to fully 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 is likely to be lower than the actual ratio in certain markets across the nation.
- 9 A text box on p. 96 of MedPAC's March 2006 Report to the Congress describes development of the MACIEs in more detail (MedPAC 2006).
- 10 CMS is currently sponsoring a demonstration project called the Medicare Physician Group Practice Demonstration 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.
- 11 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 the volume of chemotherapy drugs increased 12 percent from 2003 to 2004 and the volume of erythropoietin (for patients without end-stage renal disease) grew 36 percent (Hogan 2005).
- 12 The outpatient therapy cap policy in effect in 2006 and 2007 included a routine, automated exceptions process.
- 13 Potential changes in practice style could include not only modifying the number and types of services provided and the sites of those services but also using more nonphysician, less-expensive resources to reduce spending and use of costly services.
- 14 MedPAC identified this trend in a series of interviews conducted with health plans and consultants. Nearly all plans and purchasers mentioned measuring resource use as central to their cost-containment and quality-improvement strategies. Some collected information and gave it back to patients or providers, while others used it as a basis to pay bonuses to providers, and still others used it to select providers to be in preferred tiers or limited network plans.

15 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 then uses a contractor to obtain estimates of price changes for each input. Currently, 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 fielding a new survey that can help CMS update the Medicare Economic Index category weights. The new survey was initially fielded in April 2007, but the response rate was much lower than expected. AMA has since redesigned and refiled the survey and extended the field period through 2008.

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