Updates to the methods used to assess the adequacy of Medicare payments for physician and other health professional services

Brian O'Donnell, Kevin Hayes, and Carolyn San Soucie

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Indicators of payment adequacy for physicians and other health professionals

- **Beneficiaries' access to care**
- Quality
- Medicare payments and providers' costs

Updates

① Supply of providers

② Volume of services

Definition and role of hospitalists

Definition of hospitalists

- Physicians whose main focus is the general medical care of hospitalized patients

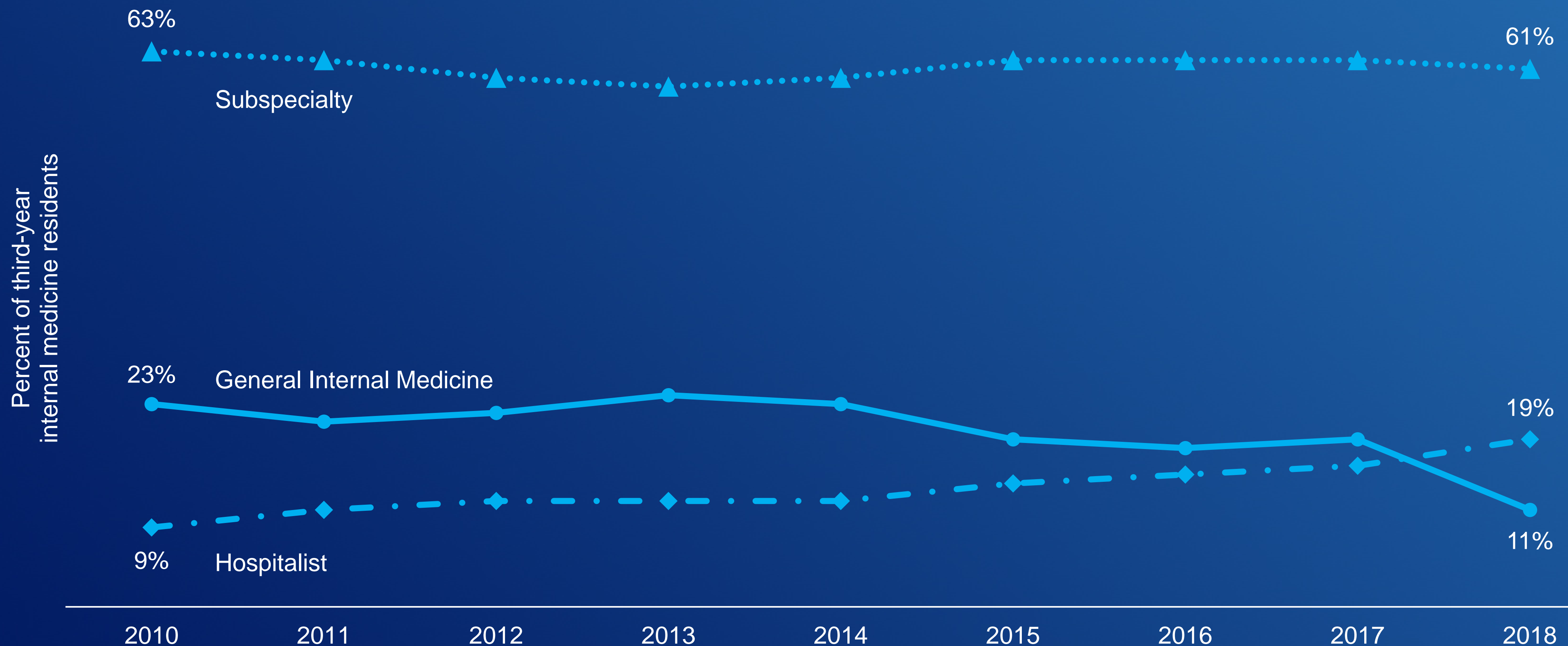
History and current role

- First structured program created in 1994
- Monitor the progress and tend to the needs of hospital inpatients
- Allow primary care and other physicians to focus on office-based care

Factors that may influence decisions to become hospitalists

Training	Salary	Schedule
Hospitalists are usually board certified in internal medicine Sub-specialization not needed	Hospitalists earn substantially more than primary care physicians (PCPs)	Hospitalists' schedules are more predictable and may be more amenable to a work-life balance

Share of third-year internal medicine residents who plan to become hospitalists increased rapidly



Numbers do not sum to 100 percent because some categories are not shown.

Source: Internal Medicine In-Training Examination Survey. American College of Physicians.

Results preliminary; subject to change.

Implications of hospitalists for our assessment of payment adequacy

Tracking primary care physicians
Used for indicator of access to primary care Four self-designated specialties: ➢ Internal medicine ➢ Family practice ➢ Geriatrics ➢ Pediatrics

Nearly all hospitalists have been included in our count of PCPs because they self-designated as internal medicine

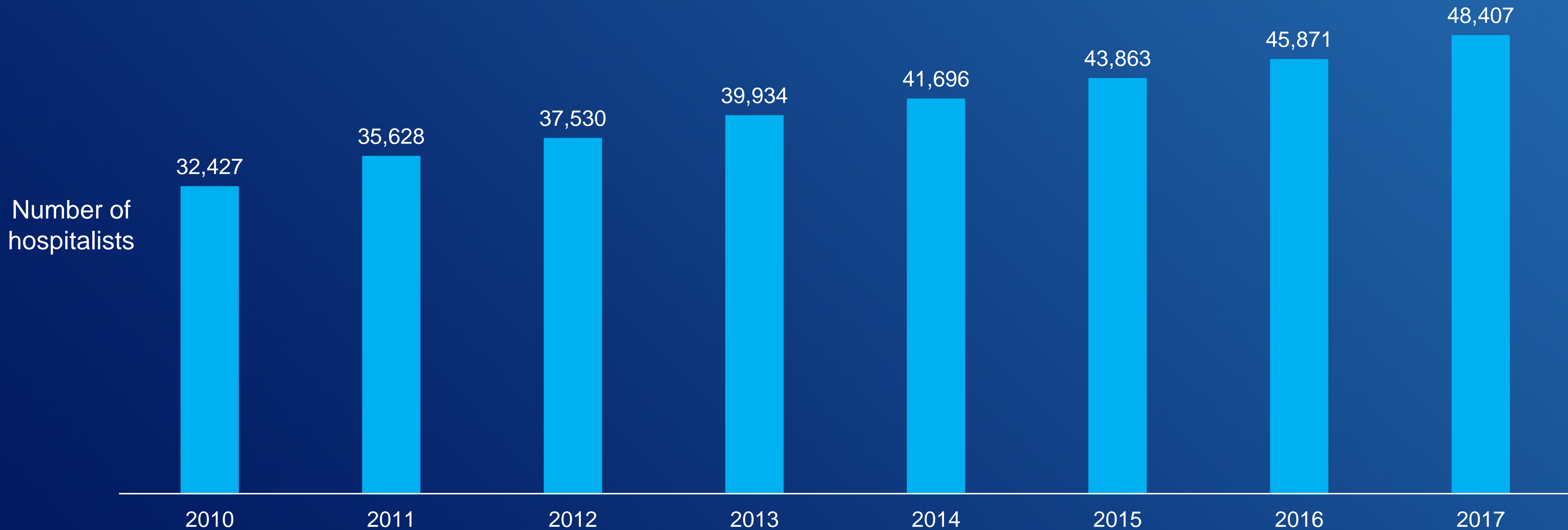
New hospitalist specialty designation allows us to distinguish hospitalists from PCPs

- A new specialty designation for hospitalists was created in 2017

1. Studied self-designated hospitalists in 2017 to better understand their billing patterns

2. Distinguished hospitalists from primary care physicians going back to 2010

Large growth in estimated number of hospitalists

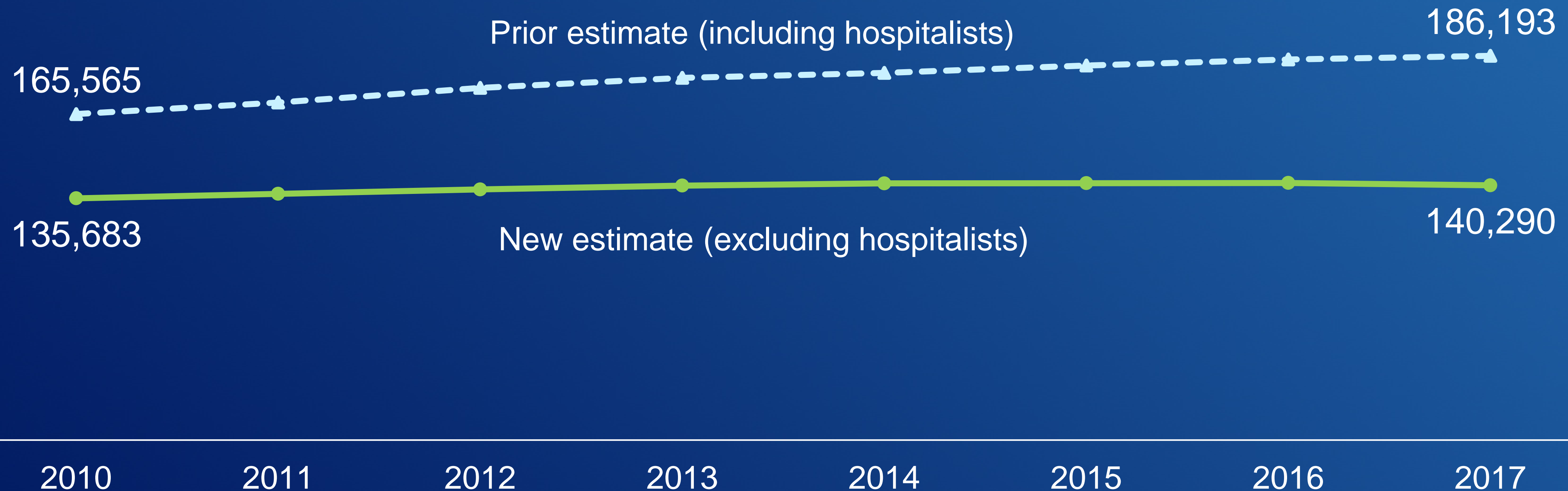


Source: MedPAC analysis of the carrier file.

Results preliminary; subject to change.

Count of PCPs lower after excluding hospitalists

- We estimate about 1 in 5 physicians we previously considered PCPs are hospitalists



Note: Counts limited to PCPs who billed for more than 15 unique beneficiaries in a given year. PCP (primary care physician).
Source: MedPAC analysis of the carrier file.

Results preliminary; subject to change.

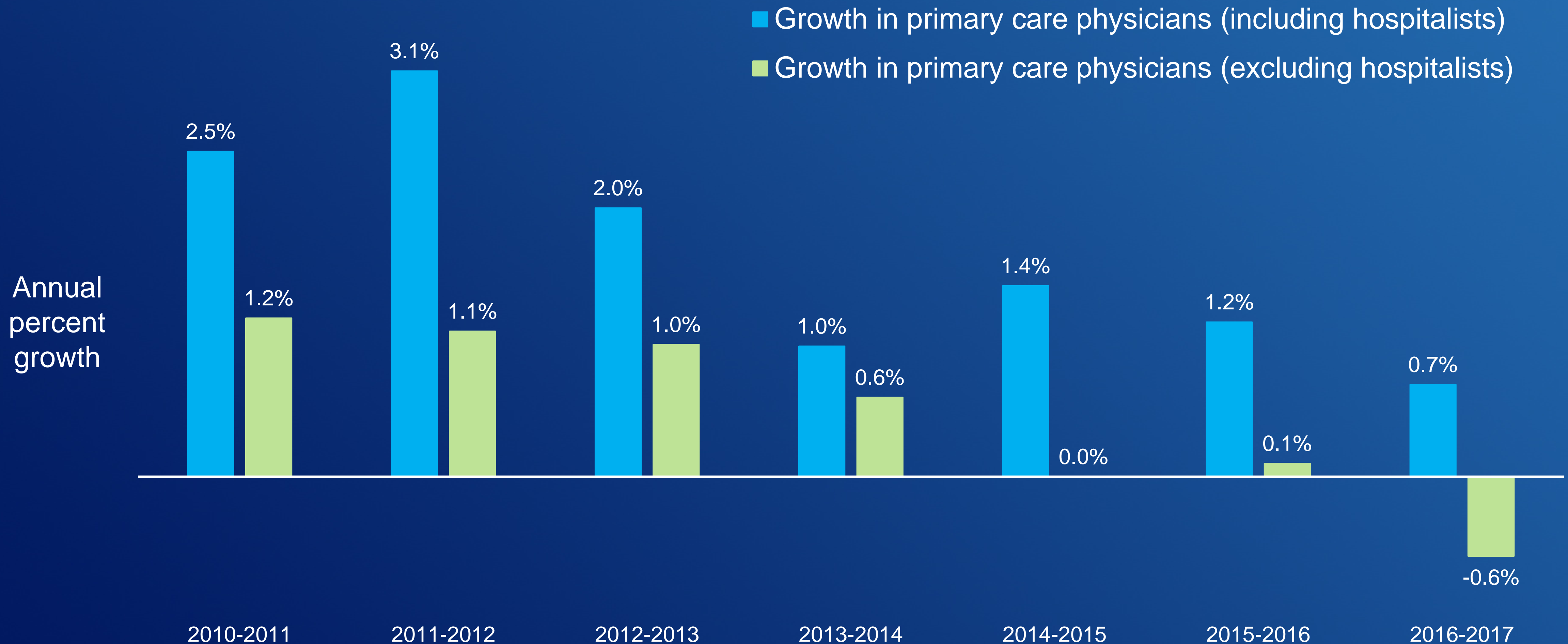
Beneficiary access to care has been adequate

- Revised counts of PCPs do not change the conclusion that beneficiary access to care has remained adequate

Results from the Commission's annual beneficiary survey

- Less likely to wait longer than they wanted for routine care than privately insured
- No large changes in trouble accessing PCPs
- Access to PCPs has remained as good as or better than privately insured

Growth in number of PCPs slower after excluding hospitalists



Note: Counts limited to PCPs who billed for more than 15 unique beneficiaries in a given year. PCP (primary care physician).
Source: MedPAC analysis of the carrier file.

Results preliminary; subject to change.

Updates to the Commission's physician fee schedule volume analysis

- **Beneficiaries' access to care**
- Quality
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Updates

① Supply of providers

② Volume of services

Background on MedPAC's traditional volume analysis

MedPAC's traditional volume analysis:

Volume = number of services × RVUs

Why we measure volume?

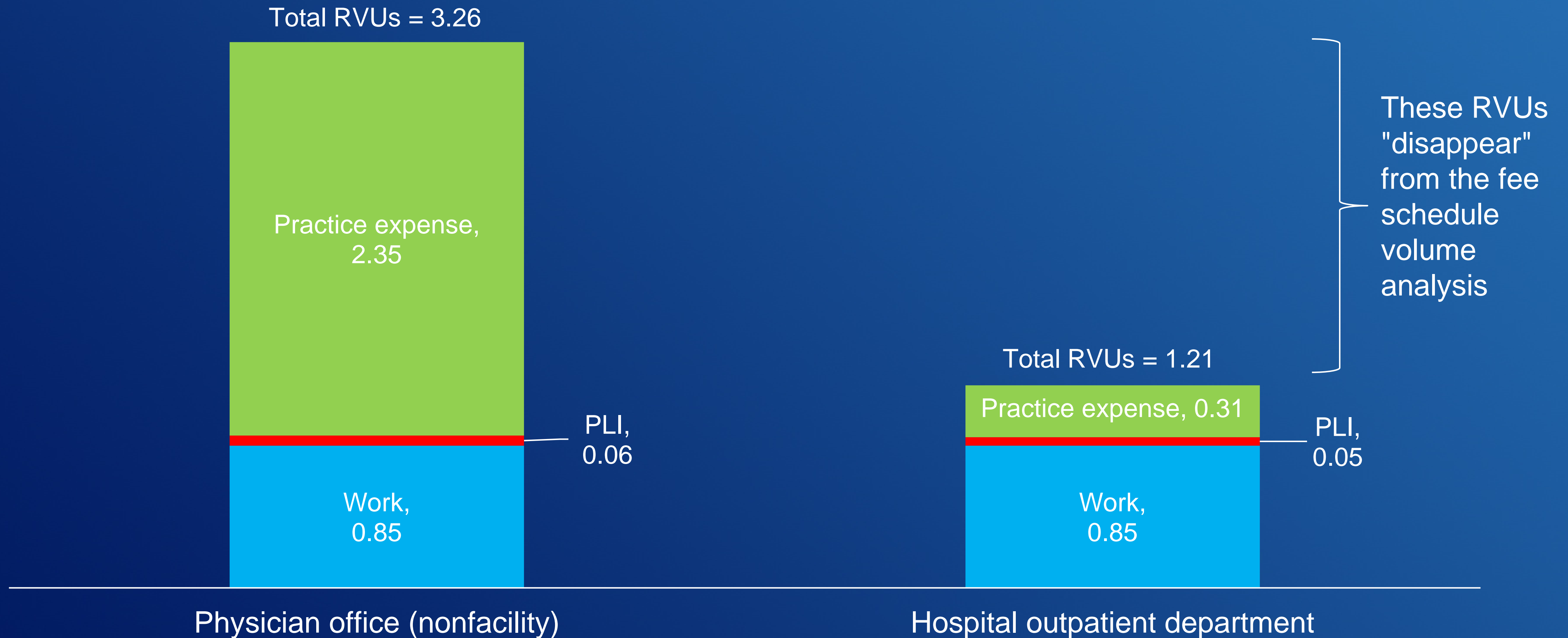
- We use volume as a measure of access and to help determine the drivers of increased spending (e.g., more services or more complex services)

Sensitivities in volume measure

- Sensitive to shifts in the site of service
- Some negative volume trends because RVUs "disappear" from volume analysis

RVUs (relative value units)

When a CT service shifts from the physician office to the HOPD, some RVUs "disappear" from the fee schedule volume analysis



Note: This figure reflects HCPCS code 70450 (corresponding to APC 5522). CT (computed tomography), PLI (professional liability insurance), RVU (relative value unit), HOPD (hospital outpatient department).

Source: Centers for Medicare & Medicaid Services.

MEDPAC

Two new analyses replace current volume analysis

Access measure: Encounters with clinicians	Spending measure: Allowed charges
Does not take into account number or complexity of services per encounter Not as sensitive to shifts in site of service	Allowed charges are a function of number of services, RVUs, and other factors (e.g., conversion factor) Similar to Commission's hospital outpatient department spending measures

MEDPAC

RVUs (relative value units)

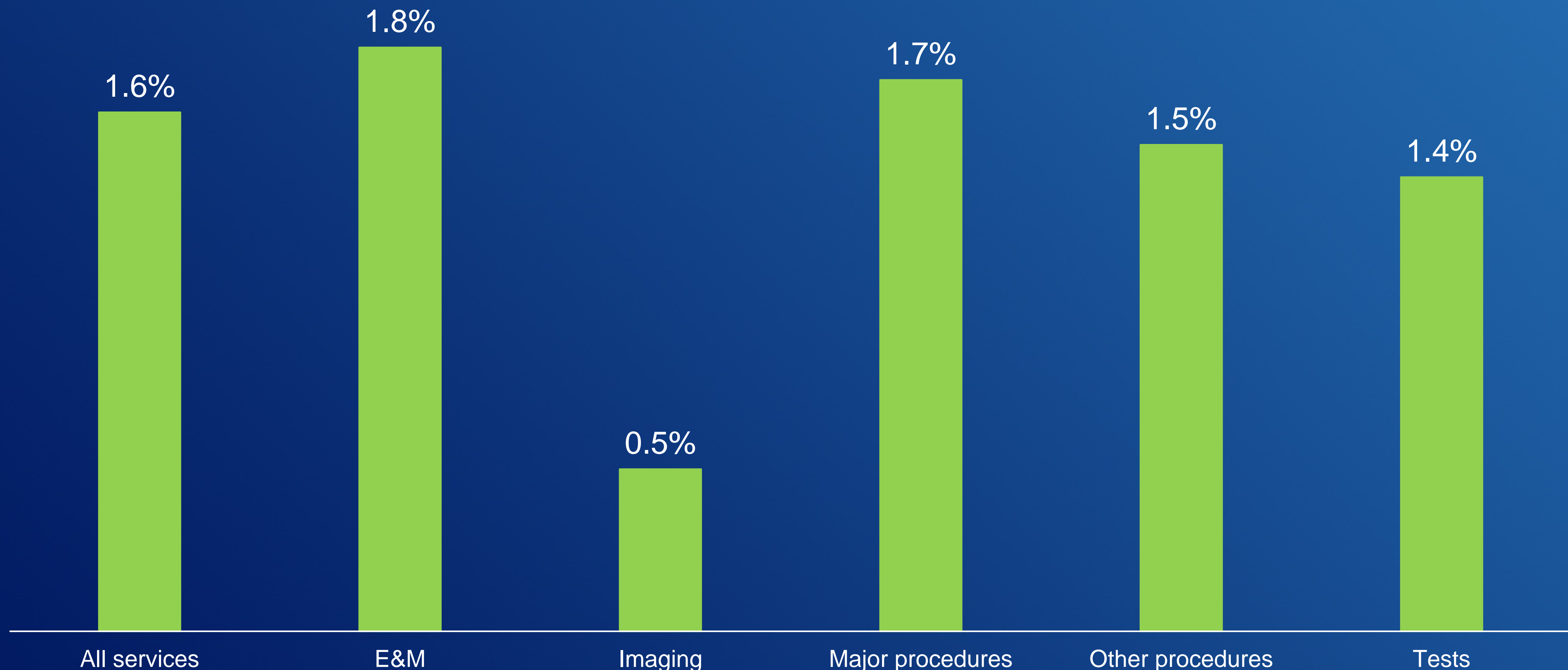
Total beneficiary encounters increased but large differences exist between types of clinicians

	Encounters per beneficiary		
	2013	2017	Average annual change (2013-2017)
Total	**20.4**	**21.1**	**0.8 %**
Primary care physicians	4.1	3.7	-3.0 %
Specialist physicians	12.3	12.4	0.3 %
APRNs and PAs	1.1	1.8	13.1 %
Other practitioners	2.5	2.8	3.1 %

Note: Hospitalists are included in the specialist physicians category. Numbers do not sum to totals because encounters with non-clinician suppliers are included in the totals but are not listed separately. Percentages calculated from unrounded numbers. APRN (advanced practice registered nurse), PA (physician assistant), FFS (fee-for-service).

Source: MedPAC analysis of the carrier file.

Per beneficiary change in allowed charges by type of service, 2016-2017



Note: Evaluation and management (E&M).

Source: MedPAC analysis of the carrier file.

MEDPAC

Results preliminary; subject to change.

Conclusions and Commission discussion

Conclusions

- Lower *absolute number* of PCPs does not change previous conclusions that beneficiaries maintained adequate access to care
- Flat or declining *trend* in PCPs reinforces Commission’s concern about future pipeline

Discussion

- Feedback on planned methodological changes
- Staff will present ongoing work about PCP pipeline at the November meeting