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

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# Measures of payment adequacy

- Access to care
  - Measures of reported access
  - Capacity and supply of providers
  - Volume of services
- Access to capital
- Quality
- Medicare payments and provider costs

# Background: Physician and other health professional services in Medicare

- $70.3 billion in 2015, 15 percent of FFS spending
- 919,000 practitioners billed Medicare: 582,000 physicians, 183,000 advanced practice nurses and physician assistants, 155,000 therapists and other providers
- Medicare Access and CHIP Reauthorization Act of 2015 established new payment updates in law
  - Update: 0.5% in 2016-2019, 0% in 2020-2025
  - 5% incentive payment each year from 2019-2024 for certain participants in Advanced Alternative Payment Models
  - Merit-based Incentive Payment System for non-APM clinicians, starting 2019

Data preliminary and subject to change.

# Commission's approach to access

- Yearly telephone survey
  - 4,000 Medicare beneficiaries
  - 4,000 individuals age 50-64 with private insurance
- Yearly focus groups of beneficiaries
- Site visits
- Other surveys of beneficiaries and providers

# MedPAC survey: Beneficiaries have comparable access to privately-insured

- Most beneficiaries are able to obtain care when needed
  - Small share of beneficiaries report trouble finding a new provider
  - Beneficiaries more likely to report trouble finding a new primary care doctor than specialist
- Minority beneficiaries report more trouble obtaining care when needed
- Minimal differences in reported access between rural and urban beneficiaries
- Medicare beneficiaries report higher satisfaction with care than privately-insured
- Over past five years, decline in rates of Medicare and privately-insured individuals reporting always obtaining regular or routine care as soon as they wanted

Data preliminary and subject to change.

# Other payment adequacy indicators

- Medicare provider participation and assigned claims remain high (95% of providers participate and 99% of claims assigned)
- Number of providers billing Medicare per beneficiary in 2015 similar to 2014
  - Number of primary care physicians unchanged, specialists fell slightly, advanced-practice nurses and physician assistants increased
- Medicare's payments to physicians and other health professionals were 78% of commercial PPO rates in 2015 (same as 2014)

Data preliminary and subject to change.

# Quality

- Commission has raised concerns about Medicare's current quality programs
  - Burdensome for providers and the program
  - Process doesn't allow for creation of uniform benchmarks
  - Many measures are not linked to patient outcomes
  - Few measures assess low-value care
- Briefing materials present three population-based measures
  - Low-value care is common in Medicare: 35-74 instances per 100 Medicare beneficiaries in 2013
  - National avoidable hospitalization rates declined for most conditions from 2013 to 2014
  - Geographic variation in rates of potentially preventable hospitalizations and emergency department visits

Data preliminary and subject to change.

# Annual volume growth was higher in 2015 than 2010-2014

- Volume for each code = number of services multiplied by fee schedule's relative value units
- Volume growth accounts for change in number of services and change in intensity (e.g., substitution of CT for X-rays)
- Volume growth per FFS beneficiary in 2015 = 1.6% (across all services)
- Average annual volume growth, 2010-2014 = 0.3%



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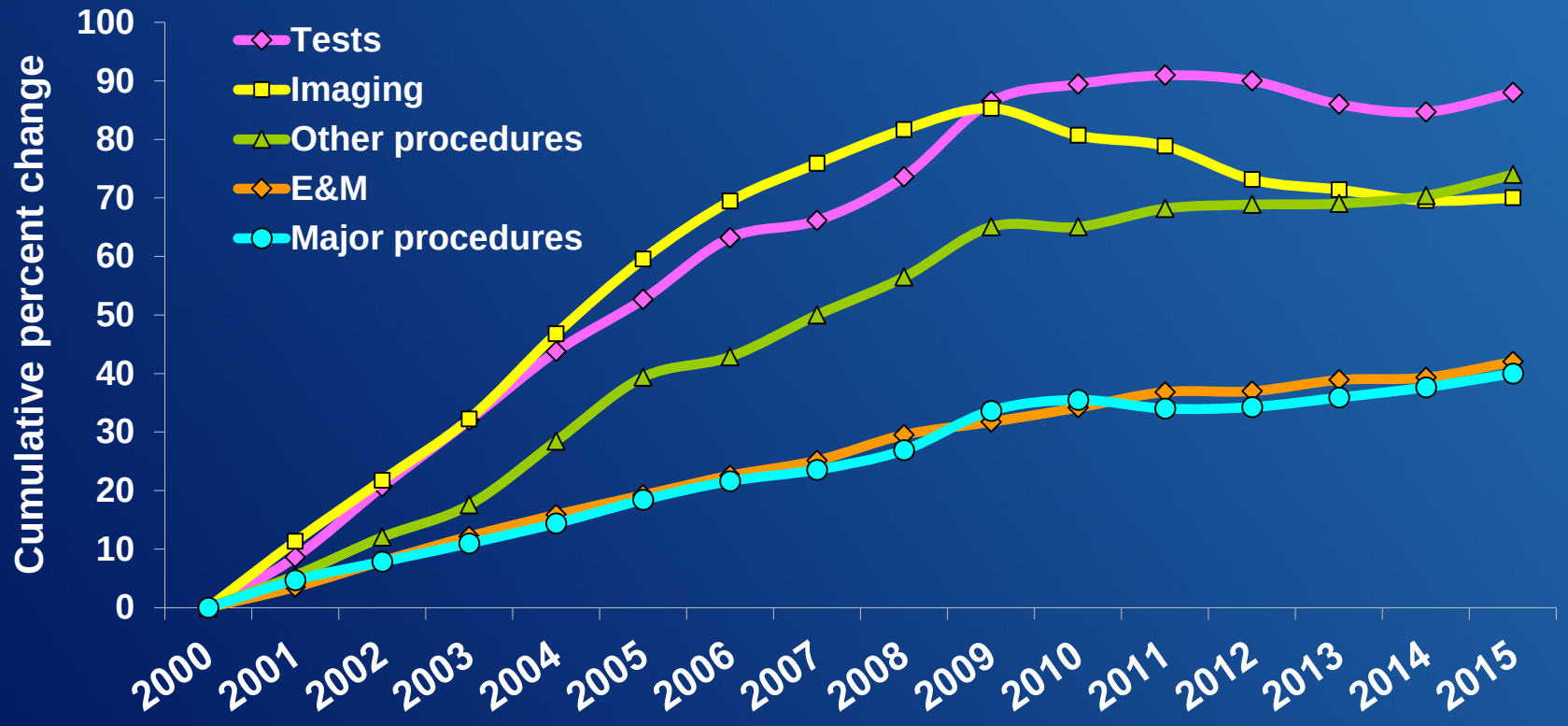
# Growth in the volume of clinician services per beneficiary, 2000-2015




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 2015, 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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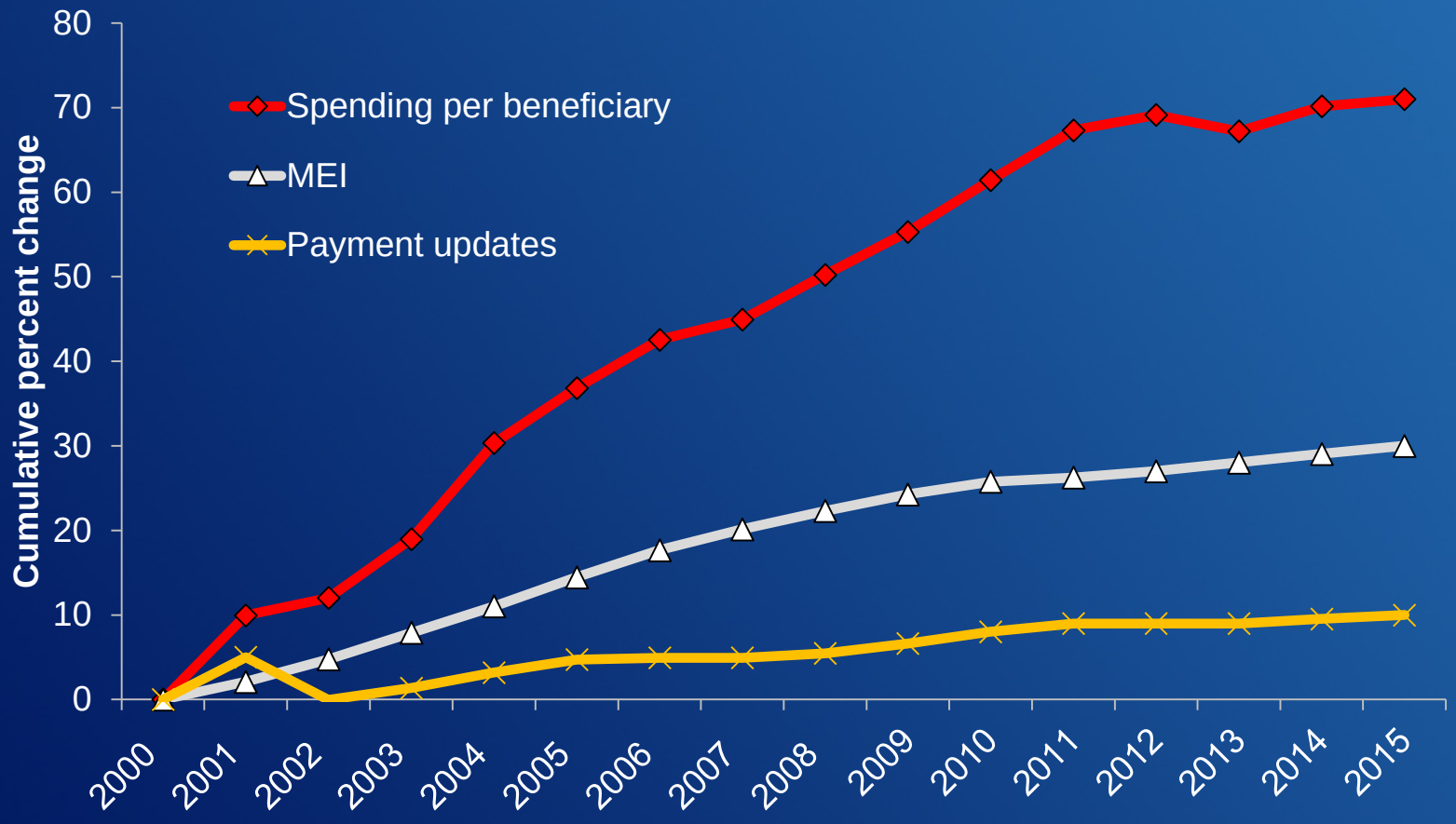
# Volume changes reflect shift of services from freestanding offices to hospitals

- Trend toward billing for some services in hospital outpatient departments (OPDs) instead of offices
  - Echocardiography grew 4.7% in OPDs in 2015, declined 3% in offices
  - Nuclear cardiology grew 0.6% in OPDs in 2015, declined 5.9% in offices
- Increases overall program spending and beneficiary cost sharing
- Fee schedule volume growth is sensitive to shifts in site of care

# Spending increased faster than input prices and payment updates, 2000-2015




Note: MEI (Medicare Economic Index).
Source: 2016 Medicare Trustees' report and Office of the Actuary, 2015.

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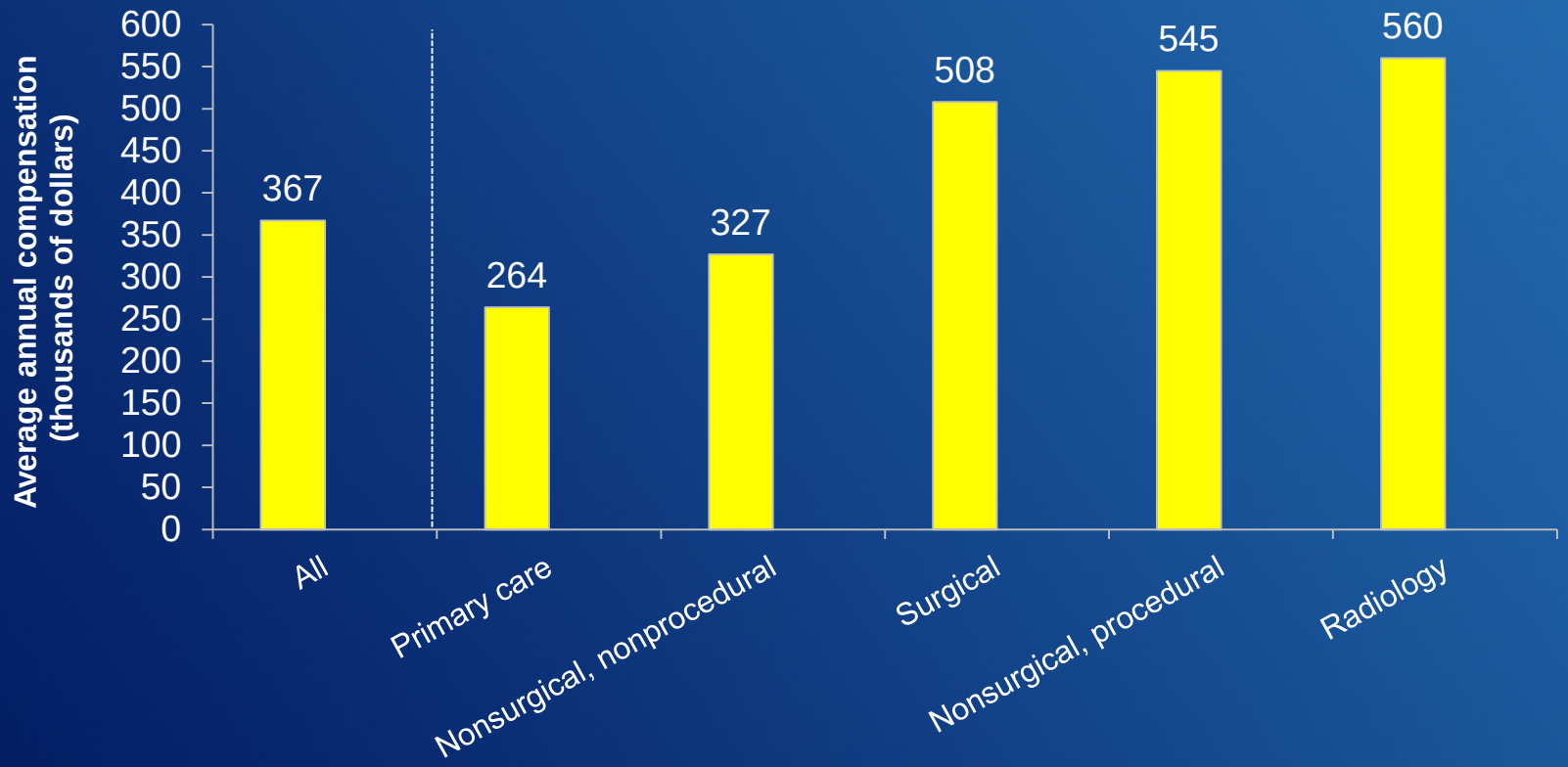
# Wide income disparities between primary care and radiology/nonsurgical procedural specialties, 2015




Source: MedPAC analysis of data from Medical Group Management Association's Physician Compensation and Production Survey, 2015.

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# Medicare payment for chronic care management and transitional care management services

- Chronic care management (began in 2015)
  - Monthly fee for non-face-to-face services
  - Almost 300,000 beneficiaries received CCM service in 2015, furnished by 7,900 providers
  - 87% of services provided by primary care providers
  - Payments in 2015 = $41 million
  - Growth in number of beneficiaries receiving CCM
- Transitional care management (began in 2013)
  - Fee for managing care for 30 days after discharge from an institutional setting
  - 616,000 beneficiaries received TCM service in 2015, furnished by 51,000 providers
  - Payments in 2015 = $136 million ($56 million in 2013)



Data preliminary and subject to change.

# Payment adequacy for physician and other health professional services has not changed

- Access indicators are stable
  - Provider participation and assigned claims
  - Number of providers billing Medicare per beneficiary
- Increase in volume of services
- Ratio of Medicare payments to private payments is stable
- Quality indeterminate

# Future work

- Options to better support primary care
- Address mispricing of fee schedule services
- Explore grouping CPT codes into families of codes
- MACRA and alternative payment models

# Important facts about ASCs

- Medicare payments in 2015: $4.1 billion
- Beneficiaries served in 2015: 3.4 million
- Number of ASCs in 2015: 5,475
- Will receive payment update of 1.9% in 2017
- Most ASCs have some degree of physician ownership

Data preliminary and subject to change.

# Comparing ASCs with OPDs

- Benefits of ASCs
  - Efficiencies for patients and physicians
  - Lower payment rates and cost sharing in ASCs vs. OPDs (OPD rates are 85% higher)
- Concern: Evidence that physicians who own ASCs perform more procedures
- Issue: Relative to OPD patients, ASC patients are less likely to be dual eligible, minority, under age 65, or age 85 or older

# Volume of services, number of ASCs, and Medicare payments have increased

| | Avg annual change, 2010-2014 | Change, 2014-2015 |
|---|---|---|
| FFS beneficiaries served | 0.5% | 1.2% |
| Volume per FFS beneficiary | 0.5% | 1.8% |
| Number of ASCs | 1.1% | 1.4% |
| Medicare payment per FFS beneficiary | 2.8% | 5.2% |

Source: MedPAC analysis of Medicare claims and Provider of Services file from CMS, 2010-2015.

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# Access to capital is good

- Positive growth in the number of ASCs (1.4% in 2014)
- ASC companies have acquired ASCs, physician practices, and anesthesia practices in recent years
- Medicare accounts for small share of total ASC revenue (~20%), so factors other than Medicare payments influence access to capital

Data preliminary and subject to change.

# ASC quality reporting (ASCQR) program

- In 2012, ASCs began reporting quality data to CMS
- In 2014, ASC payments reduced 2 percent for failure to report quality data
- In 2016, CMS made ASC-reported quality data available to the public for the first time
- CMS continues to develop new ASC measures and 12 measures scheduled for implementation by 2018

# ASCQR program: Concerns and other ideas

- Concerns
  - Significant share of ASCs fail to report data publicly
  - Two measures may be “topped out”
  - Absence of measures that apply to all ASCs and assess claims-based clinical outcomes
- Alternative methods for assessing quality
  - 2 percent of ASC claims (97,000 claims) had subsequent hospital visit after 7 days, higher rates for some
  - Surgical site infection measure
- Commission recommended a Value-Based Purchasing program (2012)

# Summary of payment adequacy measures

- Access to ASC services: Good
  - Increase in number of ASCs
  - Increase in number of FFS beneficiaries served
  - Increase in volume of services per FFS beneficiary
  - Increase in payments per FFS beneficiary
- Access to capital: Good
- Quality of care: Existing data are limited and need improvement
- ASCs do not submit cost data

# Discussion

- Physician update
- ASC update