CHAPTER 9

Review of CMS's preliminary estimate of the physician update for 2006

CHAPTER 9

Review of CMS's preliminary estimate of the physician update for 2006

In this chapter

- Spending growth in 2004
- Preliminary estimate of the physician update for 2006
- Making the case for change

CMS has an annual requirement to use a statutory formula and calculate a preliminary estimate of the next payment update for physician services and to send the estimate to MedPAC. MedPAC must then include a review of the estimate in its June report to the Congress. For 2006, CMS's estimate is an update of –4.3 percent. In general, we find that in calculating the update, CMS used estimates that are consistent with recent trends. In sending MedPAC this estimate, CMS raises a second issue: rapid growth in spending for physician services in 2004 (Kuhn 2005). CMS's preliminary analysis shows that increases in the volume of a broad range of services—office visits, minor procedures, imaging, laboratory and other tests, and drugs administered in physician offices—explain the vast majority of the increase in spending. Increases of this magnitude raise technical and policy questions and may argue for changes in the way Medicare pays for physician services, consistent with MedPAC's recommendations on paying for performance, measuring resource use, reforming the payment update for physician services, and developing quality standards for imaging providers. Future recommendations could come from planned Commission work on laboratory services, physical therapy, and possible mispricing of payments under the physician fee schedule.

Physicians are central to the delivery of health care. They evaluate and manage patients, decide when hospitalization is necessary, perform surgery in hospitals and ambulatory settings, prescribe drugs, and direct nurses and other professionals in various settings, including nursing homes, home health agencies, and dialysis facilities.

CMS's preliminary estimate is that Medicare spending for physician services rose sharply by 15.2 percent in 2004 (Kuhn 2005). Its preliminary estimate of the physician update for 2006 is –4.3 percent. The spending increase and the update are linked: A statutory formula adjusts the update if spending differs from a target based on growth in the national economy.

We expected a negative update for 2006. A large difference has accumulated between actual spending and the target. In addition, the Congress prevented negative updates that would have occurred in 2004 and 2005 in the absence of intervention. The spending increase in this preliminary estimate is large and requires further study because it has implications for the financing of Medicare and beneficiaries' out-of-pocket spending. In addition, such a large one-year increase would raise technical and policy questions about why the increase occurred and how much of it is due to better diagnosis and care versus spending that is not necessary and not contributing to the quality of care.

TABLE 9-1 **Spending growth varies by type of service, 2003–2004**

Type of service	Percent of spending	Spending increase
Visits	38%	11%
Minor procedures	20	22
Imaging	14	22
Laboratory and other tests	12	17
Part B drugs	10	17
Major procedures	6	8
Other	1	13
Total	100	15

Note: In the first column of numbers, percentages may not necessarily add to the total, due to rounding. The total spending increase is a weighted average, so the spending increases by type of service do not add to the total.

Source: Kuhn 2005 and unpublished data from CMS.

In this chapter, we discuss the implications of the spending growth in 2004. We also review the preliminary estimate of the 2006 physician update. CMS is required to submit such an estimate to MedPAC in accordance with a provision in the Balanced Budget Refinement Act of 1999 (BBRA). The BBRA also requires a MedPAC review of the estimate as part of the Commission's June report. In reviewing CMS's estimate, MedPAC's purpose is not to assess the adequacy of the update. Our analysis of the update for 2006 can be found in our March 2005 report to the Congress (MedPAC 2005). Instead, we limit our review to the technical issues involved in CMS's use of the statutory formula to calculate the update.

Spending growth in 2004

CMS states that the surge in spending occurred across a broad range of services (Table 9-1). The highest growth occurred in two categories—minor procedures and imaging, with spending for each category growing by 22 percent in one year. CMS attributes much of the increase in minor procedures to spending for chemotherapy administration and physical therapy. The increase in spending for chemotherapy administration is at least partly due to an increase in payments for the services required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Spending growth was also high for Part B drugs and for laboratory and other tests, with spending for each category growing by 17 percent.[1]

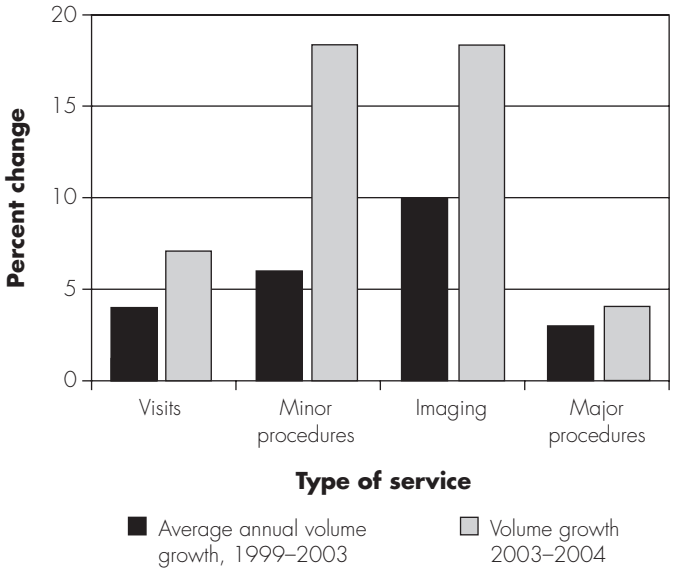
CMS attributes most of the overall rise in spending to growth in the volume of services. Growth in the number of beneficiaries accounts for only a small fraction of the increase, and CMS estimates that legislative changes—namely, provisions in the MMA—account for only about one-fifth of the increase. To understand more about the volume growth, CMS plans to work further on this issue and to discuss the results with the physician community and other stakeholders. Indeed, referring to MedPAC recommendations on measuring quality and resource use, CMS is exploring ways to confidentially share information with individual physicians about how their practices compare with those of their peers (MedPAC 2005).

In the meantime, MedPAC has analyzed 2004 volume growth for services that it has studied previously—

services that Medicare pays for under the physician fee schedule. To conduct this analysis, we decomposed CMS spending growth rates into their components: enrollment growth, the physician update for 2004, and a change in law concerning the geographic practice cost indexes (GPCIs) in the fee schedule.[2] This decomposition left a residual spending increase that we can interpret as growth in the volume of services (Boards of Trustees 2005).[3] We then compared that measure of 2004 volume growth with estimates of volume growth from 1999 to 2003 (MedPAC 2005). The results agree with CMS's conclusions about volume growth: For the services studied, growth in the volume of physician services in 2004 was considerably higher than it was from 1999 to 2003 (Figure 9-1). The biggest difference (12 percentage points) was in minor procedures, which increased 18 percent in 2004 compared with average annual growth of 6 percent from 1999 to 2003. Growth in the volume of imaging was also much higher in 2004: Eighteen percent in 2004 compared with 10 percent annually from 1999 to 2003.

FIGURE 9-1

Volume grew more rapidly in 2004 than in previous years



Note: For minor procedures, volume growth from 2003 to 2004 includes changes in the structure of payments for chemotherapy administration.

Source: MedPAC analysis.

Did all of the increases in 2004 represent services that beneficiaries need? It is possible that some of the increases are due to factors often cited as reasons for growth in spending and use of services: technological innovation, defensive medicine, direct-to-consumer advertising, shifts in the site of care, and adherence to clinical guidelines that call for more intensive treatment of chronic illness. These factors, however, are not likely the whole story because all of them have been at work for at least several years. Referring to one component of the growth in spending—a 25 percent increase in spending for advanced imaging—the CMS administrator said during a press briefing that nothing suggests that such an increase is appropriate (Precht 2005).

One consequence of the spending increase is that CMS now expects the monthly Medicare Part B premium to rise higher than previously expected—perhaps by another $1.50. This increase would be on top of the $9.50 increase already contemplated for 2006 by the trustees of the Medicare trust funds and would result in a net 14 percent increase in the premium. The increase would follow the large 17 percent increase for 2005 (Boards of Trustees 2005).

Another effect of the spending increase is a larger Part B claim on the general revenues of the U. S. Treasury. Not only does this claim impose a burden on taxpayers, but it also increases the likelihood that spending will reach a trigger in the MMA. This trigger requires legislative action if general revenues exceed 45 percent of total outlays for the Medicare program.

The jump in spending and the associated increase in use of services also raise concerns about the quality of care. By the Institute of Medicine's definition, quality problems include not just misuse and underuse of services but also overuse (Institute of Medicine 2001). If some of the increase represents overuse of services, it may have negatively affected the quality of care.

The magnitude of the spending increase in 2004 and its effects argue for change; the question is, how can the payment system for physician services be part of that change? As MedPAC has stated previously, the physician fee schedule—indeed, all of Medicare's payment systems—is neutral or negative toward quality. The Commission has also said that the update formula for physician services is inequitable because it treats all physicians and regions of the country alike regardless of their individual efficiency in furnishing care. And we further suspect that payments and costs for imaging

TABLE 9-2 **Preliminary sustainable growth rate, 2006**

Factor	Percent
Change in:	
input prices	2.8%
traditional Medicare enrollment	–2.5
real GDP per capita	2.3
Change due to law and regulations	0.0
Sustainable growth rate	2.5

Note: GDP (gross domestic product). Percents are converted to ratios and multiplied, not added, to produce the sustainable growth rate.

Source: Kuhn 2005.

services are misaligned because CMS bases the payments for practice expense on historical charges instead of relative resource use.[4] There are likely other examples of mispriced services.

These and other problems have prompted MedPAC to make a series of recommendations on paying for performance, measuring resource use, reforming the payment update for physician services, and developing quality standards for imaging providers (MedPAC 2005). More recommendations may come from work we have planned on laboratory services and physical therapy. As we discuss in more detail later in this chapter, other issues concern the physician fee schedule and possible mispricing of services, which could have an effect on the volume of services. We plan to address such issues in the context of reviewing Medicare's experience with the physician fee schedule now that it has been in place for over a decade. However, before we discuss these plans, we fulfill our statutory requirement to review CMS's estimate of the physician update for 2006. In general, we find that in calculating the update, CMS used estimates that are consistent with recent trends.

Preliminary estimate of the physician update for 2006

Medicare pays for physician services according to a fee schedule that assigns relative value units (RVUs) to services, reflecting resource requirements. These RVUs are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. Thus, the conversion factor is a key element of the payment system. Changes in the conversion factor trigger proportional changes in the payment rates for all of the more than 7,000 services represented in the physician fee schedule.

CMS updates the conversion factor annually, based on a formula in law that is designed to control spending while accounting for factors that affect the cost of physician services. CMS issues a final rule on the update in November of each year and implements the update on January 1 of the following year. To help the Congress and others anticipate the update, the BBRA requires CMS to prepare, by March 1 of each year, a preliminary estimate of the next year's update. The BBRA also requires MedPAC to review that estimate in the Commission's June report. This chapter fulfills that requirement for the 2006 update.

Calculating the update

Calculating the update is a two-step process. First, CMS estimates the sustainable growth rate (SGR). The SGR is the target rate of growth in spending for physician services and is a function of projected changes in:

- input prices for physician services;[5]
- real gross domestic product (GDP) per capita, an allowance for growth in the volume of services;[6]
- enrollment in traditional fee-for-service Medicare; and
- spending attributable to changes in law and regulation.

For 2006, CMS's preliminary estimate of the SGR is 2.5 percent (Table 9-2).

Second, CMS calculates the update, which is a function of:

- the change in input prices for physician services,[7] and
- an update adjustment factor that increases or decreases the update as needed to align actual spending, cumulated over time, with target spending determined by the SGR.

The estimate of the change in input prices for 2006 is 2.9 percent (Table 9-3). The more important part of the update calculation, however, is the update adjustment factor,

which CMS estimates at –7.0 percent, the maximum negative adjustment permitted under current law. When we combine this adjustment with the estimated change in input prices, the result is an update of –4.3 percent.

The update adjustment factor is the link mentioned earlier between spending and the update. The factor is negative because actual spending for physician services started to exceed the target in 2000 and has since remained above the target (Figure 9-2). Indeed, the update adjustment factor would be –21.1 percent if not for the –7.0 percent limit.

Reviewing CMS's estimate

Because the update adjustment factor is well beyond the statutory limit, MedPAC anticipates no changes in CMS's estimates that would change the update. In the 2006 SGR, the estimate of the change in input prices, as measured by the Medicare Economic Index (MEI), is similar to changes in the MEI for earlier years.[8] The change in real GDP per capita of 2.3 percent equals the 10-year moving average of real GDP estimates from the Bureau of Economic Analysis (BEA), adjusted for population growth (BEA 2005).

CMS expects no measurable changes in spending due to law and regulation for 2006.[9] Provisions in the MMA will expire then (e.g., floors on the GPCIs for Alaska), but CMS anticipates that the drop in spending will be very small—less than 0.1 percent. CMS also considered implementation of the Medicare Part D drug benefit and the possible effects of the benefit on the use of physician services. The agency chose not to include a specific spending change in the SGR related to the Part D benefit, relying on a recommendation of the Technical Review Panel on the Medicare Trustees Report (2004). The panel concluded that Part D could lead to higher or lower use of other health services, and the panel agreed with an assumption of no effect on utilization or costs in Part A or Part B. However, the panel recommended further research on the topic to take advantage of the natural experiment offered by implementation of Part D. Depending on the results of this research, CMS could revise the SGR's law and regulation factor in the future.

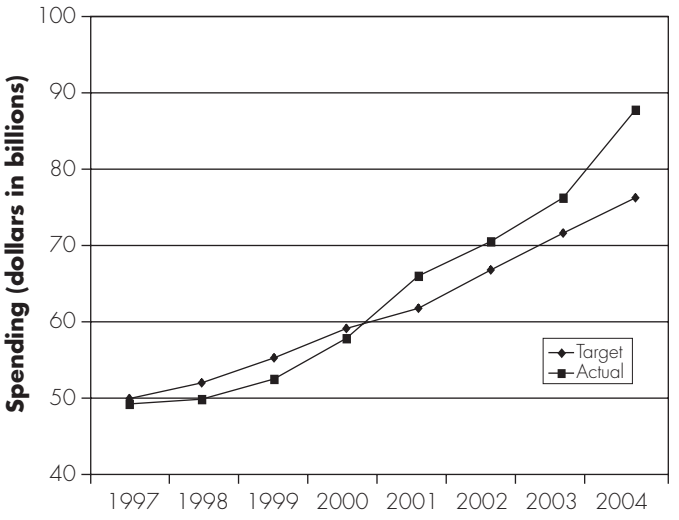
TABLE 9-3 **Estimate of the update for physician services, 2006**

Factor	Percent
Change in input prices	2.9%
Change in adjustment factor	–7.0
Update	–4.3

Note: Percents are converted to ratios and multiplied, not added, to produce the update.

Source: Kuhn 2005.

FIGURE 9-2 **Through 2004, actual spending for physician services exceeded target**



Source: Office of the Actuary 2005.

The remaining factor in the SGR estimate for 2006—the change in fee-for-service enrollment—is also uncertain. CMS assumes a decrease in fee-for-service enrollment of 2.5 percent (Table 9-2). This figure differs from the Congressional Budget Office's (CBO's) enrollment projection, which is an increase in fee-for-service enrollment of 0.5 percent for fiscal year 2006. A decrease would occur if some enrollment shifts from Medicare fee-for-service to Medicare Advantage (MA). The magnitude of such a shift (if it occurs) remains unclear, but CMS will know more in June 2005 when MA plans submit bids and identify market areas. CMS can then revise the enrollment projection, if necessary, before the update becomes final in November 2005. Even then, CMS will have limited information on changes in enrollment in 2006, but the agency will have another two years to revise

TABLE 9-4

Impact of the practice expense GPCI on the payment rate for an equipment-intensive service

Example: MRI of lumbar spine without contrast material performed in a physician's office or IDTF, 2005

Locality with lowest practice expense GPCI: Missouri, excluding Kansas City and St. Louis

	RVU		GPCI		Adjusted RVU
Physician work	1.48	x	1.000	=	1.48
Practice expense	12.93	x	0.813	=	10.51
PLI	0.71	x	0.892	=	+ 0.63
					12.63
			Conversion factor		x $37.90
			Payment rate		**$478.47**

Locality with highest practice expense GPCI: San Francisco

	RVU		GPCI		Adjusted RVU
Physician work	1.48	x	1.064	=	1.57
Practice expense	12.93	x	1.501	=	19.41
PLI	0.71	x	0.651	=	+ 0.46
					21.44
			Conversion factor		x $37.90
			Payment rate		**$812.71**

Note: GPCI (geographic practice cost index), MRI (magnetic resonance imaging), IDTF (independent diagnostic testing facility), RVU (relative value unit), PLI (professional liability insurance). Results may not equal numbers shown due to rounding. Localities considered are those in the continental United States.

Source: CMS 2004.

the enrollment estimate if better data become available, just as the agency does with changes in spending due to law and regulation.

Regardless of what happens with enrollment, CMS's calculation of the update for 2006 is very unlikely to change. To see the effect of an enrollment change, MedPAC substituted CBO's projection for CMS's projection, then calculated an update adjustment factor of –21.0 percent, almost the same as CMS's calculation of –21.1 percent based on its own estimate of enrollment growth.

The only remaining issue concerns CMS's estimates of actual spending for 2004 and 2005. Data on actual spending are nearly complete through the first three quarters of 2004 but are less complete for the last quarter of that year. Therefore, the estimate of actual spending in 2004 may increase or decrease somewhat before CMS issues a final rule on the update in November 2005. Of course, the uncertainty regarding 2005 estimates is greater than for 2004 because CMS currently has very little information on actual spending for 2005.

To address these uncertainties, the agency has used stochastic projection techniques to analyze variation in the update adjustment factor (Office of the Actuary 2005). Under a range of possible scenarios for growth in real GDP per capita and growth in the volume of physician services, the analysis shows a 100 percent probability that the update adjustment factor will equal the maximum negative adjustment of –7.0 percent.

A maximum negative adjustment has such a high probability because a different outcome would require an uncharacteristic decrease in spending for physician services in 2005. An update of 1.5 percent for 2005 has already occurred. Therefore, the only way in which spending could fall is through a substantial decrease in the volume of physician services per beneficiary. However, this decrease is very unlikely based on historical trends. From 1999 to 2003, for example, volume increased at an average annual rate of about 5 percent per year. As we discussed earlier, volume grew at an even higher rate in 2004. For this reason, MedPAC anticipates that CMS's update calculations (to be published in November 2005) will show the maximum reduction that the statute permits.

Making the case for change

Previously, the Commission has recommended policies that could work in tandem with the physician fee schedule, such as paying for performance, measuring resource use, and developing quality standards for imaging providers. Additional issues have emerged that are internal to the fee schedule. As such, they represent instances of possible mispricing. If mispricing includes Medicare overpaying for services, that mispricing could contribute to overuse of services—one of the concerns with the spending increase in 2004.

Adjusting payments geographically for input prices

Under the physician fee schedule, GPCIs adjust payment rates to account for differences in the price of inputs used in furnishing physician services. Three separate GPCIs correspond to each of three components of the fee schedule's relative value scale: physician work, practice expense, and professional liability insurance.

MedPAC's concern is with the practice expense GPCI. Current policy stipulates that the prices of some inputs—namely, equipment and supplies—do not vary geographically because physicians purchase those inputs in a national market, not locally. When constructing the GPCI, CMS accounts somewhat for this fact by holding constant the price of equipment and supplies. The problem is that the GPCI applies to the entire practice expense payment for all services, even though the cost of equipment and supplies, as a proportion of practice expense, varies by service. Therefore, for equipment- and supply-intensive services, payments are too high, relative to costs, in high-GPCI areas and too low, relative to costs, in low-GPCI areas.

The effect of the GPCI adjustment can be significant. The most frequently billed magnetic resonance imaging (MRI) study—MRI of the spine—is an example. In the locality with the lowest practice expense GPCI (areas of Missouri outside Kansas City and St. Louis), the payment rate for MRI of the spine is $478 (Table 9-4, p. 202). By contrast, the payment rate is $813—70 percent higher—in San Francisco, the locality with the highest practice expense GPCI.[10] The main reason for the difference is that the practice expense GPCI is 0.813 in the areas of Missouri. In San Francisco, it is 1.501. This difference prevails even though most of the direct costs of furnishing the service originate from the equipment, which physicians purchase in a national market.[11]

The problem with the practice expense GPCI varies, depending on the service. Across all services, equipment and supplies represented about 32 percent of direct costs, on average, in 2003 (Figure 9-3). For imaging services, however, equipment and supplies represented an average of 76 percent of direct costs. For other services—such as major procedures and evaluation and management (E&M)—equipment and supplies make up a lower-than-average share of direct costs. Within this latter group of services, the practice expense GPCI causes payments to be too low, relative to costs, in high-GPCI areas and too high, relative to costs, in low-GPCI areas.

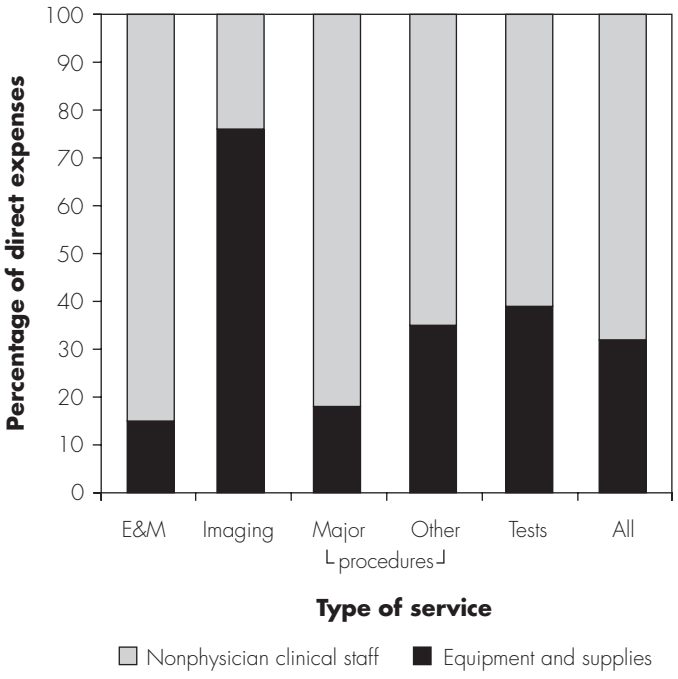
To assess the magnitude of this problem, MedPAC plans to analyze the correlation between the volume of the affected services—such as imaging—and the practice expense GPCI. To assess possible solutions, we plan to replicate CMS's practice expense methodology and to calculate the portion of each service's practice expense RVUs that we can attribute to equipment and supplies. In addition to illustrating the methods required, we can then model the payment effects of a policy change.

Revisiting the boundaries of payment localities

The GPCIs vary by geographic areas called payment localities. Of the 89 total payment localities, 34 consist of entire states (Figure 9-4). Initially, Medicare accepted the localities established by the contractors who process claims for Medicare. To set boundaries for the localities, the contractors used their knowledge of patterns in physician charges for services.

FIGURE 9-3

Direct expenses in practice expense RVUs, 2003



Note: RVU (relative value unit), E&M (evaluation and management).

Source: MedPAC analysis of practice expense input file from CMS, 2003; Medicare claims data for 100% of beneficiaries.

FIGURE 9-4

Physician fee schedule payment localities

Note: States with no shaded regions have one payment locality. Additional payment localities in the other states are indicated by variation in area shading.

Source: MedPAC analysis.

As another possible instance of mispricing of services, it may be time to revisit the boundaries of payment localities, at least in those states that do not have statewide localities. CMS has not revised the boundaries since 1997, when it consolidated 210 localities to the current 89 to simplify administration and reduce payment differences among adjacent geographic areas. In addition, physicians can initiate a change in the locality boundaries of their state. Some physicians are working toward such a change. For instance, the California Medical Association has proposed an increase in the number of localities in the state from 9 to 19.

Given that CMS has not reconfigured the localities in at least 8 years (and, in some cases, 40 years), the localities likely do not correspond to market boundaries for the inputs physicians use in furnishing services. As a result, Medicare is probably overpaying in some geographic areas and underpaying in others.

To revisit the locality boundaries, MedPAC plans to use data on input prices by county and identify cases in which the boundaries are inconsistent with variation in input prices beyond a predefined threshold. We can then model the effects of alternative locality configurations. The Commission could recommend alternative locality boundaries as appropriate.

Valuing services in the physician fee schedule

The fee schedule's RVUs are a key element of the payment system because the RVUs determine how payment rates vary, one service relative to another. Initially, research at Harvard University led to the RVUs that were implemented with the fee schedule in 1992. The expectation was that payment rates would rise for E&M services relative to other services, such as surgery and other procedural services. Analyses by the Physician Payment Review Commission (PPRC) and others showed that such changes in payment rates occurred (PPRC 1997, Iglehart 2002).

In addition to the changes in payment rates anticipated with implementation of the fee schedule, other factors have affected payments for physician services. CMS has reviewed and modified the RVUs for selected services after receiving recommendations from the RVS Update Committee (RUC).[12] CMS has established RVUs for new services using a similar process of receiving recommendations from the RUC. The volume of services has changed.

To understand the effects of these other factors affecting payments, MedPAC contracted with The Urban Institute for analyses of changes in RVUs over time and how those changes interact with growth in the volume of services. To measure these effects, the contractor developed a measure of RVU volume, which comprises units of service weighted by each service's RVU.

Preliminary findings from this work describe the effects of periodic RVU review,[13] the interaction between changes in RVUs and growth in the volume of services, and the effects of introducing new services—all during the first 10 years of experience with the physician fee schedule (Maxwell, Zuckerman, and Berenson 2005). In general, the findings highlight the importance of new services and the importance of the choices that CMS and the RUC make about the services whose RVUs are reviewed. The following specific findings are of particular interest to MedPAC:

- By 2002, CMS had not reviewed or revised the RVUs for about 50 percent of services, but those services accounted for only 16 percent of volume. For the services that accounted for the remaining 84 percent of volume, CMS had established the RVUs with recommendations from the RUC.
- CMS's review of RVUs has led to substantially more increases than decreases in RVUs because the process by which CMS and the RUC consider potentially misvalued services has given priority to services that may be undervalued rather than services that may be overvalued. The reviews have yielded this result even though the factors that can lead to a service becoming misvalued—technology diffusion, learning by doing, technology substitution, personnel substitution, reengineering, patient severity, and mandatory documentation—suggest that both undervalued and overvalued services are an issue.[14]
- Growth in units of service has driven growth in RVU volume for some services; however, for other services, growth in RVUs per unit of service was the more important factor underlying growth in volume.
- In addition to volume growth, the introduction of new services has shifted the distribution of total RVU volume among services. For E&M services, the result has been an offset of the gains in RVU volume that the services experienced because of increased RVUs.

MedPAC plans further work on the process for valuing services in the fee schedule. An initial step will be to continue the work on RVU volume, looking at the effects of volume growth and changes in RVUs on the distribution of payments by service and also by physician specialty. Next, we plan to consider the process for selecting services for review to determine whether this process adequately identifies services whose RVUs may need to decrease. This effort will include monitoring the next review of RVUs for physician work, scheduled for completion in 2007, so we can assess whether the process is becoming more successful in identifying both undervalued and overvalued services. We also plan to consider the process that CMS uses to establish RVUs for new services. In doing so, we will explore ways to ensure further review of the RVUs after physicians have gained some familiarity and become more efficient in furnishing new services. In addition, to ensure that RVUs account for the cost of an efficient physician's services, we plan to examine the RVUs for practice expense and the extent to which the RVUs represent the marginal cost (not just the average cost) of furnishing a given service.[15] We also plan to explore how CMS might distinguish the marginal costs incurred by physicians who demonstrate superior productive efficiency per unit of service.

Determining practice expense RVUs

On average, payments for practice expense account for about 44 percent of spending under the physician fee schedule. As discussed in MedPAC's *Report to the Congress: Impact of Resource-Based Practice Expense Payments for Physician Services* (2004b), CMS derived resource-based practice expense RVUs for the physician schedule with the best data available at the time. However, some of those data are becoming out of date—for instance, much of the data on physicians' aggregate practice costs date back to the mid- to late- 1990s. Although CMS has received supplemental data from some physician specialties, the accuracy of practice expense payments is becoming more of an issue as time passes. MedPAC plans to continue analyzing the data that CMS uses to establish practice expense payments and the methods that it uses to derive these payments.

Changing the unit of payment

Compared to other payment systems, the unit of payment in the physician fee schedule is very small. The fee schedule includes payment rates for many of the discrete services that a physician furnishes—visits, imaging studies, laboratory and other diagnostic tests, and procedures. In some cases, the physician furnishes the services during a single encounter with a patient. In other cases, the physician furnishes the services during multiple encounters over a period of time. Such a small unit of payment raises a long-standing concern about whether it gives physicians a financial incentive to increase the volume of services (MedPAC 1999). To address this concern, MedPAC could explore options for increasing the size of the unit of payment to include bundles of services that physicians often furnish together or during the same episode of care. MedPAC's work would address procedures for identifying the relevant services, determining payment methods for the services, and analyzing the implications for quality of care. ■

Endnotes

1 The 17 percent increase in spending for Part B drugs must include a large increase in the volume of the drugs because spending increased despite a drop in payment rates for the drugs. In 2004, CMS implemented a statutory reduction in the payment formula for the drugs, which reduced payment rates for them by 10 percentage points.

2 The Congress established floors under geographic practice cost indexes (GPCIs) as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Effective for the first time in 2004, the floors raised payments in Alaska for physician work, practice expense, and professional liability insurance (PLI). Elsewhere, payments went up for practice expense only. To analyze the effects of the GPCI floors, we used 2003 claims data from 100 percent of beneficiaries to determine how spending in that year would have changed if the floors had been in effect in that year. We conducted this analysis by payment locality and procedure code and then aggregated the results by type of service. The results were that the GPCI floors increased spending as follows: visits, 1.0 percent; minor procedures, 0.8 percent; imaging, 0.5 percent; and major procedures, 1.0 percent.

3 For minor procedures, the residual also includes a change in the structure of payments for chemotherapy administration. Although 2004 data are not yet available on the effect of this change, the 2003 data show that chemotherapy administration accounted for about 3 percent of spending for minor procedures.

4 In CMS's methodology for determining relative value units (RVUs) for practice expense, the technical components of imaging services and other diagnostic tests are in a category called the nonphysician work pool. The practice expense RVUs for those technical component services are not yet resource based. CMS plans to propose resource-based RVUs for those services in 2005.

5 For the SGR, physician services include services commonly performed by a physician or performed in a physician's office. In addition to physician fee schedule services, these services include diagnostic laboratory tests and most of the drugs covered under Medicare Part B. To estimate this factor, CMS uses a weighted average of the Medicare Economic Index (MEI), a measure of changes in input prices for physician services, the change in payment rates for laboratory services legislated by the Congress, and a weighted average of the change in payment rates for Part B–covered drugs.

6 As required by the MMA, the real GDP per capita factor in the SGR is a 10-year moving average.

7 For the update, physician services include only those services in the physician fee schedule.

8 Historical changes in the MEI are published by the CMS Office of the Actuary (2005).

9 For further discussion of changes in spending due to law and regulation, see MedPAC's *Report to the Congress: Growth in the Volume of Physician Services* (2004a).

10 For purposes of this discussion, we include localities in the continental United States (i.e., excluding Alaska, Hawaii, Puerto Rico, and the U.S. Virgin Islands).

11 In the methodology for determining practice expense RVUs, CMS defines two types of costs: direct and indirect. Direct costs are costs attributable to specific services, such as the earnings of nonphysician clinical personnel, equipment, and supplies. Indirect costs are not as readily assigned to services and include the earnings of administrative personnel, rent, and utilities.

12 The RVS Update Committee is a committee involving the American Medical Association and national medical specialty societies.

13 By law, RVUs are reviewed every five years.

14 The list of sources of changes in physician work is from CMS. It was prepared for the review of physician work RVUs that was completed in 2002 (CMS 2000).

15 MedPAC has discussed the goal of basing payment rates on a provider's marginal cost in a previous report (MedPAC 2001).

References

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2005. *2005 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Boards of Trustees.

Bureau of Economic Analysis, Department of Commerce. 2005. Current-dollar and real gross domestic product [Excel spreadsheet]. Washington, DC: BEA. February 25. http://www.bea.gov/bea/dn/gdplev.xls.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2004. Medicare program: Revisions to payment policies under the physician fee schedule for calendar year 2005. Final rule. *Federal Register* 69, no. 219 (November 15): 66236–66427.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2003. 2003 information: Practice expense input file. http://www.cms.hhs.gov/physicians/pfs/default.asp.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2000. 2000 information: Five-year review of work relative value units. http://www.cms.hhs.gov/physicians/pfs/wrvu-toc.asp.

Iglehart, J. K. 2002. Medicare's declining payments to physicians. *New England Journal of Medicine* 346, no. 24 (June 13): 1924–1930.

Institute of Medicine. 2001. *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.

Kuhn, H. B., Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2005. Letter to Glenn M. Hackbarth, Medicare Payment Advisory Commission. March 31.

Maxwell, S., S. Zuckerman, and R. Berenson. 2005. First 10 years of the fee schedule: RVU and volume changes. Presentation at MedPAC meeting, April 22, Washington, DC.

Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2004a. *Report to the Congress: Growth in the volume of physician services*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2004b. *Report to the Congress: Impact of resource-based practice expense payments for physician services*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2001. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 1999. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2005. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2006. Baltimore: CMS. http://www.cms.hhs.gov/providers/sgr/sgr2006p.pdf.

Physician Payment Review Commission. 1997. *Annual report to Congress*. Washington, DC: PPRC.

Precht, P. 2005. CMS: High-tech imaging growth feeds record spike in Medicare physician spending. *Inside Health Today* [E-mail newsletter]. April 1.

Technical Review Panel on the Medicare Trustees Report. 2004. *Review of the assumptions and methods of the Medicare trustees' financial projections*. Washington, DC: Technical Review Panel on the Medicare Trustees Report. December.