Assessing payment adequacy and updating payments: physician and other health professional services

Kate Bloniarz and Kevin Hayes

December 18, 2014

MEDPAC

Overview of presentation: physician and other health professionals

- Payment adequacy assessment
  - Access to care
  - Volume growth
  - Quality
  - Measures of financial performance
- Commission's position on the SGR
- Per beneficiary payment for primary care

Background: Physician and other health professional services in Medicare

- $68.6 billion in 2013
  - 16 percent of FFS benefit spending
- 875,000 practitioners billed Medicare
  - 575,000 physicians
  - 150,000 advance-practice nurses and physician assistants
  - 150,000 therapists and other providers
- 98% of Medicare beneficiaries received at least one fee-schedule service in 2013

Access to ambulatory care services

- Commission's approach
  - Yearly telephone survey
  - Yearly focus groups of beneficiaries and providers, and site visits
  - Other surveys of beneficiaries and providers
- Overall findings
  - Beneficiary's access to ambulatory care services is adequate
  - As good or better than for privately-insured
  - Generally unchanged from last year
  - Some groups experience more trouble

MedPAC survey: Satisfaction with overall care in the past 12 months

	Medicare		Privately insured (age 50-64)	
Very satisfied	68%		59%	
Somewhat satisfied	20%	88%	23%	82%
Somewhat dissatisfied	3%		4%	
Very dissatisfied	2%		1%	

Note: Table excludes following responses: did not receive health care in past 12 months, don't know, refused. Data preliminary and subject to change.

Source: MedPAC-sponsored telephone survey, 2014.

MedPAC survey: Most beneficiaries do not face trouble finding new doctor

	Primary care doctor	Specialist
Not looking for a new doctor	92.0%	83.2%
Looking for a new doctor	8.0	16.8
--No problem	5.5	14.4
--Small problem	1.3	1.2
--Big problem	1.2	1.2

Note: Data preliminary and subject to change. Numbers may not sum to 100% because of rounding and missing responses.

Source: MedPAC-sponsored telephone survey, 2014.

Other payment adequacy indicators

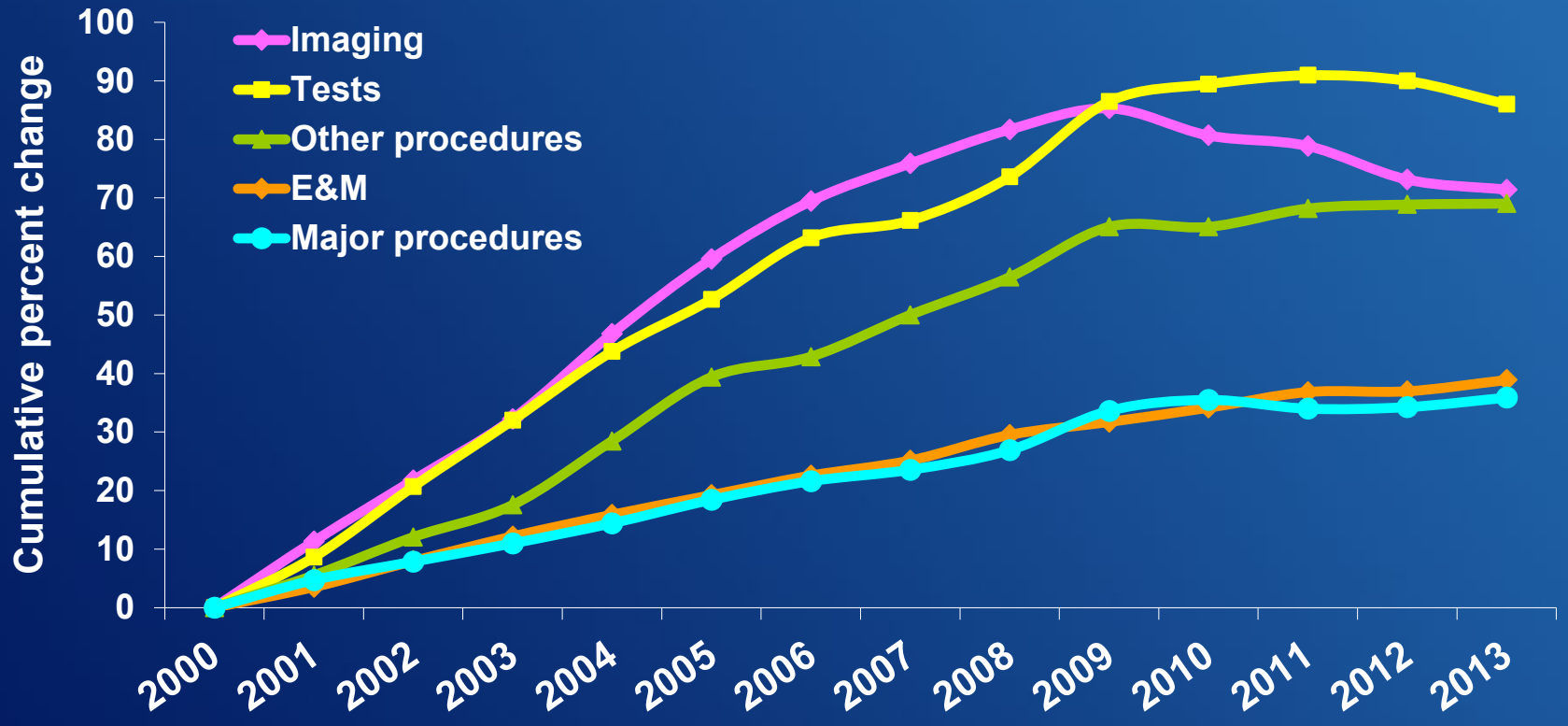
- Provider participation in Medicare
  - Rates of Medicare participation and assigned charges stable
  - Few providers “opt-out” of Medicare
- Quality
  - Commission discussing new approaches to quality
  - Illustrative example in briefing materials
- Medicare’s payments
  - Ratio of Medicare to private PPO rates: 79%

Numbers are preliminary and subject to change

Changes in service use measured as growth in the volume of services

- Volume measured by billing code as number of services multiplied by fee schedule's relative value units (RVUs)
- Volume growth accounts for change in number of services and change in intensity (e.g., substitution of CT for X-rays)
- Together with changes in fees, determines spending growth

Growth in the volume of fee schedule services per beneficiary, 2000-2013



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 2013, 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.

MEDPAC

Data are preliminary and subject to change.

Small decreases in the volume of imaging and tests do not raise concerns

- Volume grew rapidly from 2000 to 2009
  - Imaging: 85 percent
  - Tests: 86 percent
- By comparison, recent decreases in both categories have been small
- Cardiac imaging accounts for imaging decrease
- Growth has led to concerns about appropriateness (e.g., Choosing Wisely initiative)

Volume decreases include shifts in site of care

- Trend toward billing for some services in hospitals instead of professionals' offices
- This trend increases program spending and beneficiary out-of-pocket costs
- Volume sensitive to shifts in site of care
- Practice expense RVUs lower for services billed as facility (e.g., hospital)

Shift in cardiac imaging billing from professional office to hospital outpatient department

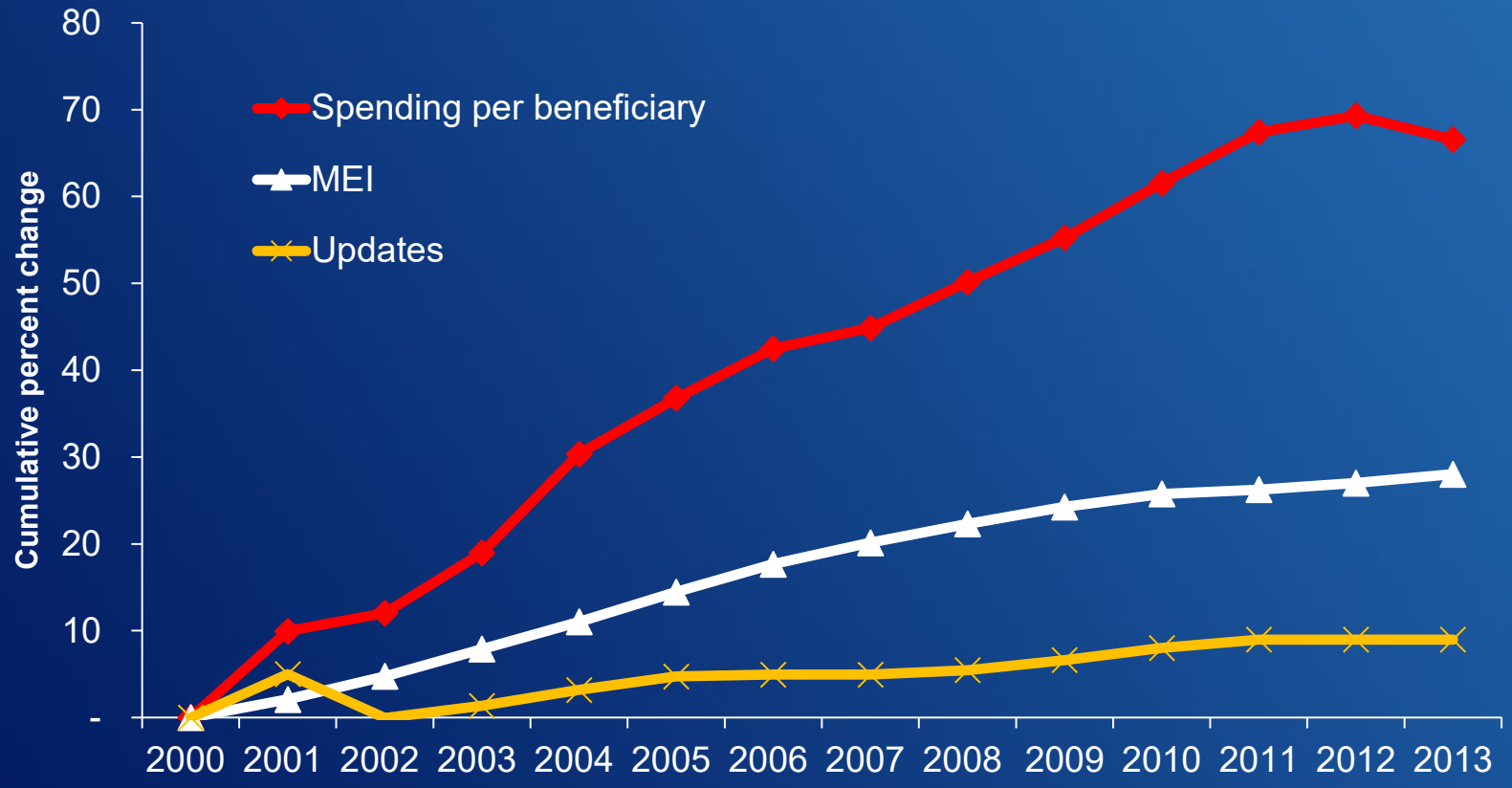
Change in cardiac imaging units of service per beneficiary, 2012-2013

	Hospital outpatient department	Professional office
Echocardiography	7.4%	−8.0%
Nuclear cardiology	0.4%	−12.1%

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.

Volume has raised spending more than increases in input prices or the updates



Note: MEI (Medicare Economic Index).
Source: 2014 trustees' report and Office of the Actuary 2014.

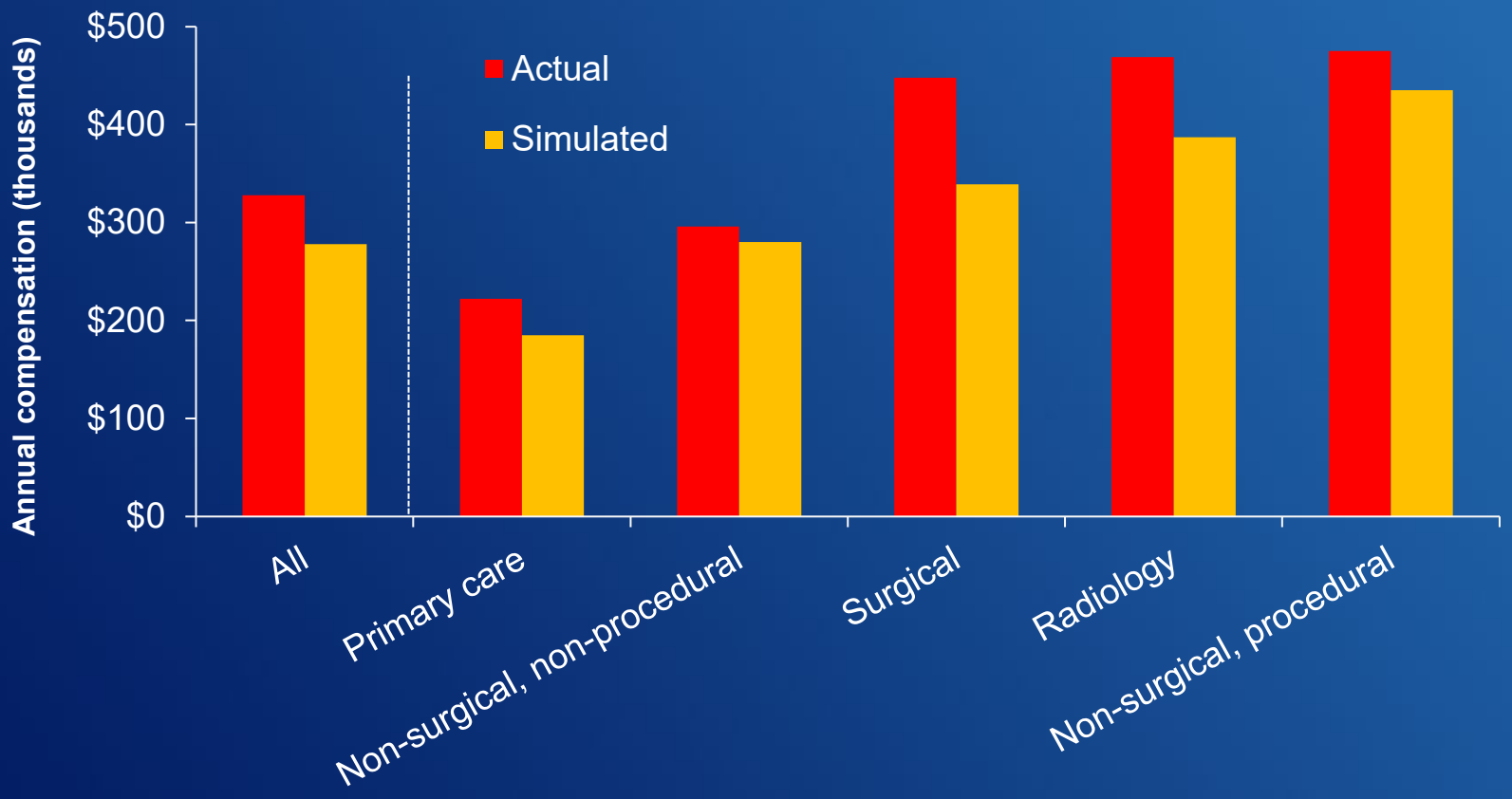
MEDPAC

Data are preliminary and subject to change.

Payment adjustments outside of the update process

- Payment adjustments are significant
- Three types
  - Applied to fee-schedule payments (e.g., work GPCI floor)
  - Not applied to fee-schedule payments but in Medicare spending totals (e.g., eHR incentive)
  - Other (e.g., CMMI demos)
- Have effectively increased payments by more than updates to conversion factor

Disparities in compensation widest when primary care compared to radiologists, non-surgical proceduralists, 2012



Note: Simulated compensation is compensation as if all services were paid under the Medicare fee schedule.
Source: Urban Institute 2014.

MEDPAC

Data are preliminary and subject to change.

Overall assessment of payment adequacy

- Payment adequacy has not changed
  - Access indicators are stable
  - Small increase in volume of services
  - Disparities in compensation raise concerns about fee-schedule accuracy
- Repeal of SGR still needed

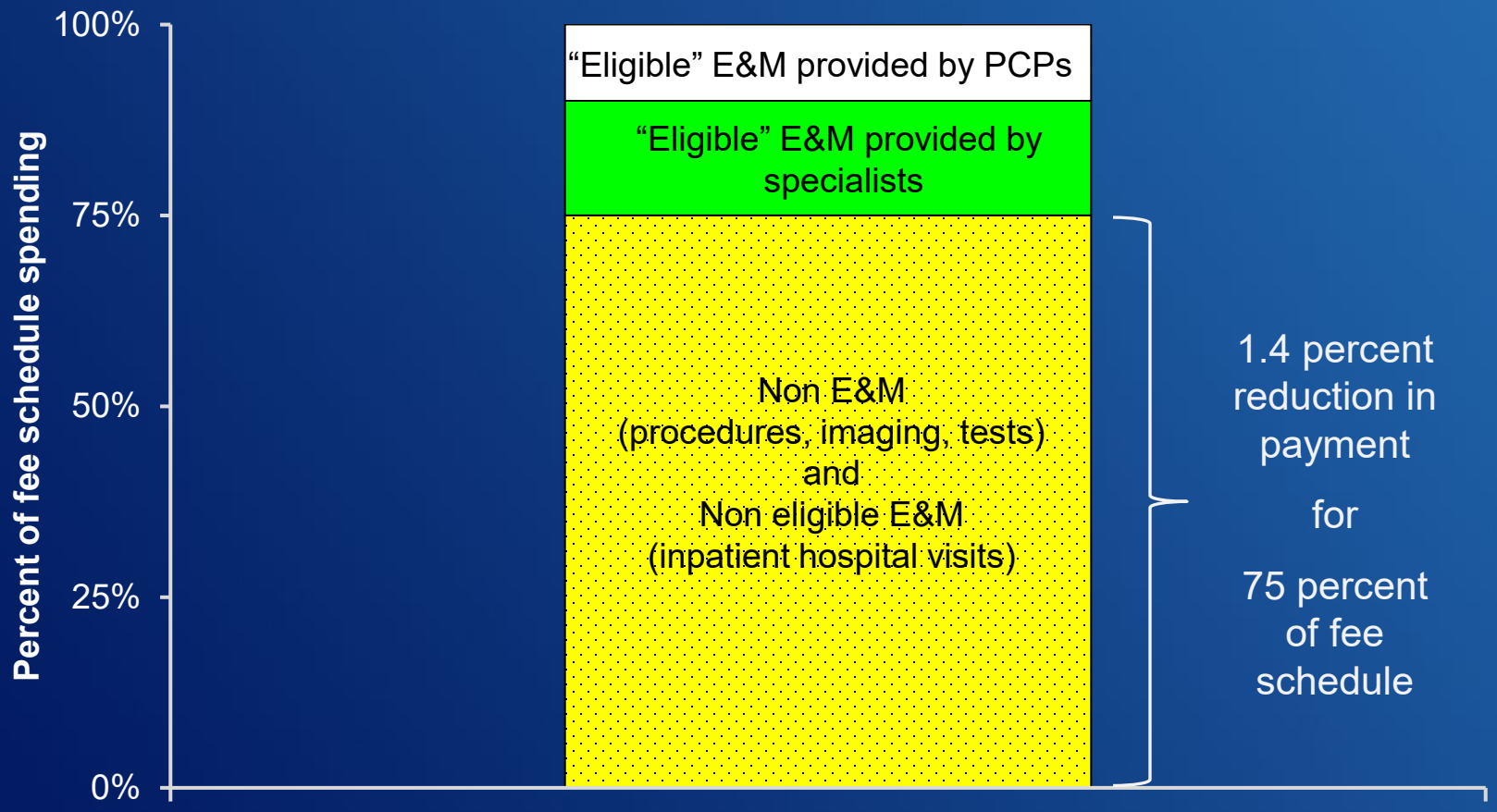
Commission's position in recent March reports: Repeal the SGR

- Repeal is urgent
- Temporary overrides
  - Uncertainty for beneficiaries and practitioners
  - Administrative burden for CMS
  - Barrier to broad-based reform
- Slowdown in spending has led to decrease in cost of repeal

Per beneficiary payment for primary care

- Rationale
  - Primary care undervalued in fee schedule
  - Differences in physician compensation
  - Per beneficiary payment could replace expiring primary care bonus
- Design features
  - Payment amount set at the level of the current bonus
  - Payable for beneficiaries prospectively attributed to practitioners
  - Payment not contingent on practice requirements

Fee schedule reduction as funding source



MEDPAC Note: E&M (evaluation and management services), PCPs (eligible primary care practitioners).

Summary

- Payments are adequate
  - Indicators of access are stable
  - Small increase in volume
  - Disparities in physician compensation raise concerns about fee-schedule accuracy
- Chairman's proposal regarding the SGR
- Chairman's draft recommendation on per beneficiary payment for primary care