Advising the Congress on Medicare issues

Assessing payment adequacy: physician, other health professional and ambulatory surgical center services

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Background: physician and other health professional services in Medicare

- Includes office visits, surgical procedures, and range of diagnostic and therapeutic services in all settings
- Medicare outlays: $68 billion in 2011, 12% of Medicare spending
- ~850,000 practitioners billed Medicare in 2011:
  - 550,000 = physicians actively billing Medicare
  - 300,000 = other health professionals (e.g., nurse practitioners, physical therapists, chiropractors)
- 97% of FFS Medicare beneficiaries received at least one fee-schedule service in 2011

Payment adequacy analysis indicators

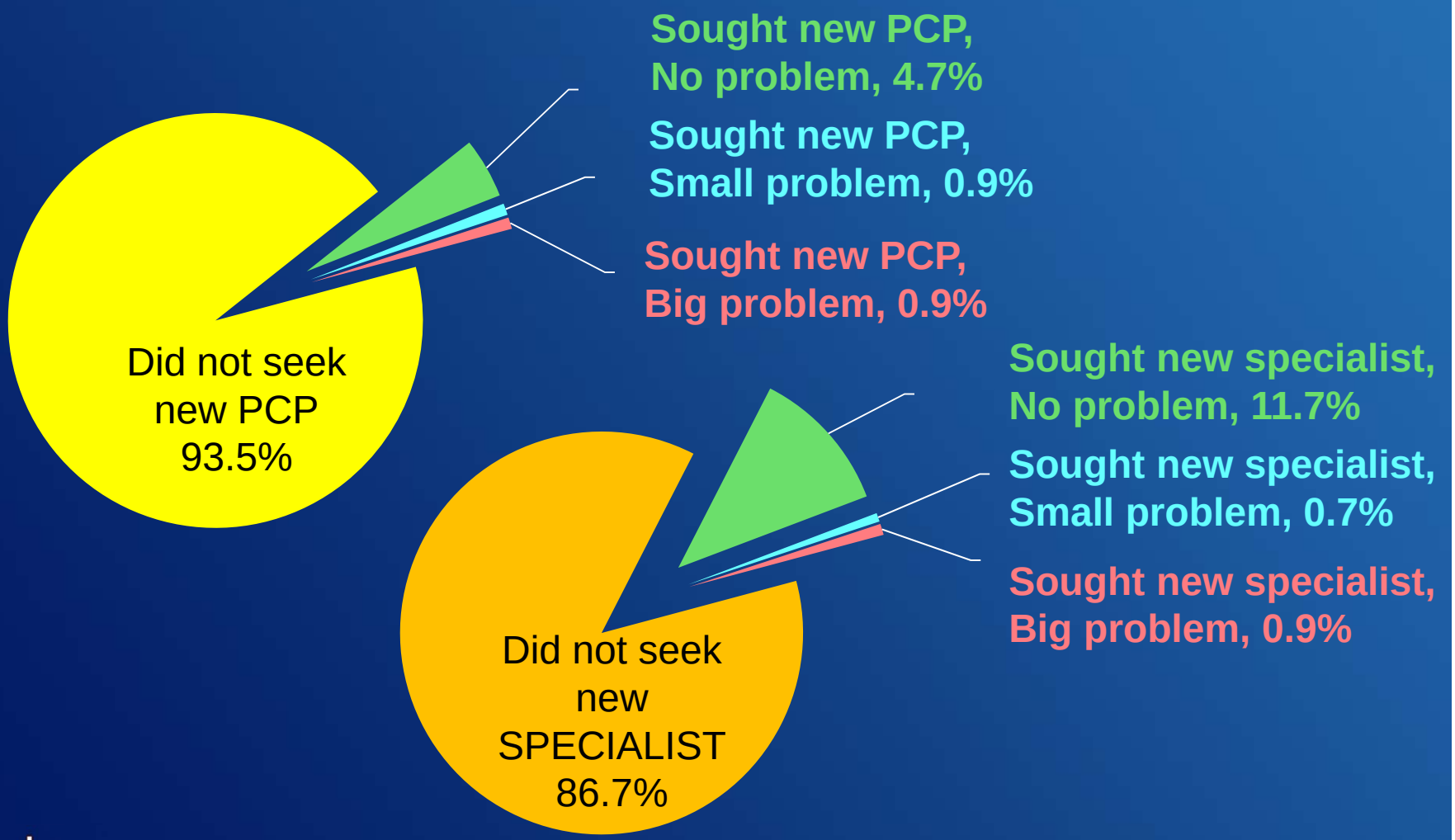
- Access
  - Annual MedPAC survey
  - Other national surveys and focus groups of patients and physicians
  - Volume growth
- Quality – ambulatory care measures
- Ratio of Medicare to private insurer payments
- Other measures of financial performance

MedPAC 2012 physician access survey

	Medicare	Privately insured (age 50-64)
Never had to wait longer for a regular or routine appointment	77%	72%
Never had to wait longer for an illness or injury appointment	84%	80%

- Minority access to specialty care continues to be worse than for non-Hispanic white beneficiaries
- Very little difference in access between rural and urban beneficiaries
- Other national surveys and focus groups of providers and beneficiaries found similar results

Most beneficiaries did not seek a new physician in the past year, but some reported problems when looking

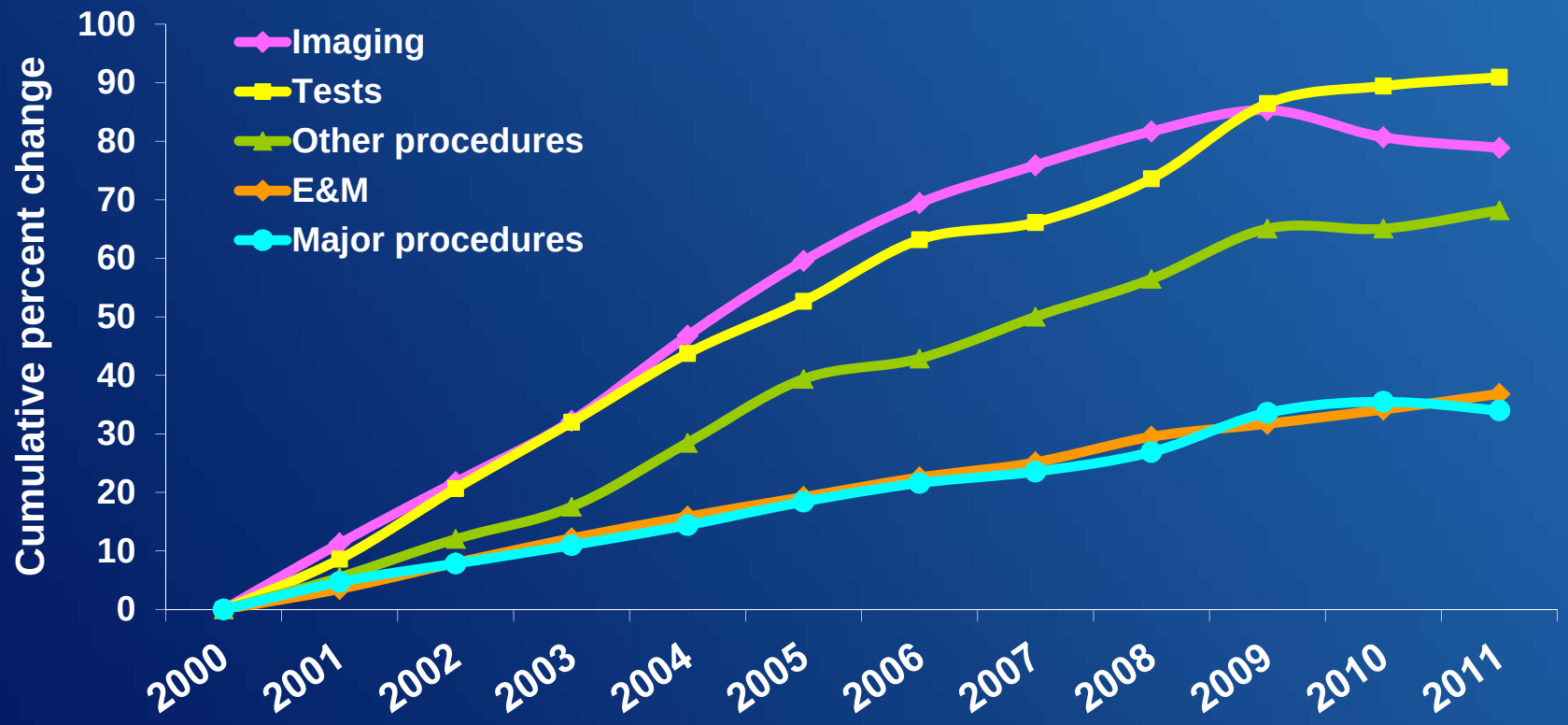


Note: Numbers may not sum to 100% because of rounding and missing responses. Numbers are preliminary and subject to change.
Source: MedPAC-sponsored telephone survey, 2012.

Most quality indicators were stable or improved from 2009 to 2011

- 32 out of 38 claims-based, ambulatory quality measures (for the elderly) improved or were stable
- Among the measures that declined,
  - Decreases were small
  - Most were process measures
  - One potentially avoidable hospitalization measure worsened
  - Some tracked findings in the private market (e.g., mammography screening)

Growth in the volume of fee schedule services per beneficiary, 2000-2011



Note: (E&M Evaluation and management). Volume growth for E&M from 2009 to 2010 is not directly observable due to a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2011, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

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Modest decrease in use of imaging

- Followed decade of rapid growth
  - cumulative decrease in 2010 and 2011 less than 4 percent
  - increase from 2000 to 2009 totaled 85 percent
- Occurred amid concerns about appropriateness

Much of decrease due to change in setting for cardiac imaging

Change in cardiac imaging units of service per beneficiary, 2010-2011

	Hospital outpatient department	Professional office
Echocardiography	17.6%	−7.2%
Nuclear cardiology	13.6%	−12.9%

Note: APC (ambulatory patient classification). Echocardiography includes services in APCs 0269, 0270, and 0697. Nuclear cardiology includes services in APCs 0377 and 0398.

Source: MedPAC analysis of outpatient claims for 5 percent of Medicare beneficiaries and carrier claims data for 100 percent of Medicare beneficiaries.

Repeat diagnostic testing in Medicare

- Geographic variation in use of imaging and other diagnostic services
  - Echocardiography
  - Imaging stress tests
  - Chest CT
  - Upper GI endoscopy
  - Pulmonary function tests
  - Cystoscopy
- Positive correlation between how frequently a test is initiated and how frequently it is repeated
- Raises questions about appropriate use, availability and adherence to imaging guidelines
- Could physicians make more effective use of their time?

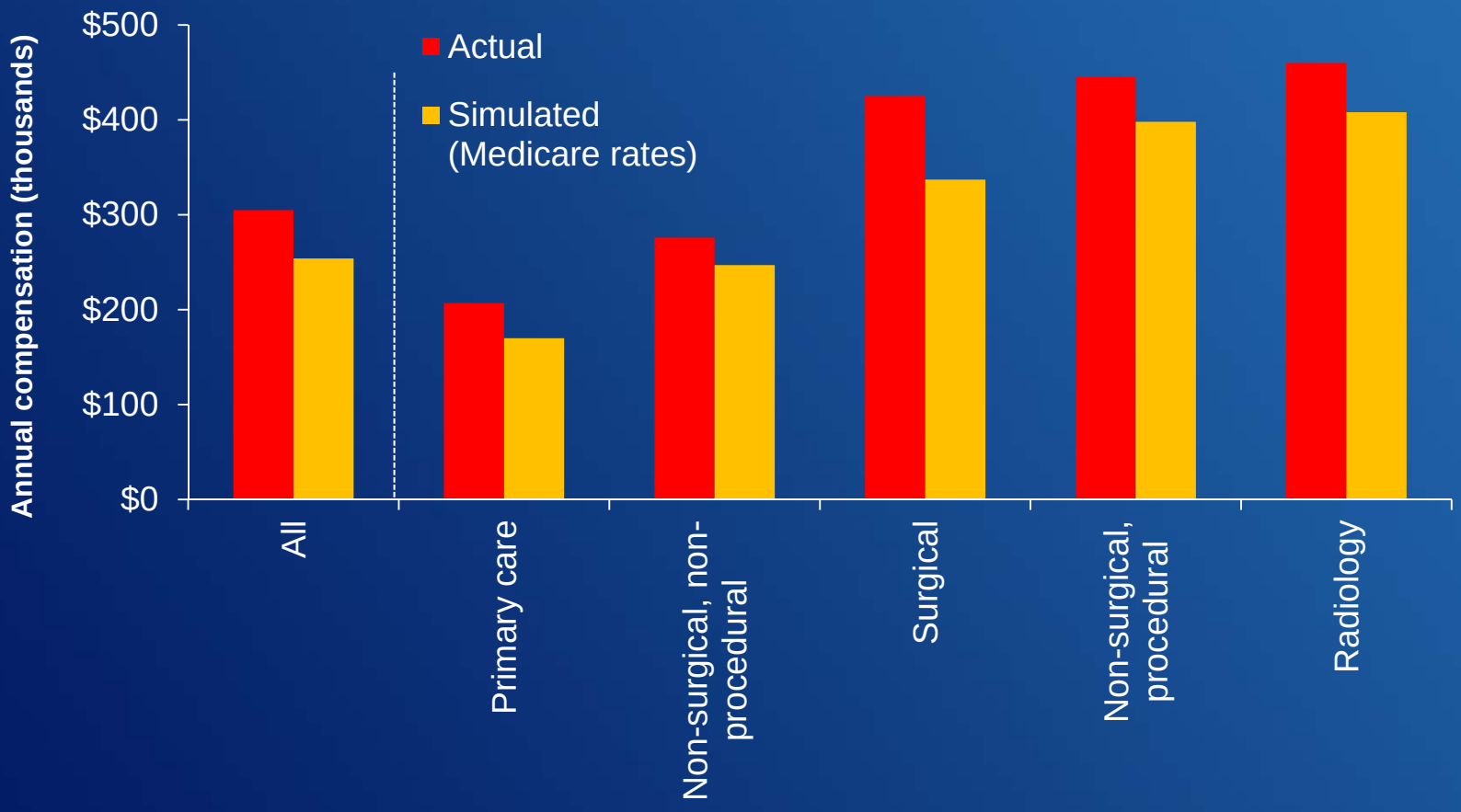
Source: Welch et al., 2012. Repeat testing among Medicare beneficiaries. *Archives of Internal Medicine*. Online first. November.

Other indicators

- Ratio of Medicare to private PPO rates continued at 80% for 2011 – same as in previous year
- Among physicians and other practitioners billing Medicare in 2011, 96% were “participating” (accept Medicare’s fee schedule amounts as payment in full for all Medicare services)
- 99% of allowed charges were paid “on assignment” in 2011

Numbers are preliminary and subject to change

Disparities in compensation widest when primary care is compared to non-surgical proceduralists and radiologists



Note: Simulated compensation is compensation as if all services were paid under the physician fee schedule.
Source: Urban Institute 2011.

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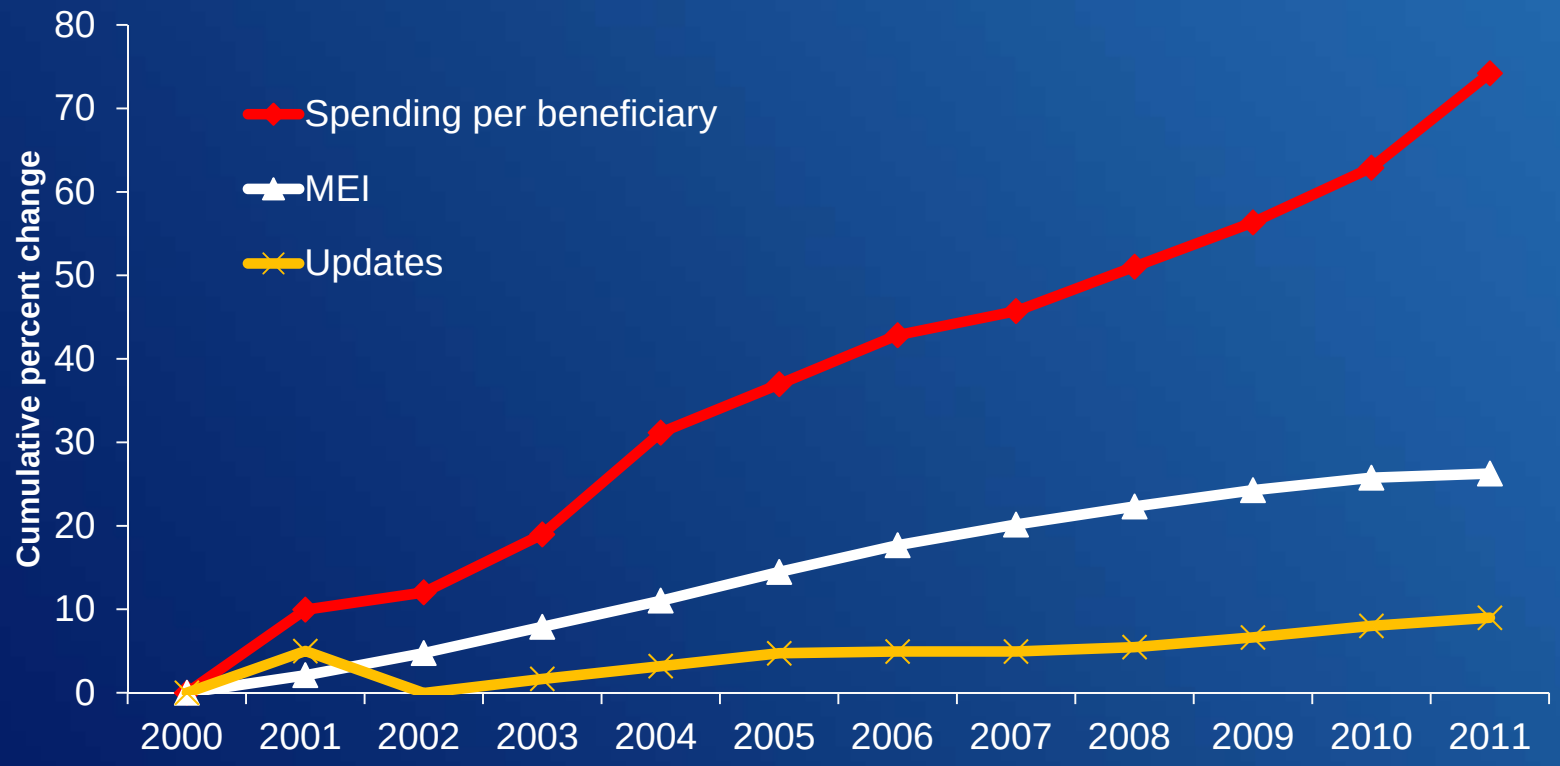
Spending has grown faster than input prices or the updates



Note: MEI (Medicare Economic Index).
Source: 2012 trustees' report and OACT 2012.

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SGR findings

The SGR is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries

- The SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth
- Temporary, stop-gap fixes to override the SGR undermine the credibility of Medicare
- The cost of SGR repeal continues to grow, creating pressure to repeal it now; potential Medicare offsets are being used for other purposes

SGR principles

- The link between cumulative fee-schedule expenditures and annual updates is unworkable and should be eliminated
- Beneficiary access to care must be protected
- Proposals to replace the SGR must be fiscally responsible

Important facts about ASCs

- Medicare payments in 2011: $3.4 billion
- Beneficiaries served in 2011: 3.4 million
- Number of ASCs in 2011: 5,344
- 90% have some degree of physician ownership
- Will receive payment update of 0.6% in 2013

Benefits and concerns about ASCs relative to HOPDs

- Benefits of ASCs
  - Efficiencies for patients and physicians
  - Lower payment rates and cost sharing in ASCs
- Concern over ASCs
  - Most ASCs have physician ownership
  - Evidence from recent studies that physicians who own ASCs perform more procedures

Comparison of ASC and HOPD patients

- Relative to HOPD patients, ASC patients are less likely to be dual eligible, minority, under 65, and 85 or older
- Patient severity (CMS-HCC risk scores)
  - Average HOPD patient has higher risk score than average ASC patient (2010)
  - For services that account for 70 percent of ASC volume, risk scores are not significantly higher among HOPD patients

Measures of payment adequacy

- Access and supply
- Access to capital
- Medicare payments
- No cost or quality data

Access to ASC services, supply of ASCs, and Medicare payments have increased

	Avg annual increase, 2006-2010	Increase, 2010-2011
FFS beneficiaries served	2.2%	0.9%
Volume per FFS beneficiary	5.7%	1.9%
Number of ASCs	171 (3.6%)	92 (1.8%)
Medicare payments per FFS beneficiary	5.1%	2.2%

Numbers are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims and Provider of Services file from CMS, 2006-2011.

Access to capital has been adequate

- Capital is required to establish new ASCs
- Number of ASCs grew at an annual rate of 3.6% over 2006-2010
- Growth has slowed: 1.8% in 2011
  - Slow recovery from economic downturn and other factors have led to slower growth

CMS adopted quality reporting program for ASCs for 2012

- ASCs began reporting 5 claims-based measures in Oct. 2012
- ASCs that do not report measures will receive lower annual update in 2014
- Commission recommended that the Congress direct the Secretary to implement value-based purchasing program for ASCs no later than 2016 (March 2012 report)

Summary of payment adequacy measures

- Access to ASC services continues to increase
  - Number of FFS beneficiaries served
  - Volume per FFS beneficiary
  - Number of ASCs
- Access to capital has been adequate
- Lack cost and quality data
  - Commission recommended that ASCs be required to submit cost data (2009, 2010, 2011, 2012)
  - No plan to collect cost data