Assessing payment adequacy: physician and other health professional services

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January 10, 2013

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Today's presentation

- Review of payment adequacy
- Additional data on access and other issues raised in December
- Update provision in American Taxpayer Relief Act of 2012
- Commission's position on repeal of sustainable growth rate (SGR)

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
- Quality – ambulatory care measures
- Measures of financial performance
- Volume growth

Additional data on access

- Reasons beneficiaries are seeking a new physician
  - Of those looking for a PCP, 20% were looking because they recently moved
  - Medicare beneficiaries are more likely than private enrollees to be seeking a PCP because their current provider stopped practicing or moved
- Do racial and ethnic minorities have more trouble finding a specialist because they lack a usual source of care?
  - Roughly equal shares of white, black and Hispanic beneficiaries report they have a primary care doctor
  - But higher shares of black and Hispanic beneficiaries report a problem finding a specialist than white beneficiaries

See a nurse practitioner or physician assistant for primary care?

	Privately insured	Medicare		
		All	Urban	Rural
All or most of your primary care	10%	9%	8%	17%
Some of your primary care	26%	21%	20%	24%
None of your primary care	62%	66%	69%	55%
Not applicable/ don't know	2%	3%	3%	4%

Source: MedPAC beneficiary telephone survey, 2012

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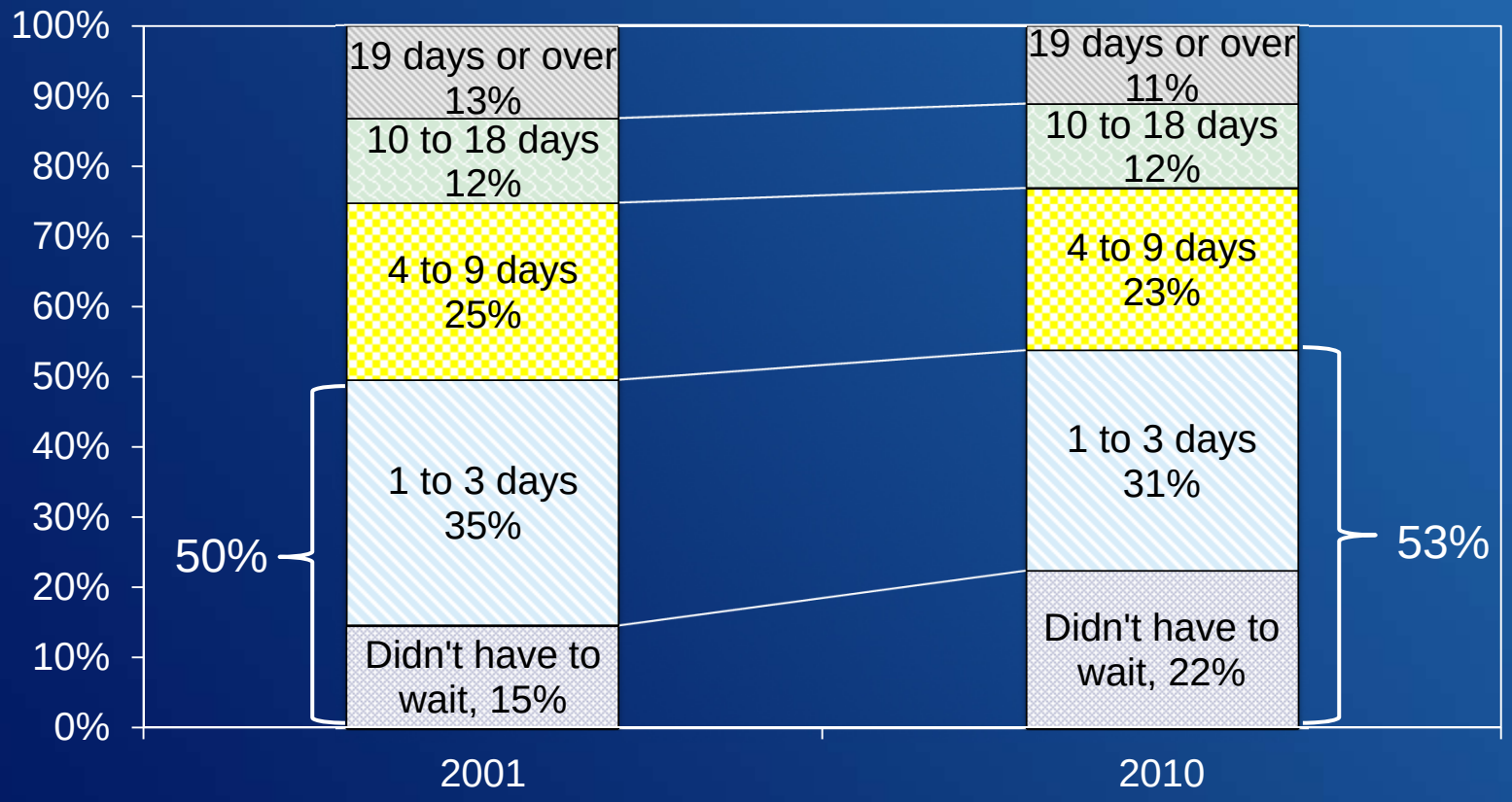
Wait times to see a physician



Source: Medicare Current Beneficiary Survey
Notes: Intervening years did not show significant differences. Non-institutionalized Medicare beneficiaries.

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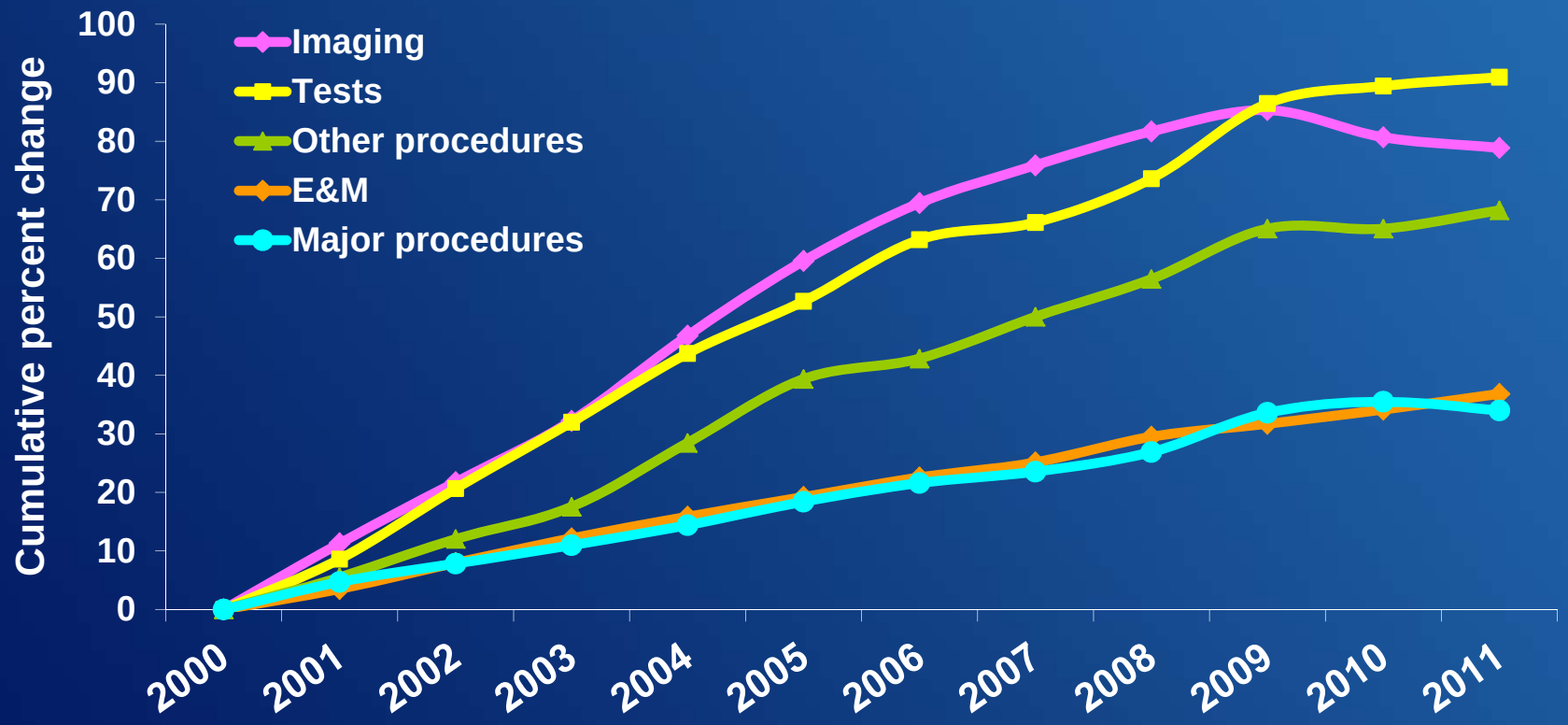
Growth in the volume of fee schedule services per beneficiary, 2000-2011



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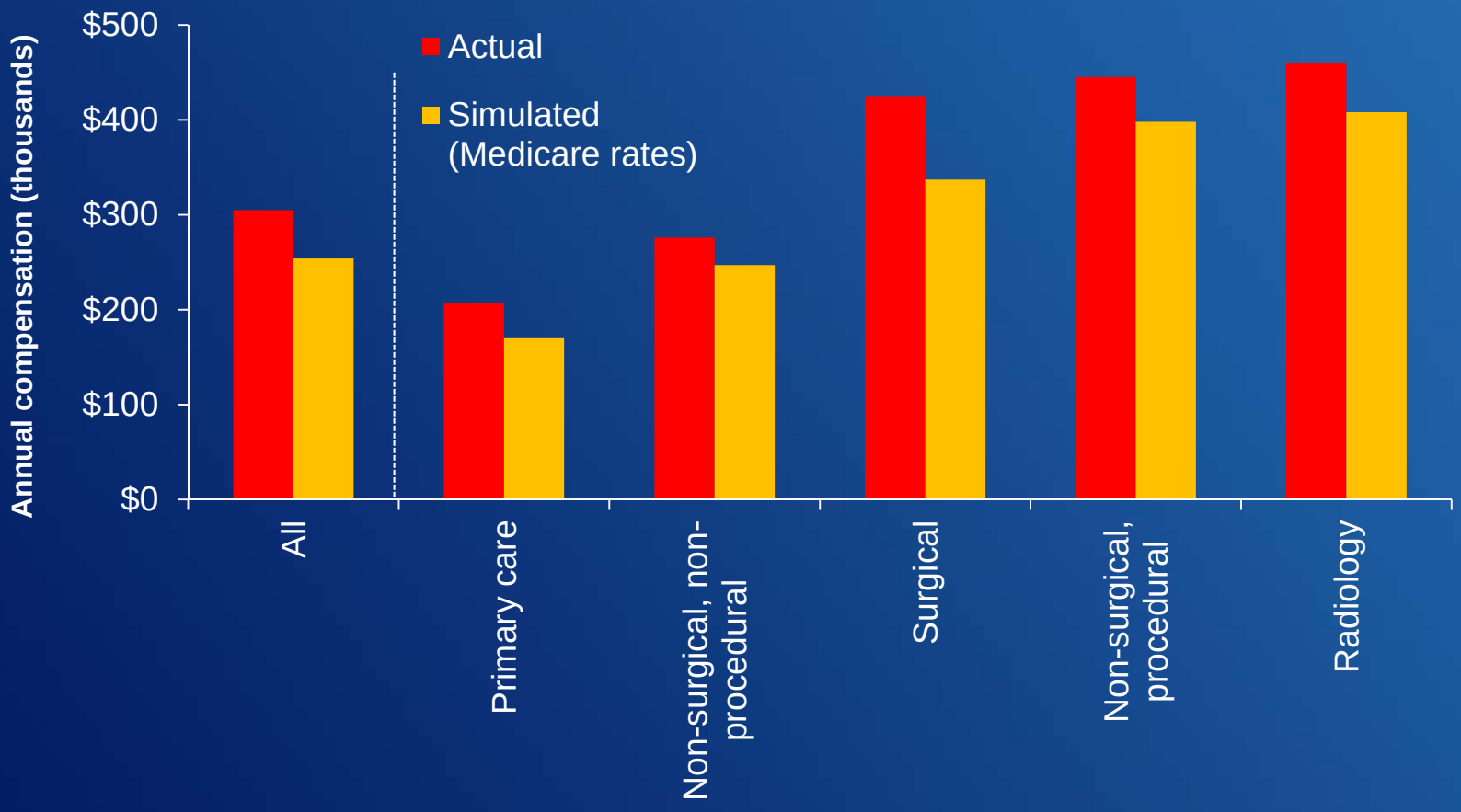
Disparities in compensation widest when primary care is compared to non-surgical proceduralists and radiologists



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

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Summary of payment adequacy indicators

- Access
  - Surveys find that Medicare beneficiaries have stable access to physician services, and access is better than for privately-insured individuals
  - Most physicians willing to accept Medicare patients
- Performance on most quality measures is stable
- Measures of financial performance are stable
- Small increase in volume growth

Update provision in American Taxpayer Relief Act of 2012

- Update for services of physicians and other health professionals: extend current payment rates through December 31, 2013
- 10-year budget score: $25.2 billion

Repeal of SGR is urgent

- October 2011 letter to the Congress
- Deferral will not lead to better choices
  - Concerns about access
  - Cost of repeal will only increase
  - Options unlikely to change in near term
  - If Medicare savings applied to deficit reduction, repeal becomes more difficult using only Medicare offsets

Principles for repeal of SGR

- Preserve access
- Rebalance payments toward primary care
- Encourage new payment models, systems
- Offset the cost of repeal
  - If within Medicare only
    - freeze or decrease fee schedule payments
    - reduce payments to other providers
    - increase beneficiary cost sharing
  - Other offsets? Medicare cuts can be reduced