Assessing payment adequacy and updating payments: Physician and other health professional services

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January 14, 2021
Background: The Medicare Physician Fee Schedule

- Includes billing codes for 8,000 clinician services delivered in a variety of settings (e.g., doctors’ offices, hospitals)
- In 2019, Medicare paid $73.5 billion to 1.3 million clinicians
- Current law: No update to base payment rates in 2022, but
  - +/- performance-based adjustment for clinicians in MIPS
  - 5% bonus for clinicians in advanced alternative payment models

Note: MIPS (Merit-based Incentive Payment System). Data are preliminary and subject to change.
New information in the draft chapter

- Analysis of access-to-care broken out by age cohorts
  - Oldest beneficiaries (80s or older) least likely to
    - be dissatisfied with care
    - have difficulty finding a new primary care provider
    - forego care during the pandemic

- More recent data on volume and revenue
  - After dropping sharply in the spring, volume of primary care visits and other services largely recovered in the summer and remained steady through November
  - Clinicians’ revenues for privately insured were above last year’s levels in July-October

- 98% of beneficiaries had at least one clinician encounter in 2019

Sources: MedPAC’s annual telephone survey; Census Bureau Health Pulse Survey; preliminary Medicare claims data; FAIR Health’s National Private Insurance Claims database. October is the most recent month of data available from FAIR Health. All data are preliminary and subject to change.
Commission’s work on primary care issues

- Prior Commission recommendations
  - CMS should regularly collect data to establish more accurate RVUs (2011)
  - Congress should establish a per beneficiary payment for primary care clinicians (2015)
  - CMS should collect data on the specialties in which APRNs and PAs practice (2019)
- Research on scholarship and loan-forgiveness programs for primary care providers (June 2019 report)
- Interviews with medical schools and stakeholders on increasing the supply of primary care physicians (Nov. 2019 presentation)
- Ongoing work on geriatricians
- We supported CMS increasing RVUs of office/outpatient E&M visits for 2021 in a budget-neutral manner

Note: RVUs (relative value units), APRNs (advanced practice registered nurses), PAs (physician assistants), E&M (evaluation and management).
Commission’s prior work on site-neutral payments

- Concern: Total Medicare payment for most services is higher in HOPD than freestanding office
  - Service in an HOPD leads to 2 payments: HOPD + physician fee schedule
- Hospitals have been purchasing physician practices and converting them to HOPDs, which increases program spending and beneficiary cost sharing
- Commission recommendations: Align total payments for E&M visits and selected other services by reducing HOPD rates (2012, 2014)
- The Congress reduced payment rates for services in new, off-campus HOPDs beginning in 2017
- CMS reduced rates for E&M visits in all off-campus HOPDs beginning in 2019
- Is there additional work you’d like us to pursue?

Note: HOPD (hospital outpatient department), E&M (evaluation and management).
## Summary of our analysis

<table>
<thead>
<tr>
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<th>Payments and costs</th>
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- Comparable access to care as privately insured
- 2020 MedPAC survey findings consistent with prior years
- Number of clinicians increasing faster than number of beneficiaries
- Volume of clinician encounters per beneficiary increasing

### Room to improve

- Wide variation in rates of ambulatory care-sensitive hospitalizations and ED visits
- Substantial use of low-value care

### Positive

- Payments per beneficiary increasing
- Growth of MEI
- Commercial payment rates higher than Medicare’s rates
- Physician compensation increasing

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Note: ED (emergency department), MEI (Medicare Economic Index).