

*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 FFS

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- Includes office visits, surgical procedures, and range of diagnostic and therapeutic services in all settings
- \$64 billion on FFS physician services (13% of total Medicare spending) in 2009
- 1 million practitioners are in Medicare's registry:
  - Half are physicians actively billing Medicare – 90% of billing
  - Rest are other health professionals (e.g., nurse practitioners, physical therapists, chiropractors) – 10% of billing
- 97% of FFS Medicare beneficiaries received at least one physician fee schedule service in 2009

# Analysis indicators

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- Access
  - Annual MedPAC survey
    - Provides most current access data (Fall 2010)
    - Nationally representative sample of Medicare beneficiaries age 65+ and privately-insured persons age 50-64
    - Oversample of minority populations
  - Other national surveys of patients and physicians
  - Volume growth
- Quality – ambulatory care measures
- Ratio of Medicare to private PPO fees
- Indirect measures of financial performance

# Most beneficiaries are able to get timely appointments

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- Medicare beneficiaries (65 and older) are less likely than privately insured individuals (age 50-64) to report unwanted delays in getting appointments.
- Among those seeking an appointment:
  - Unwanted delay in getting a **routine care** appt
    - “Never”: **75%** Medicare / **72%** privately insured
  - Unwanted delay in getting an **illness or injury** appt
    - “Never”: **83%** Medicare / **80%** privately insured

# Most beneficiaries are able to find new physicians, but primary care more problematic

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- Medicare beneficiaries (65 and older) are less likely than privately insured individuals (age 50-64) to report problems finding a new physician.
  - Few patients were looking for a new PCP
    - 7% Medicare / 7% privately insured
  - Among those seeking a new **PCP**,
    - “No problem”: 79% Medicare / 69% privately insured
    - “Big problem”: 12% Medicare / 19% privately insured
  - Among those seeking a new **specialist**,
    - “No problem”: 87% Medicare / 82% privately insured
    - “Big problem”: 5% Medicare / 6% privately insured

# Access to care for minorities

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- Minorities experience more access problems than whites; disparity is greater among privately insured.
  - Among those seeking a routine care appt, unwanted delay
    - Medicare “never”: **76%** white / **74%** minority
    - Private insurance “never”: **73%** white / **66%** minority
  - Among those seeking a **new specialist**,
    - Medicare “big problem”: **5%** white / **9%** minority
    - Private insurance “big problem”: **5%** white / **13%** minority
  - Differences were smaller among those looking for new PCPs

# Results from other patient surveys are analogous to MedPAC's survey

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- **CAHPS-FFS, 2010**

- 88% of beneficiaries: “always” or “usually” able to schedule timely appointments for routine care

- **MCBS, 2008**

- 95% of non-institutional beneficiaries have a usual source of care (doctor's office or doctor's clinic); 56% waited 9 or fewer days for most recent appt

- **Commonwealth Fund, 2007**

- Medicare beneficiaries (65+) reported fewer access problems and greater satisfaction compared with privately insured individuals

- **Center for Studying Health System Change, 2007**

- Medicare beneficiaries are less likely to report going without needed care or delaying care than privately insured individual

# Physician surveys

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- **NAMCS, 2008**

- 90% of physicians accepted (at least some) new Medicare patients
  - 83% of primary care physicians; 95% of specialists

- **Center for Studying Health System Change, 2008**

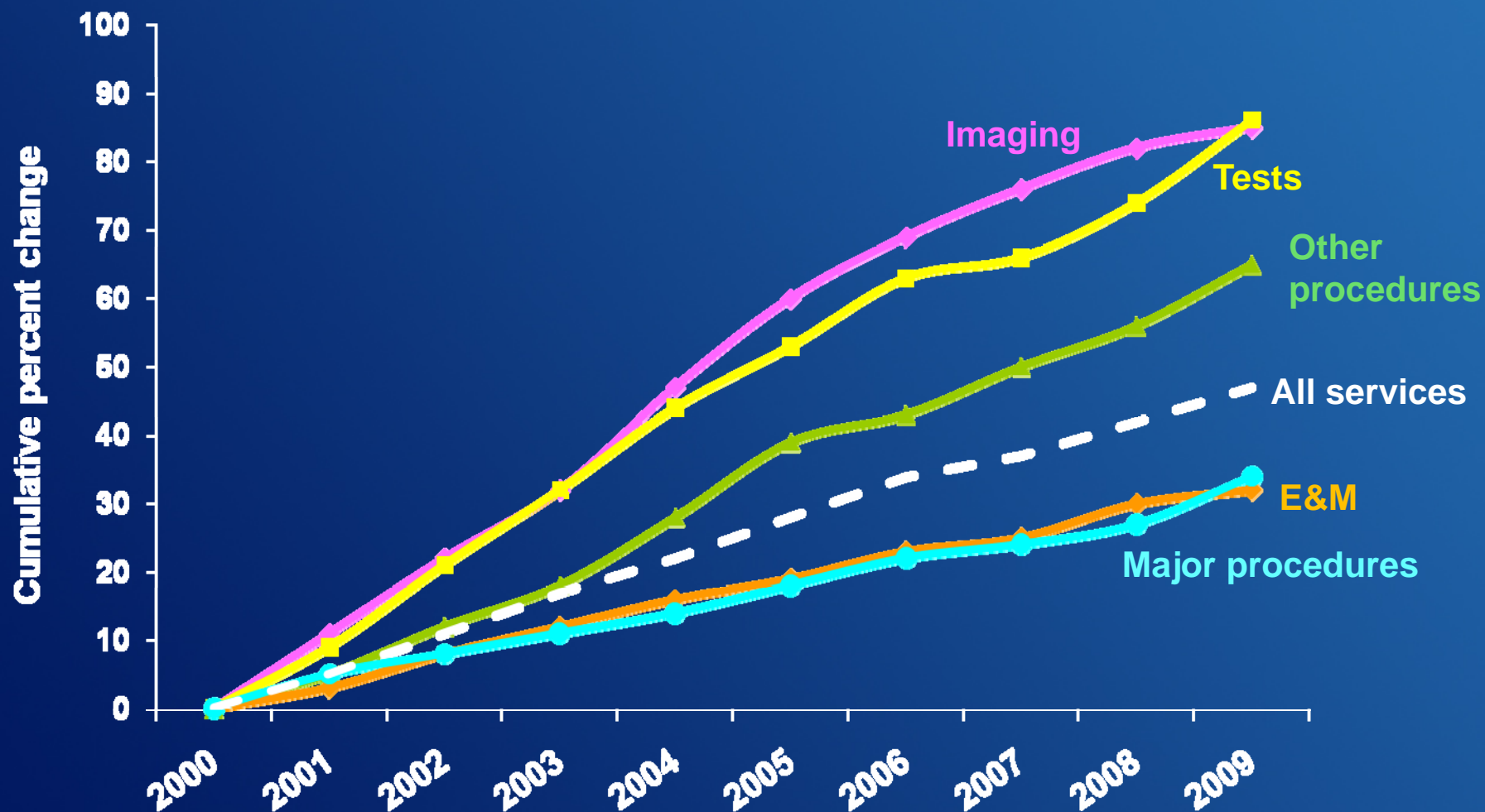
- Rate of physicians accepting “all” or “most” new patients:
  - Medicare: 74%; Private insurance: 87%; Medicaid: 53%
- Practice types more likely to accept new Medicare patients:
  - Medical and surgical specialists, rural practices, new physicians, group practices

- **AMA National Health Insurer Report Card, 2009**

- Medicare performed similar or better than private insurers on claims processing measures (e.g., accuracy, transparency)



# Volume of physician services per beneficiary continues to grow



# Most quality indicators were stable or improved from 2007 to 2009

Indicators	Number of indicators			Total
	Improved	Stable	Worsened	
<b>ALL</b>	<b>19</b>	<b>16</b>	<b>3</b>	<b>38</b>
Anemia	2	2	0	4
CAD	2	2	0	4
Cancer	2	4	1	7
CHF	5	3	0	8
COPD	1	0	1	2
Depression	0	1	0	1
Diabetes	6	1	0	7
Hypertension	0	0	1	1
Stroke	1	3	0	4

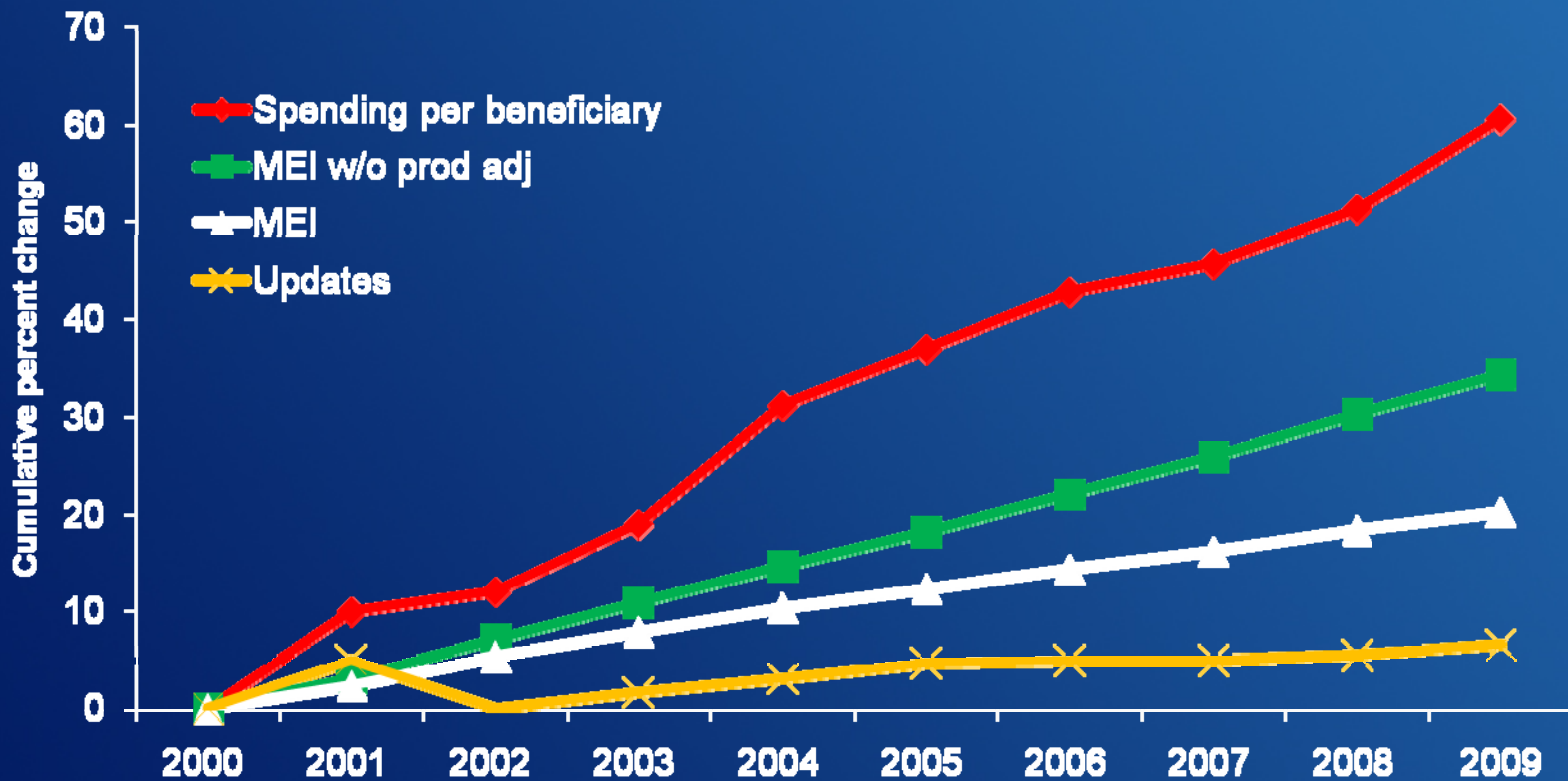
Source: MedPAC analysis of Medicare Ambulatory Care Indicators for the Elderly (MACIE) from the Medicare 5 percent Standard Analytic Files.

## Other indicators

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- Ratio of Medicare to private PPO rates continued at 80% for 2009 -- same as in previous year
- 99% of allowed charges were paid “on assignment” in 2009
- Medicare Economic Index (MEI) for 2012 is 0.7%.

# Spending has grown faster than input prices or the updates



Note: MEI (Medicare Economic Index).

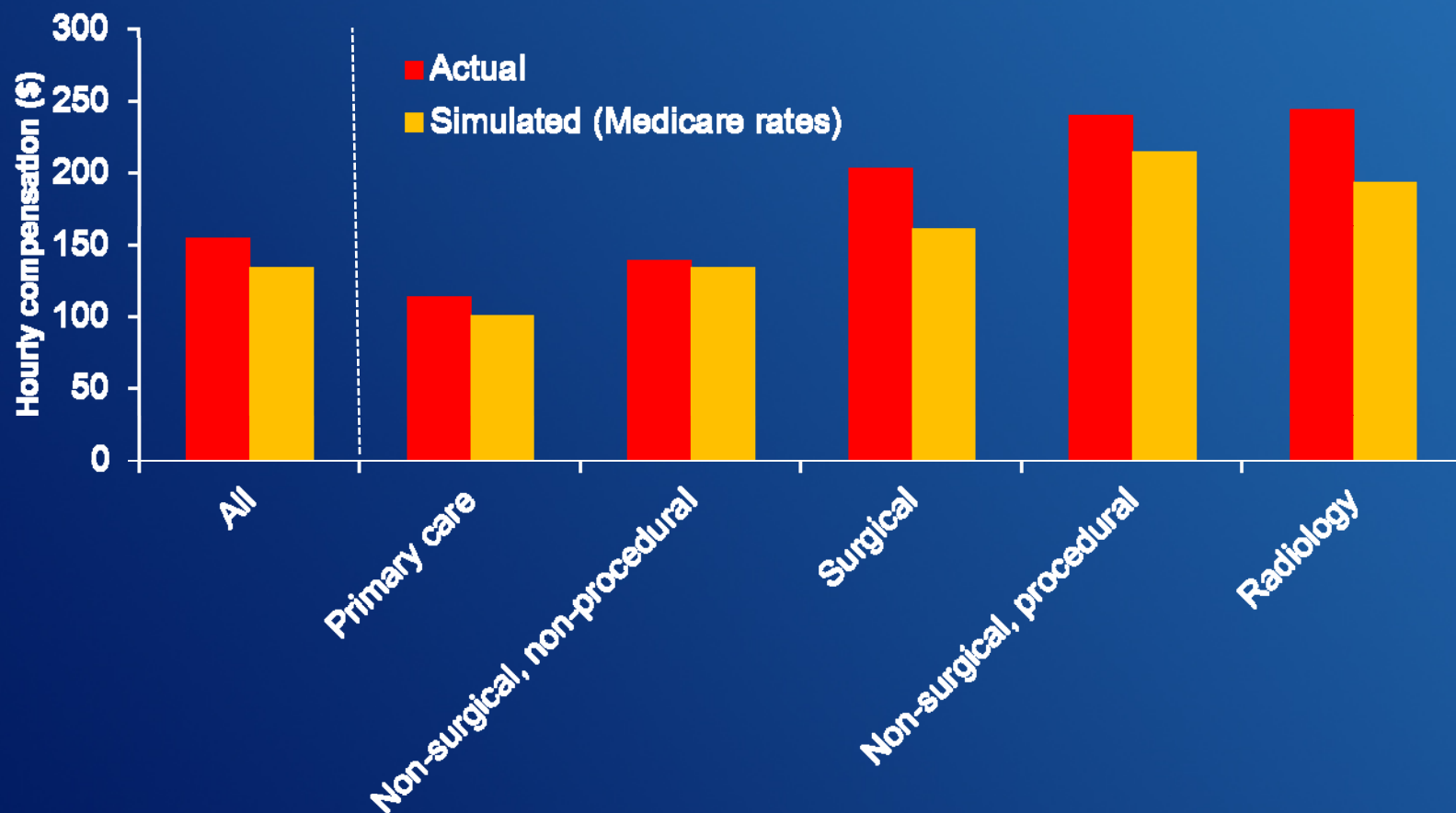
Source: 2010 trustees' reports, unpublished data from CMS, and OACT 2010.

# Physician compensation as an indicator

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- In the absence of cost reports: annual compensation after expenses
- Average for all physicians
  - \$273,000 (actual)
  - \$240,000 (simulated with Medicare rates)
- Disparities among specialties
  - Some are due to hours worked
  - Actual compared to simulated Medicare compensation is consistent with data comparing private rates to Medicare
  - Highest compensation going to specialties furnishing services with high volume growth

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



# Disparities in compensation raise concerns about equity and practitioner workforce

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- Equity
  - Mispricing can lead to compensation skewed in favor of some at the expense of others
  - Some practitioners can generate volume more readily than others
- Future of practitioner workforce
  - Mix of graduates from residency programs tilted toward specialists instead of primary care
  - Compensation is an important predictor of specialty choice

# Future work: primary care and SGR payment policies

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- Enhancing access to primary care
  - PPACA contains provisions to enhance primary care, but more levers should be explored
- Changing SGR payment policies
  - Mounting frustration from providers and their patients stemming from “temporary fixes” and payment uncertainty
  - Expenditure target approaches have both advantages and disadvantages



# Important facts about ASCs

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- Medicare payments in 2009: \$3.2 billion (5.1% increase from 2008)
- Beneficiaries served in 2009: 3.3 million (1.2% increase from 2008)
- Number of ASCs in 2009: 5,260 (2.1% increase from 2008)
- 90% have some degree of physician ownership
- ASCs will receive payment update of 0.2% in 2011

# Access to ASC services has been increasing

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	Avg annual increase, 2004-2008	Increase, 2008-2009
FFS beneficiaries served	4.4%	1.2%
Volume per FFS beneficiary	9.3%	3.4%
Number of ASCs	267 (5.8%)	109 (2.1%)

Numbers are preliminary and subject to change.

Source: MedPAC analysis of Medicare claims and Provider of Services file from CMS, 2004-2009.

# More rapid growth of surgical procedures in ASCs than HOPDs

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- From 2004-2009, volume per beneficiary grew 6.8%/year in ASCs, 0.1%/year in HOPDs
- Benefits of migration from HOPDs to ASCs
  - Efficiencies for patients and physicians
  - Lower payment rates and cost sharing in ASCs
- Concern
  - ASC growth may result in greater overall volume
  - Most ASCs have physician ownership
  - Evidence from recent studies that physicians who own ASCs perform more procedures

# Measures of payment adequacy

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- Access to ASC services has been increasing
  - Increase in number of beneficiaries served
  - Increase in volume per FFS beneficiary
  - Increase in number of ASCs
- Access to capital has been at least adequate
- Lack cost and quality data
  - Commission recommended that ASCs be required to submit cost and quality data (2009, 2010)