

SECTION
2B

Physician services

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

The Congress should update payments for physician services by the projected change in input prices less 0.8 percent in 2006.

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

SECTION 2B

Section 2B: Physician services

In this section

- Are current Medicare payments for physician services adequate?
- How should Medicare payments for physician services change in 2006?
- Update recommendation

Our analysis of beneficiary access to physician care, physician supply, private payment level comparisons, and the volume of physician services used finds that Medicare payments for physician services are adequate. Many of these indicators are stable and show that the large majority of beneficiaries are able to obtain physician care. Additionally, the volume of services used per beneficiary continues to grow. In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that payments for physician services be updated by the projected change in input prices, less an adjustment for productivity growth. At the time of this report's publication, a substantial negative update to physician fees is legislated to occur in 2006. MedPAC's recommendation for an increase in payments in 2006 would thus increase Medicare spending and beneficiary liability, but would maintain access to physician care and physician willingness to serve Medicare beneficiaries.

Background

Medicare pays for physician services according to a fee schedule. The fee schedule assigns each service relative weights intended to reflect the resources needed to provide the service. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. In general, Medicare updates payments for physician services by increasing or decreasing the conversion factor.

In 2005, Medicare's fees for physician services increased modestly through a 1.5 percent growth in the conversion factor, as legislated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA updated the conversion factor by the same amount in 2004. The MMA also targeted additional payments to certain physicians—primarily those who practice in rural areas. For example, services provided by physicians in newly established physician scarcity areas (determined separately for primary care physicians and specialists) receive a 5 percent bonus in Medicare payments through 2007.¹ The MMA also established a floor for the geographic practice cost index (GPCI) for physician work—the component of the fee schedule that accounts for geographic variation in costs for physicians' salaries and fringe benefits. This increase effectively raises payments through 2006 for services furnished in areas with below-average physician work GPCIs, which are largely rural.

Before the MMA was enacted, Medicare was slated to decrease 2004 and 2005 fees for physician services by applying the sustainable growth rate (SGR) formula. Required by statute, this formula ties physician payment updates to a number of factors, including growth in input costs, growth in fee-for-service (FFS) enrollment, and growth in the volume of physician services relative to growth in the national economy. Because the MMA overrode those reductions when it legislated conversion factor increases for 2004 and 2005, the SGR now calls for a 5.2 percent cut in the conversion factor in 2006 (Boards of Trustees 2004). Chapter 3 of this report discusses some of the problems associated with the SGR formula and reviews some alternative payment approaches to encourage efficient practice. In recommending an update for Medicare's payment for physician services in 2006, MedPAC follows its usual two-step approach. This

approach first considers the adequacy of current payments and then assesses the factors that will affect efficient providers' costs in the coming year—2006.

Are current Medicare payments for physician services adequate?

MedPAC's framework for assessing payment adequacy for physician services relies on indicators of beneficiary access to physicians and physician availability. Physicians are not required to report their costs to Medicare, as are other providers, like hospitals. Because we cannot look at financial performance directly, we first consider available information on beneficiary access to physician care, which includes a review of beneficiary and physician survey information and physician supply data. Second, we compare Medicare's reimbursement levels with those of the private sector. Third, we examine changes in the volume of physician services to assess trends that may be associated with payment levels.

In future work, MedPAC intends to examine how changes in service use and the development of new technologies and procedures, including imaging, have affected pricing—and potential mispricing—of physician services. Chapter 3 discusses this issue in more detail.

Beneficiary access to physician services

Physicians are often the most important link between Medicare beneficiaries and health care. Some 80 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 as well as payment adequacy.

To assess beneficiary access to physician services, this section examines results from surveys of beneficiaries and reviews data on physician supply and physicians' willingness to serve Medicare patients. By design, many of the surveys' questions rely on respondents' own views. For example, respondents use their own judgment when determining if they are able to schedule timely appointments. Subjective responses can be useful measures for tracking beneficiary experience and perceptions, particularly over time, but concepts such as timeliness may vary across individuals and subpopulations.

Beneficiary surveys on access to physicians

Results from several surveys conducted between 2003 and 2004 show that beneficiary access to physicians appears to be good overall. The majority of beneficiaries report that they are able to find new doctors and schedule medical appointments in an acceptable amount of time. Small subsets of beneficiaries, however, report that they experience problems.

To obtain current access measures, MedPAC sponsored a 2004 telephone survey. This survey updates results from a 2003 pilot study presented in MedPAC's March 2004 Report to Congress. For our second round—the 2004 survey—we included both Medicare and non-Medicare privately insured individuals to assess the extent to which any access problems, such as appointment scheduling, are unique to the Medicare population. (We were unable to distinguish FFS Medicare enrollees from those in Medicare Advantage in this survey.) As in the pilot year, the results from this telephone survey are weighted to be nationally representative with respect to basic demographic variables. Medicare beneficiaries younger than age 65 were excluded due to sample-size limitations.

Results from this telephone survey show that access to physicians for Medicare beneficiaries is good. Further, Medicare beneficiaries and privately insured people age 50 to 64 report very similar access experiences (Table 2B-1, p. 74). Indeed, for some indicators, Medicare beneficiaries enjoyed slightly better access than their privately insured counterparts. Differences between the sample groups are generally small and statistically insignificant. The same holds true when excluding beneficiaries age 75 and older. Changes between 2003 and 2004 for Medicare beneficiaries are too small, in most cases, to be statistically significant; future rounds of the survey would capture trends that compound over longer time periods.

The large majority of Medicare beneficiaries and people age 50 to 64 reported either no problem or a small problem with access to physicians in 2004.² Both groups reported more difficulty finding a primary care physician than a specialist, but most were able to access either type of physician with little or no problem. Specifically, the same share of Medicare beneficiaries and privately insured individuals—88 percent—reported that they experienced no problem or a small problem finding a primary care physician. Although the 4 percentage-point increase in

Medicare respondents who reported major problems accessing primary care physicians in 2004 is not statistically different from 2003, it will be important to continue tracking this question over time. Access to specialists is somewhat higher; 94 percent of Medicare beneficiaries and 91 percent of privately insured individuals reported either no problem or a small problem accessing specialists.

When categorizing the 2004 samples by urban, suburban, and rural groupings, again, Medicare beneficiaries and privately insured individuals age 50 to 64 reported similar access experiences. For both groups, access problems for primary care physicians were reported more often in urban areas than rural areas. For all three areas, at least 85 percent of the people surveyed reported no problem or a small problem finding either primary care physicians or specialists.

The 2004 survey found that most Medicare beneficiaries and people age 50 to 64 did not have to delay getting an appointment due to scheduling issues. For routine care, among those who tried to schedule an appointment, 73 percent of Medicare beneficiaries and 66 percent of privately insured individuals reported that they never experienced delays. Two percent of Medicare beneficiaries and 3 percent of privately insured individuals reported always experiencing delays. As expected, for illness or injury, timely appointments were more common. Among those who scheduled an appointment for an illness or injury, 83 percent of Medicare beneficiaries and 77 percent of privately insured individuals said they never experienced a delay. Low shares of both groups reported frequent delays in getting an appointment for illness or injury.

Another measure of access to physicians examines reasons respondents give for not seeing a physician for their medical problems. In the 2004 survey, 6 percent of Medicare beneficiaries and 11 percent of privately insured individuals said they think they should have seen a doctor for a medical problem in the past year, but did not. Within this subset, physician availability issues (appointment time, finding a doctor) were listed as the problem by just 7 percent of the Medicare beneficiaries and 11 percent of the privately insured people. The remaining reasons given by individuals in this subset included cost, low perceived seriousness of the problem at the time of the illness, and procrastination.

**TABLE
2B-1**

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

Survey question	Medicare			Privately insured
	Age 65 and older	Age 65-74		Age 50-64
	2003	2004	2004	2004
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past year, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it . . ."				
Primary care physician				
No problem	75%	77%	75%	73%
Small problem	18	11	14	15
Big problem	7	11	9	13
Specialist				
No problem	85	89	91	83
Small problem	8	5	3	8
Big problem	5	5	2	8
Unwanted delay in getting an appointment: Among those who had an appointment, "How often did you have to wait longer than you wanted, to get a doctor's appointment?"				
For routine care				
Never	71	73*	74	66*
Sometimes	21	21*	21	26*
Usually	3	4	3	5
Always	5	2	2	3
For illness or injury				
Never	80	83*	82	77*
Sometimes	16	13*	14	19*
Usually	3	2	2	3
Always	1	2	2	2
Not accessing a doctor for medical problems:				
"In the past year, do you think you should have seen a doctor for a medical problem, but did not?"	7	6*	6	11*

Note: Numbers may not sum to 100% due to rounding. Missing responses are not presented. For the 2003 survey, n=1040 Medicare beneficiaries; for the 2004 survey n= 4122 (2087 Medicare; 2035 privately insured).

* Indicates a statistically significant difference between the 2004 Medicare and privately insured populations, at a 95% confidence level.

Source: MedPAC-sponsored telephone surveys, conducted September–October 2003 and August–September 2004.

A much larger beneficiary survey, the Consumer Assessment of Health Plans Survey for Medicare fee-for-service (CAHPS-FFS), includes questions related to beneficiary access to physicians. We focused on two questions: one on access to specialists and the other on appointment scheduling for routine care. Sponsored by

CMS, the CAHPS-FFS survey is conducted annually, primarily by mail. It samples between 100,000 and 120,000 beneficiaries, including community-dwelling, institutionalized, and disabled individuals. The data from this survey are not as recent as the data we have from the MedPAC-sponsored telephone survey discussed earlier.

Results from the CAHPS-FFS survey questions we examined also show that the large majority of Medicare beneficiaries report good access to physicians—consistent with responses from the MedPAC-sponsored telephone survey. Specifically, more than 90 percent of beneficiaries reported either no problem or small problems accessing a specialist (Table 2B-2). Also, the majority of beneficiaries reported being able to schedule timely appointments for routine care either always or usually. On this indicator, the CAHPS-FFS survey shows a slight decline between 2000 and 2003, but a slight improvement from 2002 to 2003.

In 2003, CMS sponsored another survey—the Targeted Beneficiary Survey (TBS)—devoted specifically to beneficiary access to physicians in 11 market areas suspected of access problems (Lake et al. 2004). These 11 market areas were chosen based on relatively high rates of physician access problems reported on the 2001 CAHPS-FFS and in other CMS monitoring activities on physician access.³ The 2003 study found that even in these selected areas, only a small percentage had access problems attributed to physicians not taking new Medicare patients. Scheduling delays were more common in these market areas. Overall, the study showed that access problems were more likely among certain subgroups in these markets.

Specifically, the TBS found that more than 90 percent of beneficiaries within these 11 markets reported either no problem or a small problem “getting a personal doctor they were happy with since joining Medicare.” Similarly, among those needing a specialist, more than 90 percent reported either no problem or a small problem seeing one in the past six months. Among beneficiaries seeking routine care appointments, 73 percent reported that they always got an appointment as soon as they wanted and 21 percent said they usually got an appointment as soon as they wanted. Among those seeking urgent care, 83 percent reported that they always receive care as soon as they wanted and 9 percent said they usually received care as soon as they wanted. (Note that this urgent-care measure does not distinguish site of care, such as a doctor’s office or a hospital emergency room.) When looking at the ability to obtain timely appointments, results in the 11-market survey are similar to those found in MedPAC’s survey.

Transitioning beneficiaries—those new to a market area, new to Medicare, or recently disenrolled from a Medicare+Choice plan—had slightly higher rates of reported problems seeing a specialist and “getting a personal doctor they were happy with since joining Medicare,” but the rates of reported difficulty getting timely routine appointments or urgent care were similar to those of the other Medicare FFS beneficiaries in the survey.

**TABLE
2B-2**

Most beneficiaries report good access to specialty and routine care

Survey question	2000	2001	2002	2003
Within the past 6 months. . .				
If you or your doctor thought you needed to see a specialist, how much of a problem, if any, was it to see a specialist?				
No problem or small problem	93.6%	94.8%	94.3%	94.5%*
Big problem	6.4	5.2	5.7	5.5*
If you made an appointment for regular or routine care, how often did you get an appointment as soon as you wanted?				
Always or usually	92.5	92.1	90.3	91.5*
Sometimes	6.4	6.7	7.9**	6.8*
Never	1.2	1.2	1.8**	1.6*

Note: Numbers may not sum to 100 percent due to rounding; n > 100,000.

*Indicates a statistically significant change between 2000 and 2003, at a 95% confidence level.

**Indicates a statistically significant change between 2002 and 2003, at a 95% confidence level.

Source: MedPAC analysis of 2000–2003 Consumer Assessment of Health Plans Survey (CAHPS) data for fee-for-service Medicare from CMS.

Overall, 95 percent of beneficiaries surveyed on the TBS said the ease of seeing a doctor in the past year had either stayed the same or gotten easier. Among those who reported problems accessing physicians, fewer than 4 percent said that the problems they experienced were due to physicians not taking Medicare patients or not taking assignment. Other reasons beneficiaries gave for access problems included the doctor was not taking any new patients, they did not like the doctor, and transportation issues.

Changes in the supply of physicians

Our analysis of Medicare FFS claims data shows that the number of physicians providing services to Medicare beneficiaries has kept pace with growth in the beneficiary population in recent years. For our supply analyses, we examined the ratio of physicians who bill FFS Medicare to FFS beneficiaries. In our calculations, we conservatively categorized physicians who saw fewer than 15 patients as out of the Medicare market, under the assumption that they did not regularly serve FFS beneficiaries, and provided services to beneficiaries for only a short time during a year or only on an emergency or temporary basis while covering for colleagues.

Comparing growth in the number of physicians with growth in the Medicare population, we see that from 1999 to 2003, the number of physicians who regularly saw Medicare FFS patients grew by 8.8 percent, but Medicare Part B enrollment grew by only 3.6 percent (Table 2B-3). This difference in growth rates led to an increase in the number of physicians per 1,000 beneficiaries, from 11.7 to 12.3.⁴

A large share of the physicians who regularly treated FFS beneficiaries in 2003 (83 percent) did so in 1999, and thus appeared to stay in the Medicare market during those years. Moreover, physicians who started seeing Medicare beneficiaries on a regular basis during that time period outnumbered those who stopped—by about 1.6 to 1.0. (Again, we consider physicians to be regularly treating FFS beneficiaries when they bill for at least 15 in the year.⁵) Despite the overall increase in physicians who regularly saw Medicare FFS beneficiaries, the supply of physicians was still somewhat dynamic, with small shares of physicians either starting or stopping their regular Medicare practice. These changes affect existing patient-

**TABLE
2B-3**

The number of physicians regularly billing FFS Medicare has increased

	Number of physicians	Number of beneficiaries enrolled in Part B (millions)	Physicians per 1,000 beneficiaries
1999	432,355	37.022	11.7
2000	444,187	37.315	11.9
2001	457,292	37.657	12.1
2002	466,299	37.946	12.3
2003	470,213	38.364	12.3
Change 1999-2003	8.8%	3.6%	5.1%

Note: FFS (fee-for-service). Calculations include physicians (allopathic and osteopathic) treating at least 15 different beneficiaries in a given year. Nurse practitioners, physician assistants, psychologists, and other health care professionals are not included in these calculations. The beneficiary count includes those in FFS and Medicare Advantage, on the assumption that physicians are providing services to both types.

Source: MedPAC analysis of Health Care Information System, 1999-2003 from CMS.

physician relationships and could explain, in part, the small, but persistent, share of beneficiary complaints about access problems.⁶

Looking at supply trends in the past decade, the Government Accountability Office (GAO) also found increases in physician supply across the United States between 1991 and 2001 (GAO 2003). GAO reports that during the study period, the number of physicians in the United States increased by 26 percent—twice the rate of total population growth in the study period. The mix of generalists to specialists remained about the same—one-third generalists to two-thirds specialists. These findings, therefore, do not suggest current physician supply problems on a national level.

This chapter does not address future physician workforce issues. Research that projects long-term physician supply trends draws varying conclusions (IOM 1996, Cooper et al. 2002). Further research to examine long-term future physician supply issues and policy options to address possible concerns is needed.

Physician survey on willingness to accept new beneficiaries A key indicator in examining physician supply is the degree to which physicians are accepting new Medicare patients. The most recent data indicate that the large majority of physicians in the United States are willing to accept new Medicare beneficiaries.

The National Ambulatory Medical Care Survey (NAMCS) is conducted in 52 reporting periods to ensure that responses are spread evenly throughout the year. Results from the 2003 NAMCS survey indicate that among physicians with at least 10 percent of their practice revenue coming from Medicare, 94 percent accepted some or all new Medicare patients (Burt 2004). In comparison, 96 percent of *all* office-based physicians reported that they had open practices, and thus were accepting some or all new patients. These figures do not differ significantly from the percentage reported on the 2002 NAMCS. Both the overall patient acceptance rate and the Medicare acceptance rate increased by 1 percentage point. Additionally, the number of physicians accepting Medicare patients increased between 2002 and 2003.

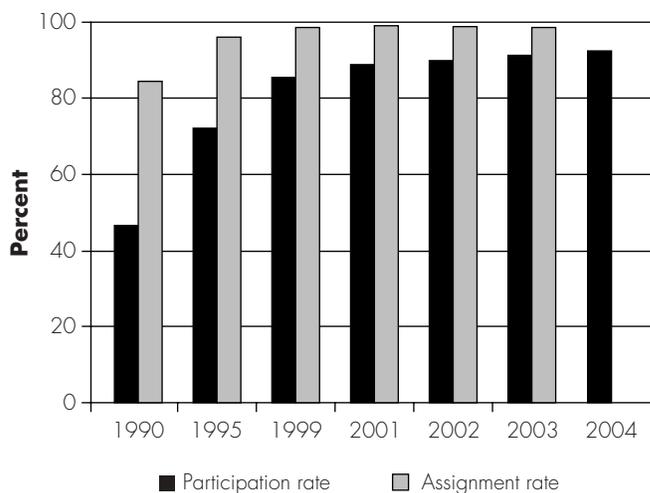
The small share of physicians who leave the Medicare market, or who report reluctance to serve Medicare beneficiaries, may be responding to a variety of factors other than, or in addition to, payment adequacy. These other factors may relate to local conditions such as physician supply, demand for physician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

Assignment and participation rates To supplement our data on the supply of physicians treating Medicare patients and patients' access to physician care, we examine assignment rates (the share of allowed charges for which physicians accept assignment) and physician participation rates (the share of physicians signing Medicare participation agreements). Claims data show that 99 percent of allowed charges for physician services were assigned in 2003 (Figure 2B-1). That is, for almost all allowed services, physicians agreed to accept the Medicare fee schedule charge as the service's full charge.

Further, while 96 percent of allowed charges were for services provided by participating physicians, 3 percent were for services provided by nonparticipating physicians who decided to accept assignment. Only 0.9 percent of allowed charges were for services provided by nonparticipating physicians who did not accept assignment. For this small amount of nonassigned charges, physicians likely billed higher amounts, making the beneficiary liable for added coinsurance.⁷

The number of participating physicians as well as the participation rate has increased. Physicians report that they sign participation agreements and accept assignment to take advantage of several associated benefits. Chief among them is that when physicians accept assignment, they can receive payments directly from Medicare (less the beneficiary cost-sharing portion) rather than collecting from the beneficiary. This arrangement provides a major convenience for many physicians. The high rate of assigned charges also reflects the fact that the majority of physicians and nonphysician providers who bill Medicare agree to participate in Medicare—92 percent in 2004 (Figure 2B-1).

FIGURE 2B-1 Participation and assignment rates have grown to high levels, 1990–2004



Note: Participation rate is the percent of physicians and nonphysician providers signing Medicare participation agreements. Assignment rate is the percent of allowed charges paid on assignment. The assignment rate for 2004 is not shown; it requires calculations from claims not yet available.

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

Participating physicians agree to accept assignment on all allowed claims in exchange for a 5 percent higher payment on allowed charges. Participating physicians receive other valuable benefits, including having their name and contact information listed on Medicare’s website and the ability to verify a patient’s Medicare eligibility and medigap status. Medicare’s physician participation agreement does not require physicians to take Medicare patients.

Private payer payment rates for physician services

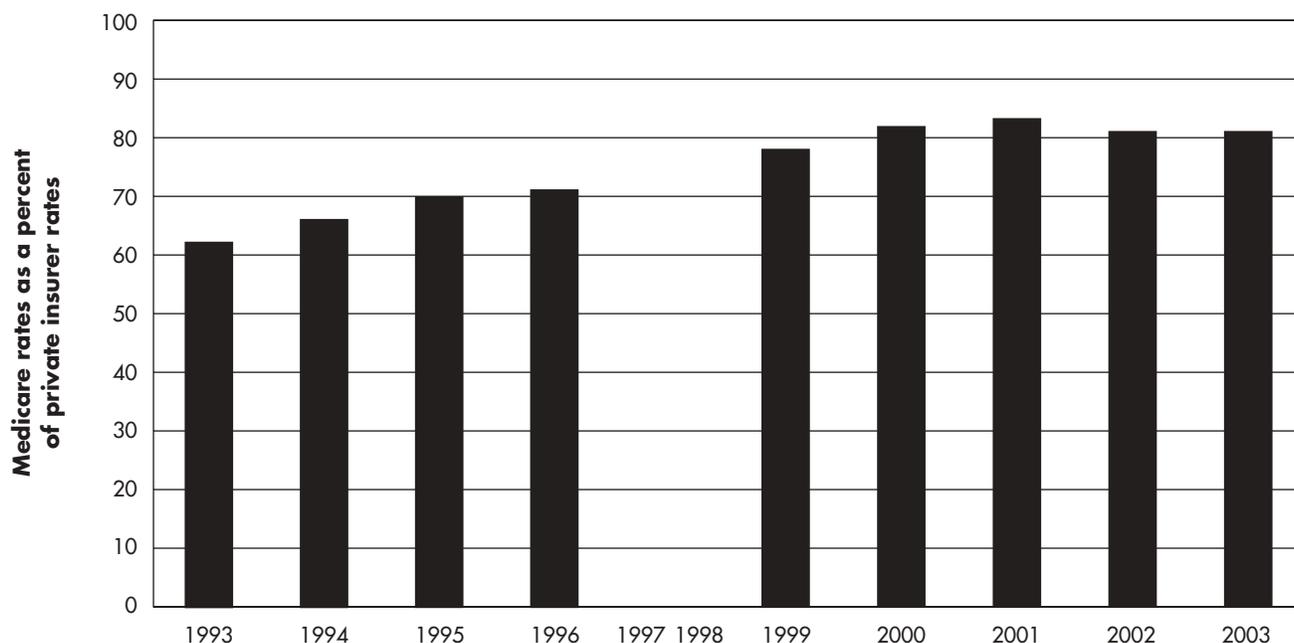
Although Medicare payment rates for physician services have historically been below private insurer rates, on average, between 2002 and 2003, we see no change in the ratio of Medicare to private physician rates (Figure 2B-2). Averaged across all services and areas, 2003 Medicare rates were 81 percent of private rates—identical to the 2002 ratio (Hogan 2004). Hence, private and Medicare fees rose at the same rate, on average, between 2002 and 2003.

To analyze trends in Medicare rates for physician services relative to private rates our contractor, Direct Research, LLC, used two large private claims databases.⁸ In addition to physician fee comparisons, this analysis estimates average annual fees based on private enrollment trends for different types of plans, such as HMOs, preferred provider organizations (PPOs), and traditional indemnity insurance. This research finds that the difference between Medicare and private payment rates narrowed considerably since the mid-1990s, when Medicare rates were about 66 percent of private payment rates. Enrollment shifts in the private market from higher-paying indemnity plans to lower-paying HMOs accounted for much of the narrowing between Medicare and private insurance rates from the mid-1990s to 2001.

Between 2001 and 2002, private insurance payment rates continued to fall—about 1 percentage point—due primarily to enrollment in lower-paying plans, but Medicare rates fell more, due to a 5.4 percent cut in Medicare’s fee schedule conversion factor. The net effect, therefore, was that overall Medicare rates for physician services, as a percentage of private rates, fell from 83 percent in 2001 to 81 percent in 2002.

FIGURE 2B-2

Medicare payment rates for physician services as a percent of average private insurer rates, 1993–2003



Note: Data are not available for 1997 and 1998.

Source: Direct Research, LLC.

Between 2002 and 2003, a slight reversal in private enrollment occurred toward plan types with higher physician fees—namely, PPOs and traditional indemnity plans (Gabel et al. 2004). This change in private enrollment mix had the effect of increasing average private fee levels by 1 percentage point. Simultaneously, Medicare’s fee schedule conversion factor increased modestly. In consideration of these shifts and payment rate differences, the net effect was that Medicare fees and private insurance fees increased at about the same rate, resulting in no change to the ratio of Medicare fees to private fees—81 percent—in 2003.

Changes in the volume of physician services used

Changes in the volume and intensity of services may be another indicator of the adequacy of Medicare’s payments for services. Using claims data from 1999 through 2003, we calculated per capita growth in the units of services beneficiaries used. We then weighted the units of services used by each service’s relative value units (RVUs) from the physician fee schedule. The result is a measure of growth—or volume—that accounts for changes in both the number of services and the complexity, or intensity, of those services (Table 2B-4, p. 80). 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.

Across all services, per-capita volume grew 4.9 percent between 2002 and 2003. This growth is slightly lower than the average annual volume growth seen in previous years (i.e., 5.2 percent between 1999 and 2002).⁹ Among broad categories of services—evaluation and management, major procedures, other procedures, imaging, and tests—volume growth rates varied, but all were positive. As we have seen before, per-capita volume for imaging and tests grew the most. From 2002 to 2003, the imaging volume growth rate was 8.6 percent, and the growth rate for tests was 9.4 percent.

The imaging category includes the services that have the highest volume growth. Nuclear medicine, computed tomography, and magnetic resonance imaging (MRI) all had double-digit growth (ranging from 13.2 percent to 16.5 percent per capita) between 2002 and 2003. Although quite high, these services appear to be growing at a slightly slower pace than in previous years. Between 2001 and 2002, for example, volume growth for MRI was 17.4 percent per capita. Chapter 3 of this report discusses the

issue of volume increases in imaging and explores some ways to address volume growth in imaging services through a variety of policy options.

These continued increases in per capita volume have raised Medicare spending and are in part responsible for the negative updates required by the SGR formula. The SGR target accounts for a moving average of changes in real gross domestic product (GDP) per capita, input prices, growth in FFS enrollment, and other legislated factors. By 2003, the cumulative impact of actual spending was about \$6 billion higher than the SGR target for that year (Office of the Actuary, CMS 2004). MedPAC recently released a report that looks in more detail at the factors that underlie growth in the volume of physician services and spending for those services (MedPAC 2004a).

Although all broad categories of service increased in volume, some individual services decreased. The largest decrease (8.6 percent) was for coronary artery bypass graft (CABG). This decrease was the steepest of all procedures and follows a several-year trend. Between 2000 and 2001, CABG volume declined 4.1 percent (MedPAC 2004b). One likely explanation for this decrease is that it represents substitution of less invasive services. Specifically, CABG volume is decreasing while the volumes of two newer procedures for treating coronary artery disease are increasing—namely, coronary angioplasty and coronary artery stent insertion (NCHS 2004).

Between 2002 and 2003, there was a 1.2 percent decrease in the volume of new-patient office visits. Although average annual growth for these services has historically been low, a decline is unusual. The decline indicates that beneficiaries are seeing new doctors slightly less often, on average. It is important to monitor this trend closely over time to determine if this measure signals problems in accessing physicians for new-patient appointments. This slight decrease, however, could suggest that beneficiaries are satisfied with their physicians and are seeking new doctors less frequently.

Quality incentives in payment to physicians

Other chapters in this report, which examine payment adequacy for types of services, analyze the quality of care provided to Medicare beneficiaries. Medicare does not routinely collect information on the quality of physician care. Through our pay-for-performance initiative, discussed in Chapter 4, Medicare could begin to assess physician quality.

**TABLE
2B-4**

**Use of selected physician services per beneficiary
in fee-for-service Medicare, 1999–2003**

Type of service	Percent change in units of service per beneficiary		Percent change in volume per beneficiary*		Percent of total volume*
	Average annual 1999–2002	2002–2003	Average annual 1999–2002	2002–2003	
All services	4.3%	3.6%	5.2%	4.9%	100.0%
Evaluation and management	2.3	2.2	3.4	3.9	42.1
Office visit—established patient	2.4	2.5	3.2	3.9	18.1
Hospital visit—subsequent	2.2	1.8	2.8	3.5	8.4
Consultation	4.5	3.3	5.9	5.0	5.9
Emergency room visit	3.7	1.9	6.8	4.8	2.7
Hospital visit—initial	0.6	1.3	0.9	2.1	2.1
Office visit—new patient	0.7	-1.9	0.4	-1.2	2.0
Nursing home visit	-0.1	1.8	1.4	4.0	1.8
Imaging	5.4	4.2	10.1	8.6	14.8
Echography—heart	9.4	6.2	11.8	7.6	2.1
Standard—nuclear medicine	13.8	9.1	17.8	13.2	2.2
Advanced—CT: other	14.3	12.9	16.6	14.6	2.0
Advanced—MRI: other	17.4	15.9	19.5	16.5	1.6
Standard—musculoskeletal	3.6	3.6	5.9	4.5	1.3
Advanced—MRI: brain	16.9	8.0	15.5	8.6	1.0
Standard—chest	0.4	0.5	-0.3	0.1	0.7
Advanced—CT: head	5.6	4.6	5.1	4.2	0.4
Imaging/procedure—heart, including cardiac catheterization	5.6	1.6	8.0	4.6	0.3
Major procedures	3.6	2.8	3.4	2.9	9.9
Coronary artery bypass graft	-0.9	-7.4	-2.6	-8.6	0.8
Knee replacement	9.5	11.9	8.6	11.1	0.7
Coronary angioplasty	8.5	5.8	7.6	6.0	0.5
Hip fracture repair	-1.6	0.4	-1.4	1.5	0.4
Hip replacement	6.4	6.1	5.9	5.9	0.4
Explore, decompress, or excise disc	8.7	7.6	9.6	7.6	0.4
Colectomy	1.0	-2.2	0.2	-2.3	0.3
Other procedures	8.7	5.8	6.3	4.9	20.8
Minor—other, including outpt rehab	19.1	7.1	17.5	9.8	3.6
Cataract removal/lens insertion	0.9	0.0	1.1	0.2	1.9
Colonoscopy	11.3	2.8	11.4	3.1	1.2
Upper gastrointestinal endoscopy	4.1	2.6	3.6	2.5	0.6
Cystoscopy	1.7	2.6	1.8	3.2	0.6
Arthroscopy	7.3	12.7	6.7	5.9	0.2
Tests	4.2	4.9	7.9	9.4	3.7
Electrocardiogram	1.7	0.8	1.9	0.8	0.7
Cardiovascular stress test	9.0	4.9	11.0	7.4	0.6
Electrocardiogram monitoring	3.1	1.6	4.4	1.7	0.2
Lab test—other (physician fee schedule)	12.7	10.6	14.8	12.0	0.2

Note: CT (computerized tomography). To put service use in each year on a common scale, we used the relative weights for 2003. For billing codes not used in 2003, 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.

*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 from all 12 months of each year.

Medicare's fee-for-service program does not pay physicians based on quality. A physician who provides high-quality care receives the same payment as one who provides low-quality care. Further, fee-for-service payments provide financial incentives for physicians to deliver a higher volume of services, regardless of whether the services are clinically appropriate.

The Commission recognizes that the quality of care physicians provide has a tremendous effect on the health and health care of Medicare beneficiaries. Chapter 4 of this report provides further discussion and recommendations on how Medicare could establish payment incentives for physician services to improve quality. The chapter outlines the Commission's goals, objectives, and criteria for paying providers based on the quality of their performance.

How should Medicare payments for physician services change in 2006?

After considering current payment adequacy, we also analyze changes in costs projected for the coming year. For physicians, we examine two factors to forecast input costs: change in input prices and MedPAC's policy goal of increased productivity. Input price changes, which include inflationary growth, generally increase expected physician expenses; productivity growth, on the other hand, reduces costs and thereby decreases expected physician expenses.

Input price inflation

To measure input price inflation for physician services, we use the Medicare Economic Index (MEI), which CMS constructs from various data sets on price information and survey data supplied by the American Medical Association (AMA). The MEI provides a weighted average of price changes for inputs used to provide physician services. For 2006, the MEI forecasts that input prices for physician services will increase by 3.5 percent (Table 2B-5). For our calculations, we exclude CMS's adjustment for productivity in the MEI.

Within this aggregate estimate are individual input cost changes. CMS sorts specified inputs into two major categories: physician work and physician practice expense. Physician work includes salaries and fringe benefits allotted for physicians. Physician practice expense

**TABLE
2B-5**

Medicare Economic Index weights and forecasted input price changes for physician services for 2006

Input component	Category weight	Price changes for 2006
Total	100.0%	3.5%
Physician work	52.5	3.4
Wages and salaries	42.7	3.2
Fringe benefits (nonwage compensation)	9.7	4.2
Physician practice expense	47.5	3.6
Nonphysician employee compensation	18.7	3.5
Wages and salaries	13.8	3.2
Fringe benefits (nonwage compensation)	4.8	4.3
Office expense	12.2	2.0
Professional liability insurance	3.9	8.4
Medical equipment	2.1	1.6
Drugs and supplies	4.3	3.0
Pharmaceuticals	2.3	3.7
Medical materials and supplies	2.0	2.2
Other professional expense	6.4	2.1

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight by its price proxy. Forecasted price changes are not adjusted for productivity. Numbers may not sum to 100% due to rounding.

Source: Unpublished, fourth-quarter 2006 estimates from CMS, dated September 21, 2004.

includes nonphysician employee compensation, office expenses, professional liability insurance (PLI), drugs and supplies, and medical equipment.

To calculate the projected costs for these inputs, CMS first estimates the share, or weight, of physicians' practice revenues attributable to each input, based primarily on data supplied by the AMA. CMS attributes 52.5 percent of physician revenues to physician work and 47.5 percent to practice expense, which includes a PLI weight of 3.9 percent (CMS 2004). In 2004, CMS updated its input category weights based on 2000 survey data from 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 (including an increase in the PLI share from 3.2 percent to 3.9 percent).¹⁰

CMS uses more timely data to forecast input price changes. CMS currently projects that from 2005 to 2006, input prices for physician work will increase 3.4 percent, based on increases of 3.2 percent in wages and salaries and 4.2 percent in nonwage compensation. Practice expenses are projected to increase by 3.6 percent. This projection includes an 8.4 percent increase in PLI, which continues to be the fastest growing input cost. As 2006 approaches, this figure may change to reflect updated premium information.

Some physicians—particularly those practicing in certain geographic areas and those whose specialties include high-risk procedures—report PLI premium increases that are much higher, and thus make up a significantly higher percentage of their revenues than forecasted in the MEI. The MEI, however, is not designed to reflect price changes for individual physicians; instead it is designed to account for an average price change for all physicians. The fee schedule, on the other hand, is the primary tool that reimburses services *differentially* to account for PLI premium variation by service and geographic area.¹¹

Productivity growth

In making our update recommendation, MedPAC has adopted a productivity objective, or goal, to encourage provider efficiency. The beginning of this chapter (p. 36) discusses the source of our productivity estimates and our rationale for incorporating productivity goals into our payment update analyses. We currently estimate productivity growth to be 0.8 percent for 2006. This estimate is similar to CMS's when it adjusts the MEI. In considering both expected productivity growth and forecasted input price inflation, the cost of producing physician services would be adjusted by an increase of about 2.7 percent during the coming year.

Update recommendation

RECOMMENDATION 2B

The Congress should update payments for physician services by the projected change in input prices less 0.8 percent in 2006.

RATIONALE 2B

Access, supply, and volume measures suggest that the majority of Medicare beneficiaries are able to obtain physician services with little or no problems. Our analysis finds that current Medicare payments for physician services are adequate. Currently, the projected change in input prices for 2006 is 3.5 percent, and MedPAC's goal for 2006 productivity growth is 0.8 percent. Because CMS updates the MEI forecast quarterly, this recommendation allows for the Congress to use the most recent MEI estimates.

IMPLICATIONS 2B

Spending

- Our estimates indicate that this recommendation for 2006 would increase federal program spending by more than \$1.5 billion in the first year and \$5 billion to \$10 billion over five years, relative to current law. Any positive update would increase spending relative to current law because, at the time of this report's publication, statute calls for substantial negative updates from 2006 to 2012, under the SGR. Over longer periods of time, however, the impact would be lower because the SGR would extract the added spending.

Beneficiary and provider

- This recommendation would increase beneficiary liability for cost sharing and premiums, but would maintain current levels of beneficiary access to physician care. It would also help maintain physician willingness to provide services to Medicare beneficiaries. ■

Endnotes

- 1 Services provided in an area that qualifies for the scarcity-area bonus and the pre-existing 10 percent shortage-area bonus can receive both incentive bonuses.
- 2 At the 95 percent confidence level, the margin of error ranged from ± 7.2 percent to ± 2.15 percent, depending on the survey question.
- 3 Specifically, CMS combined the 2001 CAHPS-FFS measures with state-level information taken from CMS monitoring activities, including environmental scanning reports by CMS regional offices and telephone calls to 1-800-Medicare and Medicare carriers in 2002. Areas designated as eligible for site selection generally met two criteria: (1) They had high rates of 2001 access problems reported on the CAHPS-FFS measures, and (2) they were located in states where CMS monitoring efforts in 2002 indicated emerging physician access issues related to Medicare payment or Medicare physician participation.
- 4 In previous analyses on this topic, we included physicians who saw fewer than 15 patients. Because we excluded such physicians in our current analysis, the total number of physicians presented in this chapter is lower than that reported in our March 2004 Report to the Congress (MedPAC 2004b).
- 5 If we considered the threshold for being in the Medicare market as having at least *one* FFS patient, the ratio of physicians who started seeing FFS beneficiaries exceeded those who stopped by 1.84 to 1.0.
- 6 As another supply analysis, we analyzed changes in physicians' median caseload of Medicare patients. We found that between 1999 and 2003 median caseloads grew by 13 patients, but fluctuated less than 5 percent from year to year.
- 7 This practice is called balanced billing. Medicare limits the amount physicians may balance-bill a patient. The total nonassigned charges for a service may not exceed the fee schedule amount by more than 9.25 percent, which is equal to 115 percent of the nonparticipating physicians' allowed charge (95 percent of the fee schedule amount).
- 8 To compare Medicare and private payment rates, the contractor first calculated a price index for each type of private plan (HMO, point-of-service, preferred provider organization, and indemnity). Each price index was a weighted average of service-level price comparisons between Medicare and private payment rates, using Medicare's volume in each service as the weights. These plan-specific estimates were then weighted based on estimates of private enrollment in each type of plan.
- 9 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 definition of physician services, such as Medicare Part B drugs and laboratory services. Estimates of volume growth from CMS illustrate this point (Grissom 2003). According to these estimates, volume growth for 2001 to 2002 was 6 percent to 8 percent. The low end of this range is volume growth for services paid under the physician fee schedule, which is the definition of physician services used in this report. The high end of the range includes volume growth for the broader definition of physician services.
- 10 As of 2004, CMS updated its input category weights based on 2000 survey data from 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, with an increase in the PLI share.
- 11 The final rule for the 2005 physician fee schedule adjusted the PLI relative value units to account for new data on PLI differences by service and geographic area (CMS 2004). These budget-neutral adjustments primarily resulted in increases for surgical services and other medical procedures.

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