



Advising the Congress on Medicare issues

Physician services: assessment of payment adequacy

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Overview

- Overall update for physician services
 - Payment adequacy indicators
 - Expected cost changes
 - Recommendation
- Changing payments for expensive imaging
 - Equipment use standard
 - Recommendation

Annual MedPAC telephone survey of Medicare and privately insured (August-October 2008)

- Timely appointments:
 - A large share of beneficiaries reported “never” experiencing a delay in getting an appointment (76% for routine care; 84% for illness/injury).
 - Medicare beneficiaries were more likely to report never experiencing a delay compared with privately insured individuals.
- Seeking a new physician:
 - Only 6% of Medicare and privately insured sought a new PCP.
 - Among those seeking a PCP, similar shares of Medicare (28%) and privately insured (26%) experienced problems
 - Access to specialists is better for both groups, particularly Medicare.
- Minorities in both groups reported more difficulty accessing physician services than whites.

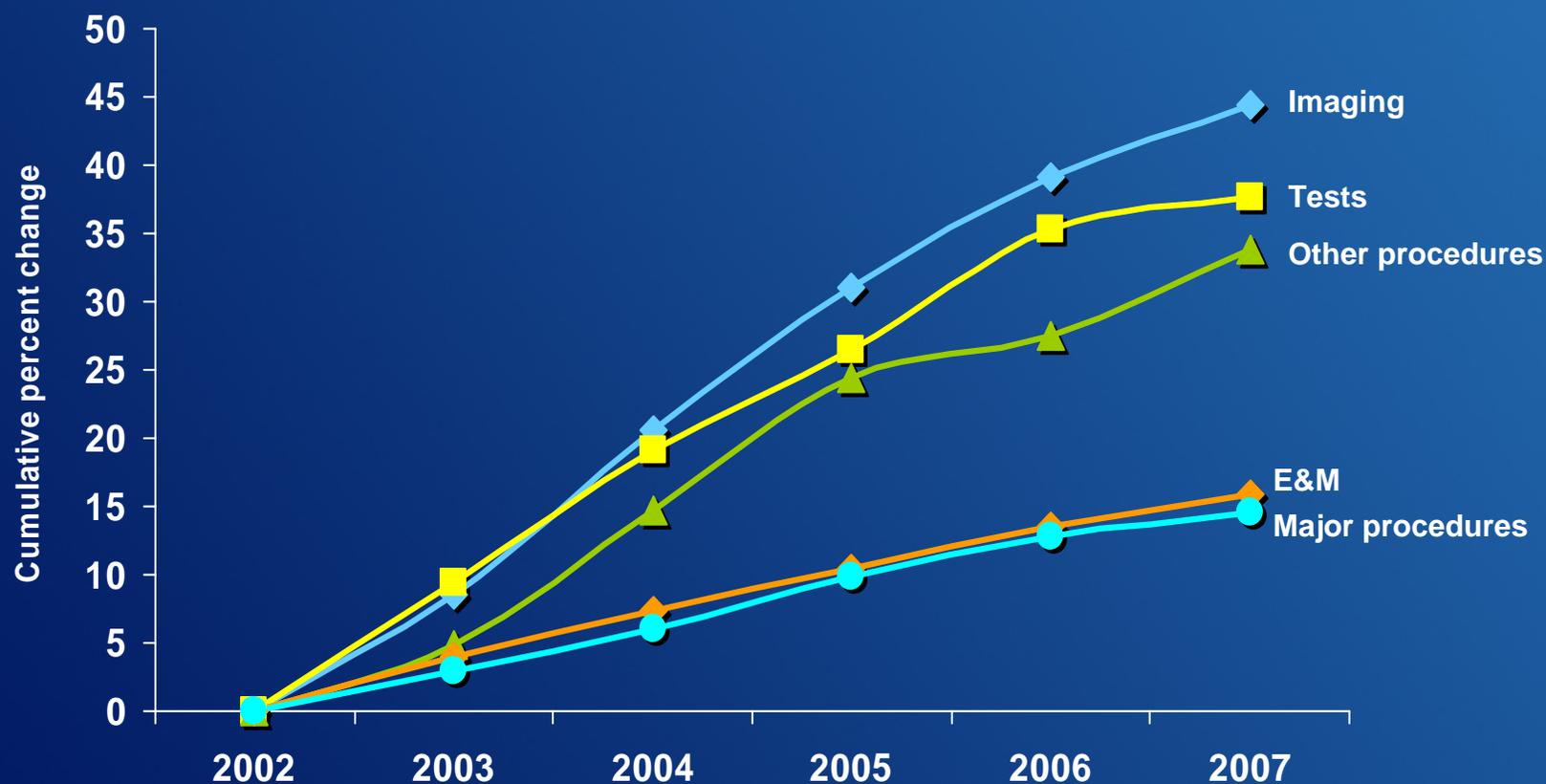
Access to physicians, by patient income

- Methodologically difficult to compare incomes between Medicare beneficiaries and privately insured individuals
- Few clear correlations between access measures and income
- For both insurance categories, lowest income individuals were most likely to not access care when they thought they needed it.
- Rate of looking for a new PCP
 - Medicare: equally likely across all income categories (~6%)
 - Private insurance: lower income individuals were more likely to report looking for a new physician

Other access indicators

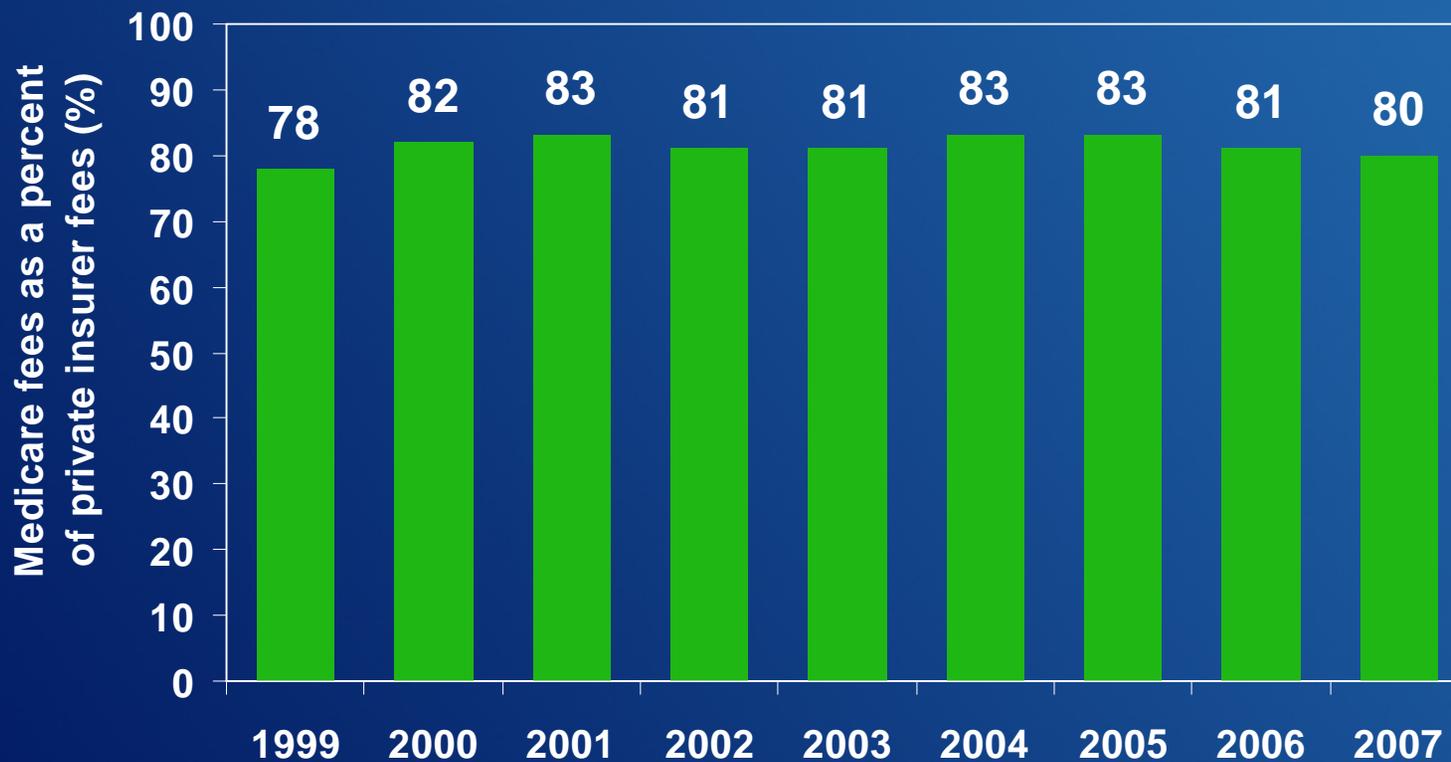
- Other national surveys (HSC, AARP, CAHPS-FFS) show analogous results to the MedPAC survey.
- In certain local markets, MedPAC survey and focus group research found access rates were similar to national rates, even in areas suspected of access problems.
- Shares of emergency department visits by Medicare and privately insured individuals grew at similar rates over last decade.
- Share of physicians signing participation agreements and taking assignment continues to be high.

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

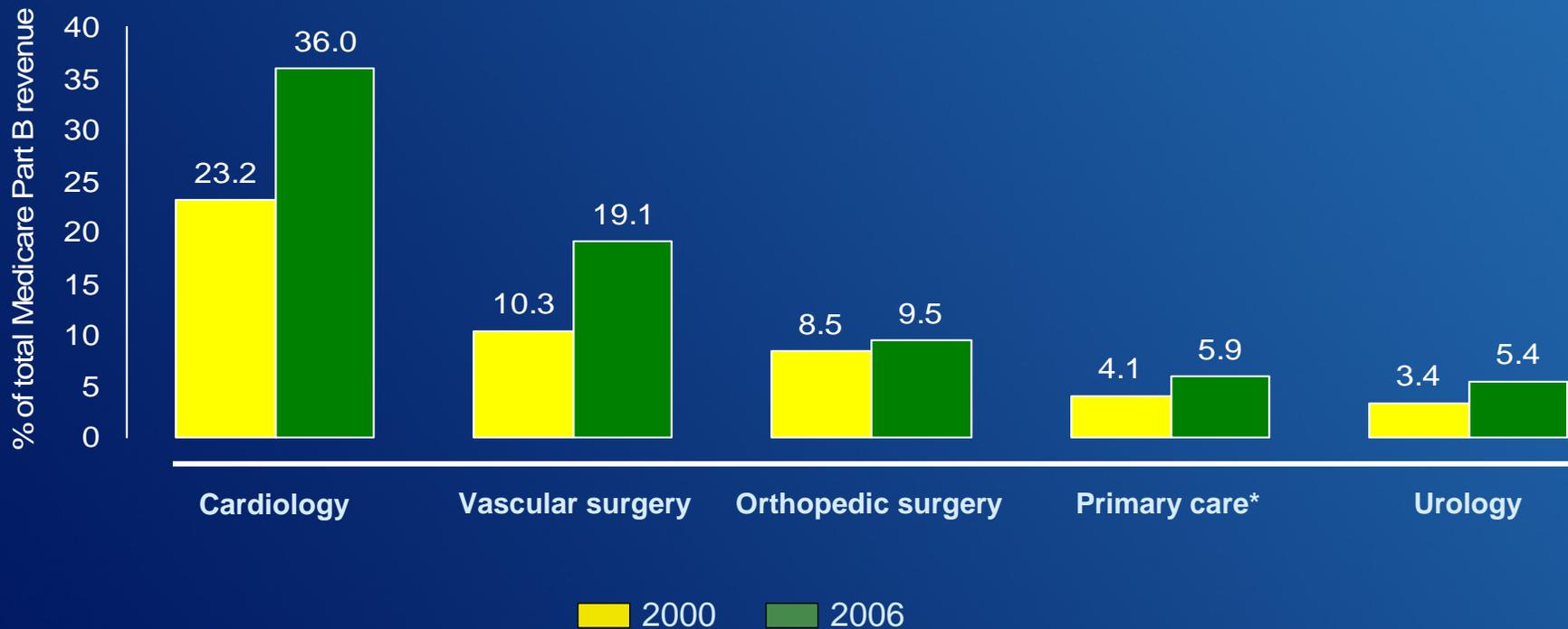
- Input price inflation: 2.4%*
 - Physician work: 2.8%
 - Physician practice expense: 1.9%
- Productivity goal: 1.3%

* 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.

FFS policy changes affecting primary care

- Policy changes completed or in progress
 - Physician fee schedule changes +10.6%
 - 2007 review of physician work RVUs for E&M services
 - Method for valuing practice expense
 - Ongoing review of potentially misvalued services (e.g., rapid-volume growth, site of service changes)
 - Medical home demonstration (TRHCA, MIPPA)
- MedPAC recommendations not yet adopted
 - Payment adjustment for primary care services furnished by practitioners who focus on primary care
 - Equipment use standard for imaging machines – pending vote

Increase in share of revenue from in-office imaging, by specialty



Source: GAO analysis of Medicare Part B claims data, 2008.

*Includes general and family practitioners and internists.

Changing fee schedule payments for expensive imaging services

- Rapid volume growth of expensive imaging services may signal mispricing
- Cost of imaging equipment per service is key component of practice expense RVUs
- CMS assumes that all equipment used 25 hours/week (50% of time providers are open for business)
- If equipment actually operated more frequently, its cost per service declines

Problems with Medicare's equipment use rate for expensive imaging machines

- Setting use rate at 25 hrs/wk (instead of higher level) leads to higher PE RVUs for services with costly imaging equipment
- Encourages low-volume providers to purchase expensive machines
- Additional MRI and CT machines are associated with more services (Baker et al., *Health Affairs*, 2008)

Results from NORC survey of imaging providers in 6 markets

Hours used per week

	Mean (NORC survey)	Median (NORC survey)	CMS's current assumption
CT providers	42	40	25
MRI providers	52	46	25

Setting normative equipment use standard for expensive imaging machines

- A normative standard of 45 hrs/wk would discourage providers from purchasing expensive machines unless they could use them at close to full capacity
- Standard of 45 hrs/wk would allow some down time for maintenance, patient cancellations
- Start using 45 hrs/wk standard for diagnostic imaging machines that cost > \$1 million
 - Secretary should explore also applying standard to imaging machines that cost < \$1 million

Impact of increasing equipment use rate for costly imaging machines

- Would reduce PE RVUs for costly imaging services
- Would increase PE RVUs for other physician services, due to
 - Lower PE RVUs for costly imaging services
 - Money that would have returned to Part B trust fund under outpatient cap policy

Impact of increasing equipment use rate for MRI and CT machines from 25 to 45 hrs/wk

Type of service	Change in PE RVUs
E & M	+1.1%
Imaging	-7.9*
Major procedures	+1.0
Other procedures	+2.6
Tests	+3.8

Note: PE (practice expense). Estimates assume 2005 volume and 2010 PE RVUs.

* Reduction to imaging payments would be significantly smaller than shown here because the model does not include the effects of the outpatient cap on imaging services.

Source: NORC/SSS analysis for MedPAC.