



Advising the Congress on Medicare issues

Updating payments for physician services

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Overview

- Analysis of payment adequacy for physician services and expected cost changes
- Improving payment accuracy for MRI and CT services
- Trends in ambulatory surgical centers

Indicators for access to physician services

- Annual MedPAC telephone survey
 - Provides most current access data (last fielded August-October 2008)
 - Nationally representative sample of Medicare beneficiaries age 65+ and privately-insured persons age 50-64
- Other national surveys
- Local markets telephone survey

Most beneficiaries are able to get timely appointments

Among beneficiaries seeking an appointment	Medicare (65 and older)			Privately insured (age 50-64)		
	2006	2007	2008	2006	2007	2008
Routine care delays						
Never	75%	75%*	76%*	69%	67%*	69%*
Sometimes	18	18*	17*	21	24*	24*
Usually	3	3	3*	5	4	5*
Always	3	3	2	4	3	2
Illness or injury delays						
Never	84	82*	84*	79	76*	79*
Sometimes	11	13*	12*	15	17*	16*
Usually	2	3	1	2	3	2
Always	1	2	1	2	3	2

Note: Numbers may not sum to 100% due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Sample sizes for each group (Medicare and privately insured) was 2,000 in years prior to 2008. For 2008, samples sizes for each group were 3,000. Sample sizes for individual questions varied.

* Indicates a statistically significant difference between the Medicare and privately insured populations in the given year at a 95% confidence level.

Source: MedPAC-sponsored telephone surveys, conducted August-October 2006, 2007, and 2008.

Access problems are more likely for Medicare and privately insured minorities

Among beneficiaries seeking an appointment	Medicare (65 and older)			Privately insured (age 50-64)		
	White	Minority	National	White	Minority	National
Routine care delays						
Never	77%*+	70%+	76%*	70%*	65%	69%*
Sometimes	17*	18*	17*	23*	25*	24*
Usually	3	4*	3*	4+	9*+	5*
Always	1*+	5*+	2	3*	1*	2

Note: Numbers may not sum to 100% due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Sample sizes for each group (Medicare and privately insured) were 3,000. Sample sizes for individual questions varied. The "white" category includes white non-Hispanic survey respondents. The "minority" category includes black non-Hispanic, Hispanic, and other races.

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

+ Indicates a statistically significant difference by race within the same insurance coverage category, at a 95% confidence level.

Source: MedPAC-sponsored telephone surveys, conducted August-October 2008.

Most beneficiaries are able to find new physicians

Among beneficiaries seeking a new physician	Medicare (65 and older)			Privately insured (50-64)		
	2006	2007	2008	2006	2007	2008
Primary care physician						
No problem	76%	70%*	71%	75%	82%*	72%
Small problem	10	12	10	15	7	13
Big problem	14	17	18	10	10	13
Specialist						
No problem	80	85	88*	83	79	83*
Small problem	7	6	7	9	11	9
Big problem	11	9	4*	7	10	7*

Note: Numbers may not sum to 100% due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Sample sizes for each group (Medicare and privately insured) was 2,000 in years prior to 2008. For 2008, samples sizes for each group were 3,000. Sample sizes for individual questions varied.

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Source: MedPAC-sponsored telephone surveys, conducted August-October 2006, 2007, and 2008.

Results from other surveys are analogous to MedPAC's survey

- **Center for Studying Health System Change**

- 3 surveys have tracked patient access over last decade (1997-2007)
- Medicare beneficiaries are less likely to report going without needed care or delaying care than privately insured individuals.

- **AARP**

- Small survey conducted in 2007.
- Compared to privately insured adults age 50 to 64, Medicare respondents in sample were:
 - Less likely to encounter problems accessing physicians
 - More likely to be “extremely satisfied” or “very satisfied” with access to physicians.

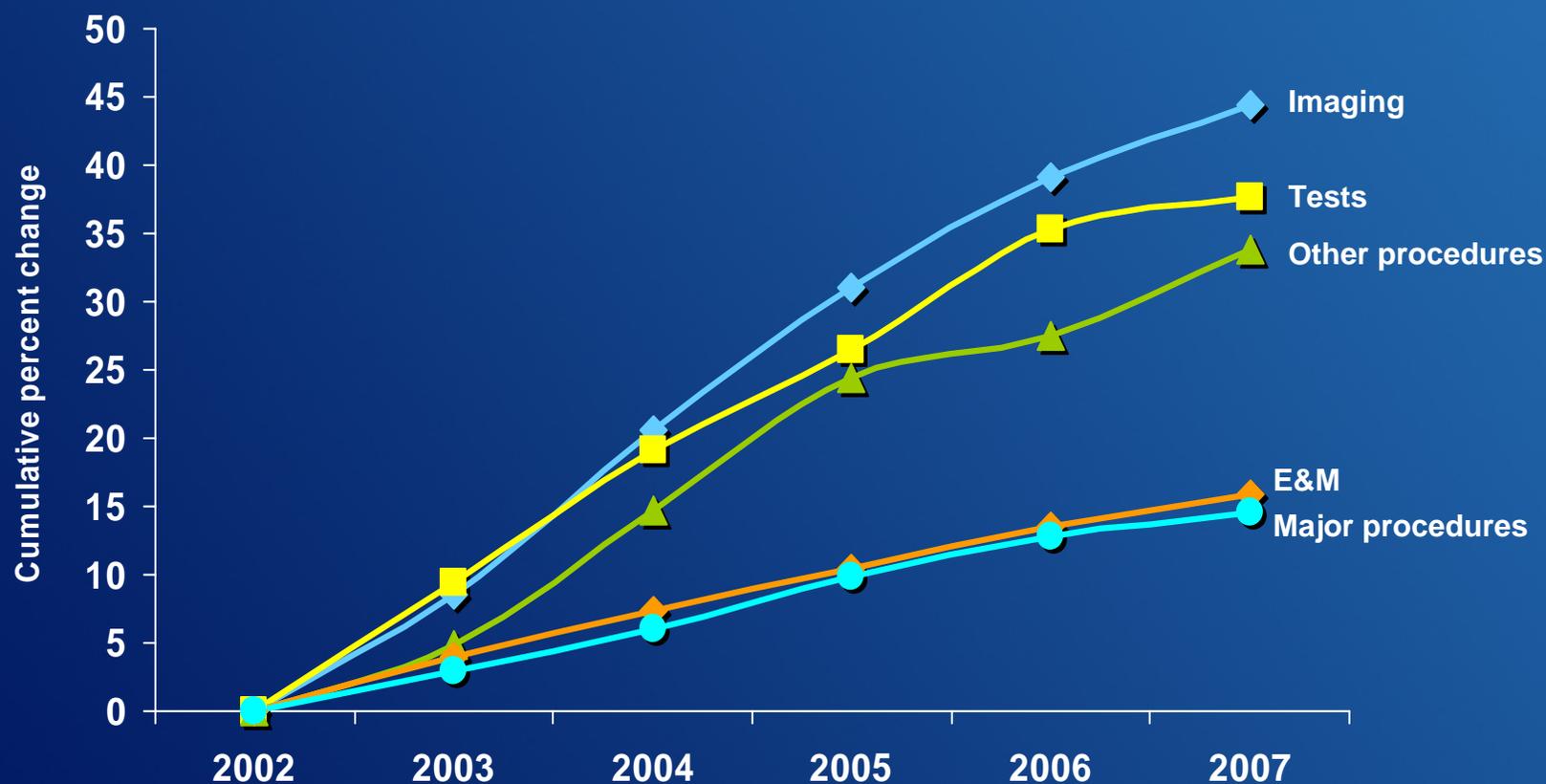
- **CMS -- CAHPS-FFS**

- Large (almost) annual survey, 2000-2006
- Majority of Medicare FFS beneficiaries are able to schedule routine care appointments and access specialists without major problems.

Access in selected local markets

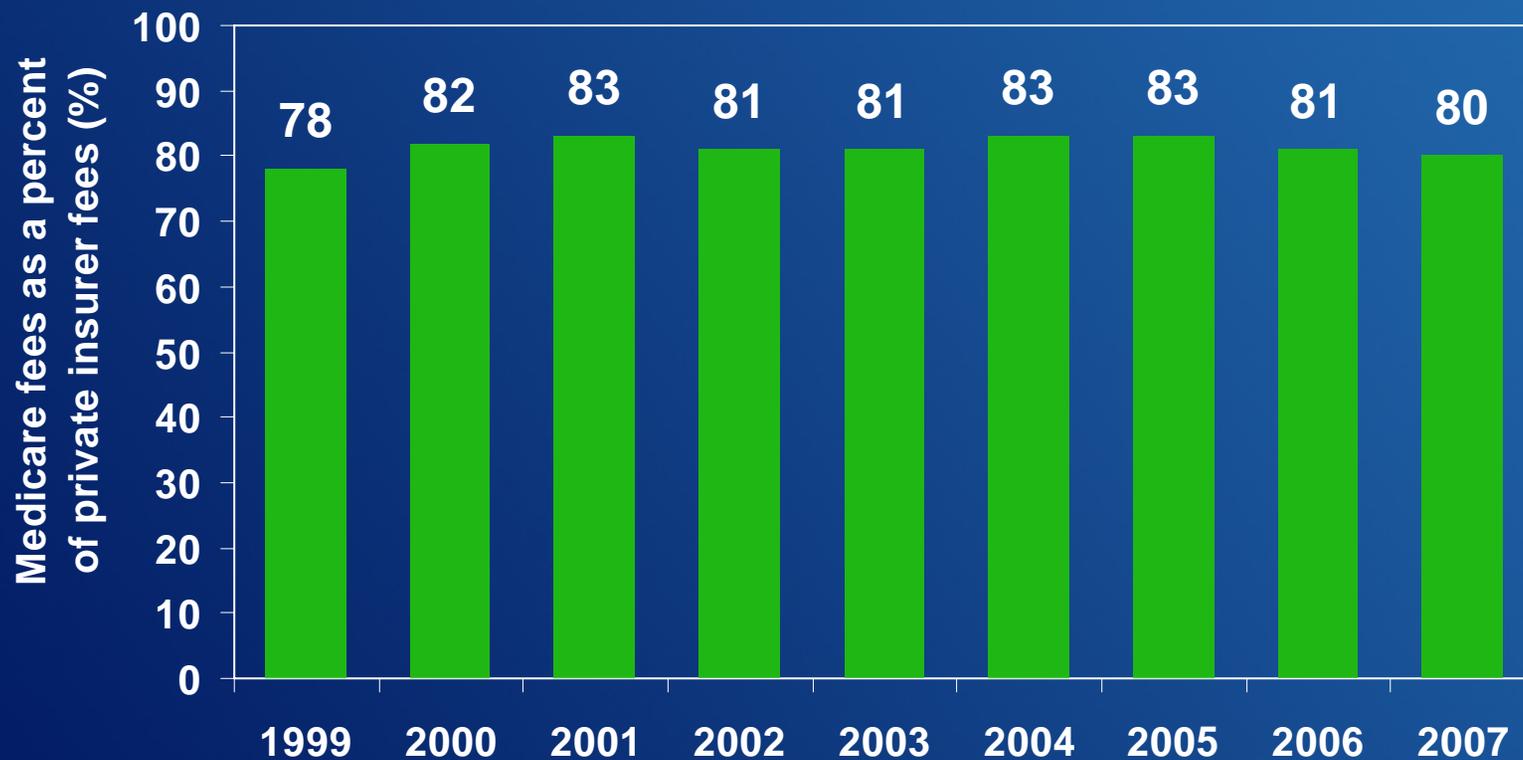
- Telephone survey
 - Selected 5 market areas based on relatively low beneficiary access scores on 2006 CAHPS-FFS
 - Our survey found that access in these local areas is within range of the national results
 - Similar experience in CMS's earlier targeted access study
- Focus groups
 - 9 beneficiary focus groups in 3 market areas
 - Access varied between areas, but almost all participants said they had a regular physician
 - Most reported that they could get appointments with this doctor within a day or two
 - Some problems were not limited to FFS Medicare (e.g., overall physician availability)

Growth in the volume of physician services per beneficiary continues to grow



Note: (E&M Evaluation and management).
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

Ratio of Medicare to private payer physician fees is steady



Current forecast of cost changes expected in 2010

- Input price inflation: 2.4%*
 - Physician work: 2.8%
 - Physician practice expense: 1.9%
- Productivity growth: 1.3%

* These input cost forecasts exclude productivity adjustments that are integrated into CMS's publicly released Medicare Economic Index (MEI); thus, they are higher than the MEI.

MedPAC recommendation for primary care services (June 2008)

Increase payments for FFS primary care services furnished by practitioners who focus on primary care.

- Budget neutral
- Primary care-focused practitioners:
 - Specialty designation is defined as primary care and/or
 - Those whose pattern of claims meets a minimum threshold of furnishing primary care services

How CMS estimates cost of medical equipment for practice expense RVUs

- Cost of equipment per service = *cost per minute* * number of minutes used
- *Cost per minute* based on % of time equipment is used and other factors
- CMS assumes that all equipment used 50% of time providers are open for business (25 hours/week)
- If equipment used more frequently, costs per service are lower

Results from NORC survey of imaging providers in 6 markets

Hours used per week

	Mean	Median	CMS's current assumption
CT providers	48	40	25
MRI providers	65	50	25

Evidence for increasing use rate for MRI and CT machines to 90%

- NORC survey results
- Data from IMV survey on number of services per unit suggest that machines used more than 25 hours/week (Baker et al., *Health Affairs*, 2008)
- Increasing CMS's equipment use rate to 90% would imply machines are used 45 hours/week (50 hours * 0.90 = 45)

Important to improve accuracy of physician fee schedule rates for imaging

- Rapid growth in number of CT and MRI machines has led to high capacity in market
- Accurate rates could help manage future volume growth, but other policies are needed
- Would not affect outpatient hospital rates
- Hospitals provide access for emergency cases
 - 95% of rural hospitals provide CT services in their communities
 - 79% of rural hospitals provide MRI services in their communities

Impact of increasing use assumption for MRI and CT machines

Would increase practice expense RVUs for physician services (other than CT and MRI), due to

- Lower MRI and CT rates
- Additional money from Part B trust fund (some savings from outpatient cap on imaging rates would return to physician fee schedule)

Ambulatory surgical centers (ASCs)

- ASC: Distinct entity that exists to furnish surgical services not requiring an inpatient stay
- Have their own prospective payment system
- ASCs are a source of revenue for many physicians; most ASCs have some degree of physician ownership
- 2010 is first year since 2003 that payment update is allowed by law

Medicare spending on ASC services

- Spending per FFS beneficiary grew at an average of 8.4 percent per year during 2002-2007
- CMS projects continued growth, from \$2.9 billion in 2007 to \$3.9 billion in 2009

Access to ASC services has been increasing

	Avg increase 2002-2006	Increase 2007
Number ASCs	278	257
Percent increase, number ASCs	7.0%	5.5%
Percent increase, volume per beneficiary	10.7%	5.9%

Source: MedPAC analysis of provider of services file from CMS and 5% claims files from CMS.

No cost data available

- In contrast to other facilities, ASCs do not submit cost data to CMS
- However, cost data are important for determining the adequacy of Medicare payments to ASCs