Assessing payment adequacy and updating payments: Physician and other health professional services and Supporting Medicare safety-net clinicians

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December 8, 2022

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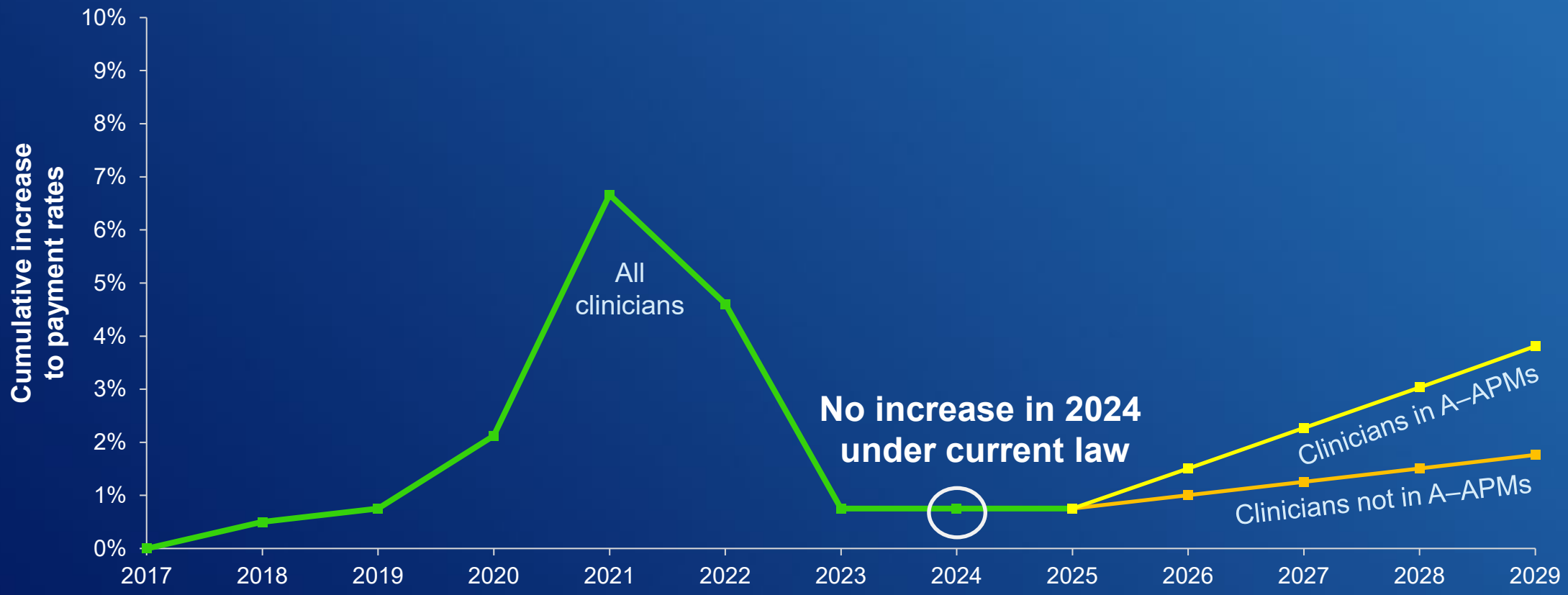
Background: Medicare's physician fee schedule

- Pays for clinician services in a wide variety of settings (hospitals, nursing homes, doctors' offices)
- Spending on physician fee schedule services declined in 2020, then increased in 2021

- Clinicians were paid $40B in relief funds in 2020 (more than offsetting their all-payer pandemic losses), plus funds in 2021

Note: FFS (fee-for-service). Spending on physician fee schedule services refers to allowed charges (Medicare payments plus beneficiary cost sharing obligations) for FFS beneficiaries. Data are preliminary and subject to change.
Source: MedPAC analysis of Medicare fee-for-service claims data; CMS, Accounting for federal COVID expenditures in the National Health Expenditure Accounts, 2021, https://www.cms.gov/files/document/accounting-federal-covid-expenditures-national-health-expenditure-accounts.pdf.

In 2023, Medicare clinician payment rates will return to 2019 levels, following temporary increases in 2020-2022



Note: A-APMs (advanced alternative payment models). Graph shows increases to payment rates in nominal terms. Graph does not show CMS adjustments to payment rates to ensure that changes to values of individual billing codes are budget neutral. Graph also does not show annual MIPS adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or annual 5 percent A–APM bonuses available from 2019 to 2024, because these adjustments are one-time and not built into subsequent years' payment rates.

Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015, the Bipartisan Budget Act of 2018, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Consolidated Appropriations Act, 2021, An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, and the Protecting Medicare and American Farmers from Sequester Cuts Act.

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We assess the adequacy of Medicare's payment rates for clinicians using three categories of indicators

Access to care

- Patient experiences in surveys and focus groups
- Supply of clinicians
- Volume of clinician encounters

Quality of care

- Ambulatory care-sensitive hospital use
- Patient experience scores

Clinicians' revenue & costs

- Growth in clinicians' input costs
- Spending per Medicare beneficiary
- Ratio of commercial payment rates to Medicare's payment rates
- Physician compensation

Update recommendation for physician fee schedule in 2024

One way we assess access to care is through our annual survey of Medicare beneficiaries and privately insured people

- We changed our survey mode in 2022
  - Previously: Interviewer-administered telephone survey
  - Now: Self-administered online/mail survey
- Higher shares of both groups reported problems obtaining care
  - Could be due to:
    - Real changes in the environment and/or
    - Changes to our survey mode
- But as with prior years, Medicare beneficiaries' access to care was equal to, or better than, that of privately insured people

Note: The Commission also changed our sampling and weighting approaches. Our survey continues to have a sample size of approximately 4,000 Medicare beneficiaries ages 65+ and 4,000 privately insured people ages 50-64. Our survey was fielded in August 2022. Results have a margin of error of +/-1.9 percentage points at the 95% confidence level. Data are preliminary and subject to change.

Key findings from the Commission's 2022 survey

- 11% of beneficiaries looked for a new primary care provider (PCP)
  - Half did so because their PCP retired / stopped practicing (5% of all beneficiaries)
  - Half of the beneficiaries looking for a new PCP had problems finding one (6% of all beneficiaries)
- 26% of beneficiaries looked for a new specialist
  - A third of these beneficiaries had a problem finding one (8% of all beneficiaries)
- 18% of beneficiaries reported foregoing care in the past year
  - A fifth of these beneficiaries couldn't get an appointment soon enough (4% of all beneficiaries)

Note: Data are preliminary and subject to change.

The supply of clinicians billing Medicare is stable

- The number of clinicians billing under the fee schedule grew by an average of 2.5% per year from 2016 to 2021
- Changes varied by the type and specialty of clinician (2016-2021)
  - Rapid growth in APRNs and PAs
  - Growth in specialists
  - Modest decline in number of primary care physicians
- Nearly all clinicians who billed under the fee schedule in 2021 accepted Medicare's payment rates as payment in full

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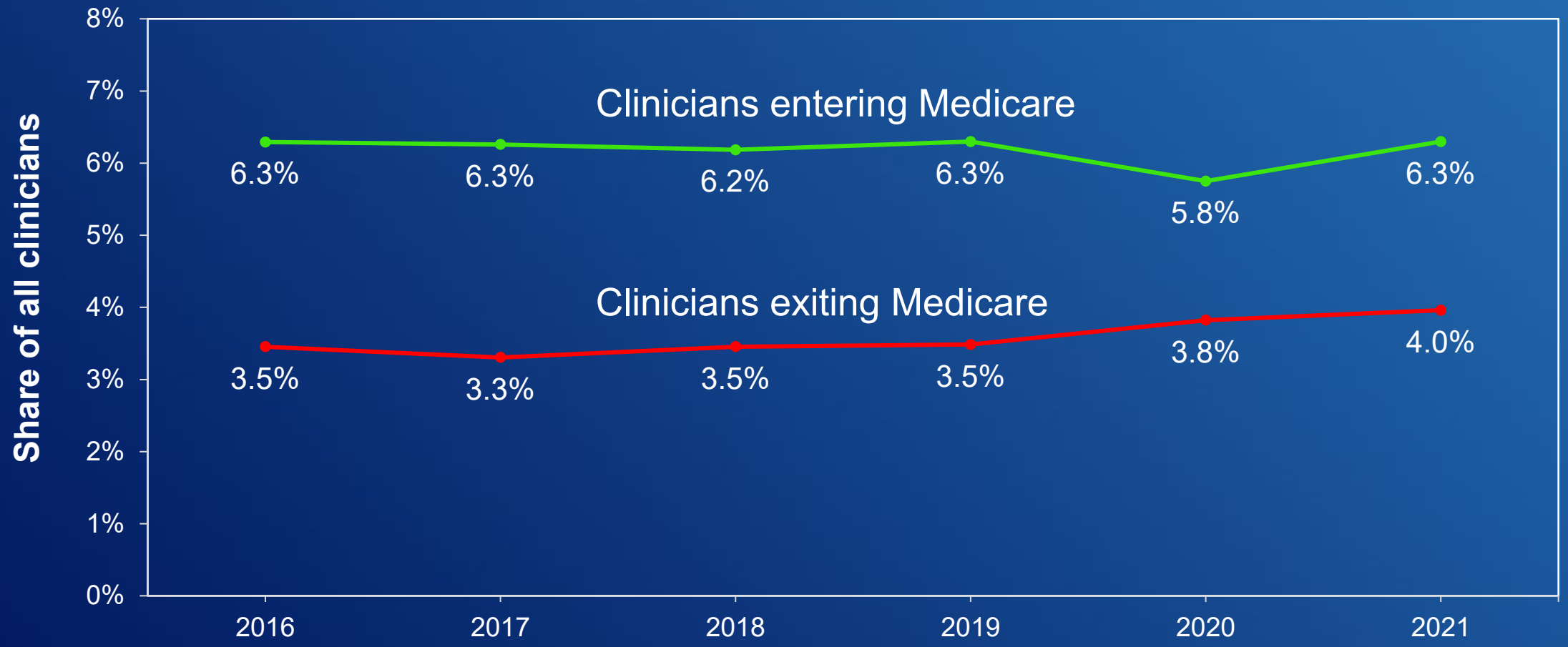
Note: APRNs (advanced practice registered nurses), PAs (physician assistants). Data are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data and Medicare Trustees report.

Trends in the share of clinicians entering and exiting traditional Medicare, 2016-2021



Note: Clinicians entering Medicare are defined as clinicians who billed the physician fee schedule for more than 15 beneficiaries in a year who did not bill the fee schedule for any beneficiaries in the prior year. Clinicians exiting Medicare are defined as clinicians who did not bill the fee schedule for any beneficiaries in a year but who billed for more than 15 beneficiaries in the prior year.
Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries

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Number of clinician encounters per FFS beneficiary from 2016 to 2021

- Clinician encounters per FFS beneficiary grew by an average of 0.2% per year
  - This includes 11.1% decline in 2020 and 9.4% increase in 2021
- Changes in the number of encounters per beneficiary varied by type and specialty of clinician
  - Encounters with primary care physicians decreased by 3.5% per year
  - Encounters with APRNs and PAs increased by 8.7% per year

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Note: FFS (fee-for-service), APRNs (advanced practice registered nurses), PAs (physician assistants). APRNs includes nurse practitioners. Data are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data and Medicare Trustees report.

Quality of care in 2021 is difficult to assess, partly due to the effects of the coronavirus pandemic

- Geographic variation in rates of ambulatory care-sensitive hospital use signals opportunities to improve
  - Rates of ambulatory care-sensitive hospitalizations and ED visits are about twice as high in some hospital service areas than others
- CAHPS patient experience scores are high
  - Rating of health plan (FFS Medicare): 83/100
  - Rating of health care quality: 87/100

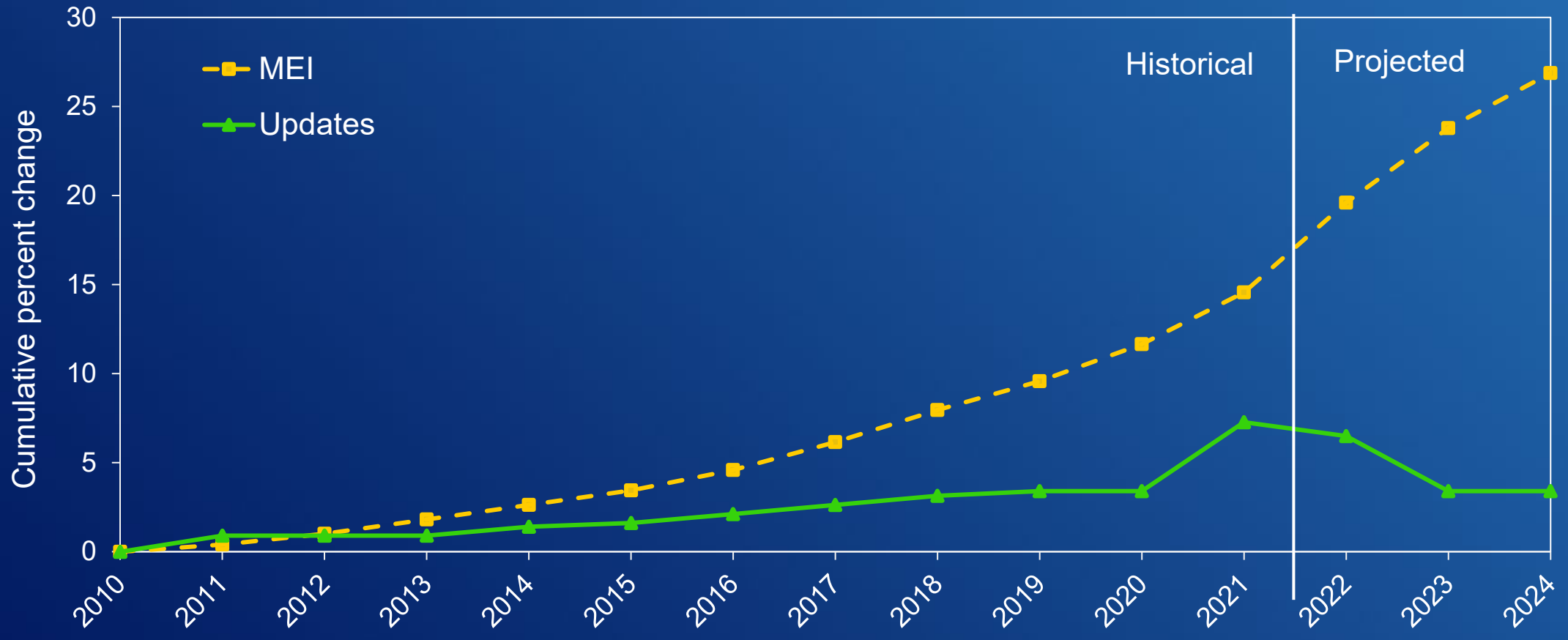
Note: ED (emergency department), CAHPS (Consumer Assessment of Healthcare Providers and Systems), FFS (fee-for-service). CAHPS scores are linear mean scores up to 100. Data are preliminary and subject to change.
Source: FFS CAHPS mean scores publicly reported by CMS; MedPAC analysis of 2021 Medicare FFS claims data.

Clinicians' input costs are growing more rapidly

- Medicare Economic Index (MEI) measures clinicians' input costs and is adjusted for economy-wide productivity
- Before 2021, MEI typically grew 1%-2% per year
- MEI increased 2.6% in 2021
- Projected to increase 4.4% in 2022, 3.5% in 2023, 2.5% in 2024

Source: CMS market basket data.

MEI growing at faster rate than updates to physician fee schedule services, 2010-2024



Note: MEI (Medicare Economic Index). Data are preliminary and subject to change. Graph shows increases to payment rates in nominal terms. Graph does not show annual MIPS adjustments or annual 5 percent A–APM bonuses available from 2019 to 2024 because these adjustments are one-time and not built into subsequent years' payment rates. Graph does not show CMS adjustments to payment rates to ensure that changes to the fee schedule's work relative value units are budget neutral.
Source: CMS market basket data; MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015 and the Bipartisan Budget Act of 2018.

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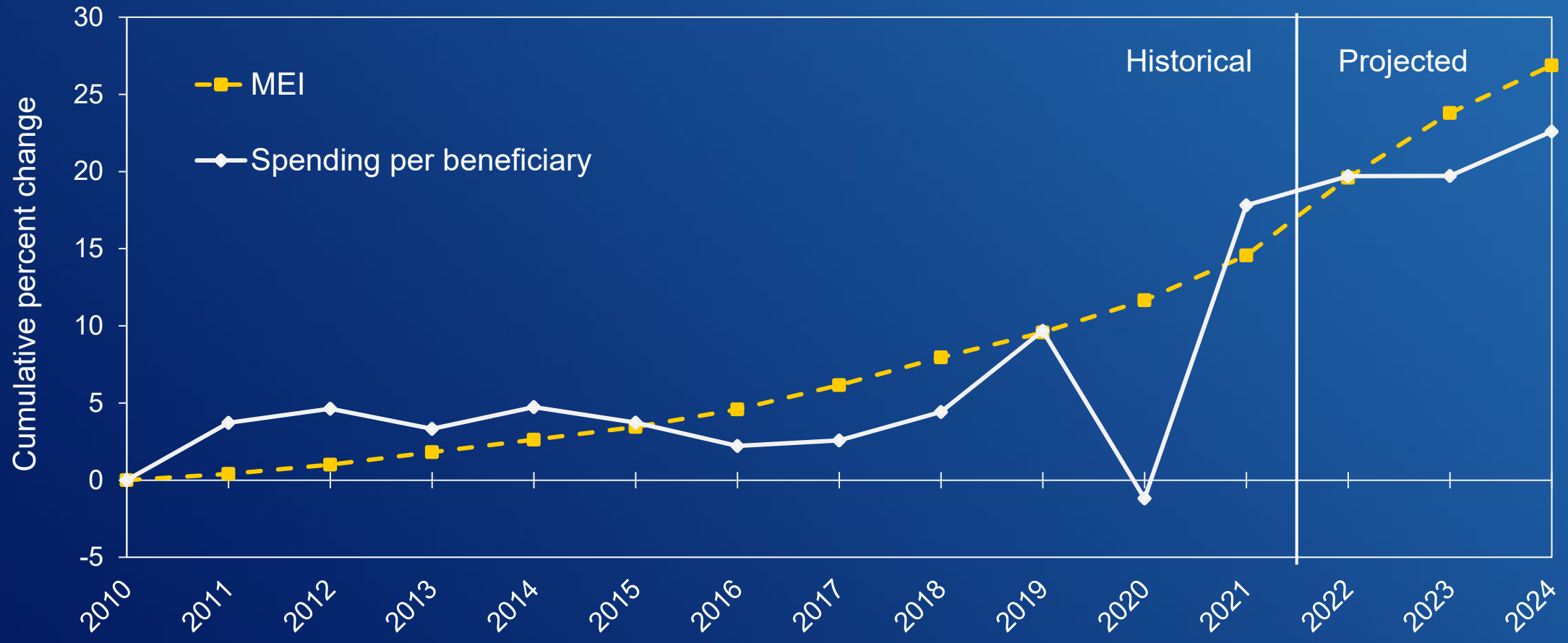
Physician fee schedule spending per FFS beneficiary has largely kept pace with MEI growth, 2010-2024



Note: FFS (fee-for-service), MEI (Medicare Economic Index). Data are preliminary and subject to change. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule.
Source: 2022 annual report of the Boards of Trustees of the Medicare trust funds; CMS market basket data.

Commercial payment rates remain higher than Medicare rates for clinician services but the gap declined in 2021

- Commercial PPO payment rates were 134% of FFS Medicare rates in 2021, down from 138% in 2020
  - Driven by a decline in the ratio of commercial rates to Medicare rates for E&M office/outpatient visits (127% in 2020 vs. 114% in 2021)
  - Medicare payment rates for these E&M visits increased in 2021
- Overall ratio has grown since 2011 as commercial prices have risen due to greater consolidation of physician practices

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Note: PPO (preferred provider organization), FFS (fee-for-service), E&M (evaluation and management). Data are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data and data on paid claims for PPO enrollees of a large national insurer.

Median physician compensation from all payers grew by 3% per year from 2017 to 2021

- Median compensation (all specialties) was $315,000 in 2021
  - Compensation much lower for primary care ($264,000) than nonsurgical, procedural specialties ($450,000) and radiology ($482,000)
- Differences in compensation probably reflect Medicare's historical underpricing of E&M office/outpatient visits
- CMS substantially increased RVUs for these E&M visits in 2021; impact on compensation is unclear
- No consistent relationship between physician compensation and practice ownership (hospital owned or physician owned)

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Note: E&M (evaluation and management), RVUs (relative value units). Data are preliminary and subject to change.
Source: SullivanCotter's Physician Compensation and Productivity Survey, 2022.

Summary: Most indicators suggest payment rates have been adequate, but rising input costs are a concern

Access to care

- Beneficiaries' access comparable to, or better than, privately insured
- Total number of clinicians stable, PCPs declining
- Clinician encounters per beneficiary declined in 2020, partially rebounded in 2021

Quality of care

- Wide variation in rates of ambulatory care-sensitive hospitalizations and ED visits
- Patient experience scores remain high

Clinicians' revenue & costs

- MEI projected to grow 4.4% in 2022, 3.5% in 2023, 2.5% in 2024
- Total FFS Medicare payments increased by $8B in 2021
- Payments per beneficiary declined in 2020, but fully rebounded in 2021
- Commercial PPO payment rates were 134% of FFS Medicare rates in 2021
- Physicians' median compensation grew 3%/year, on average, from 2017 to 2021

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Note: Primary care physicians (PCPs), ED (emergency department), MEI (Medicare Economic Index), PPO (preferred provider organization). Data are preliminary and subject to change.

Clinicians who serve as safety-net providers may have lower revenues

- Some clinicians serve a disproportionate number of low-income beneficiaries
- Clinicians are prohibited from collecting cost sharing from many low-income beneficiaries
- Most states do not make cost-sharing payments on behalf of dually enrolled beneficiaries
  - Reduces clinician revenue by an estimated $3.6 billion annually

Note: Results are preliminary and subject to change.

New Medicare safety-net funding to support clinicians is warranted

- Cannot measure profitability directly, but we can infer that treating low-income beneficiaries is less profitable
  - May put some clinicians at financial risk
  - May hinder access to care for low-income beneficiaries
- Lower-income beneficiaries report having more difficulty accessing clinician care
- Targeted financial support for safety-net clinicians does not exist in physician fee schedule

Key features of clinician safety-net policy

- All clinicians should receive add-on payments for all fee schedule services furnished to qualified low-income FFS beneficiaries
- Add-on payment rates should be higher for primary care clinicians (15%) than non-primary care clinicians (5%)
- Add-on payments should not apply to beneficiaries enrolled in Medicare Advantage or be included in MA benchmarks
- Cost of add-on payments should not be offset

Note: FFS (fee-for-service), MA (Medicare Advantage).

Discussion

- Physician fee schedule update recommendation
- Clinician safety-net recommendation