Assessing payment adequacy: fee-schedule and ambulatory surgical center services

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Background: fee-schedule services in Medicare

- Includes office visits, surgical procedures, and range of diagnostic and therapeutic services in all settings
- Medicare outlays: $62 billion in 2010
- ~900,000 practitioners billed Medicare in 2010:
  - 571,000 = physicians actively billing Medicare
  - 317,000 = other health professionals (e.g., nurse practitioners, physical therapists, chiropractors)
- 97% of FFS Medicare beneficiaries received at least one fee-schedule service in 2010
- MedPAC letter to the Congress “Moving forward from the SGR” (October 2011)

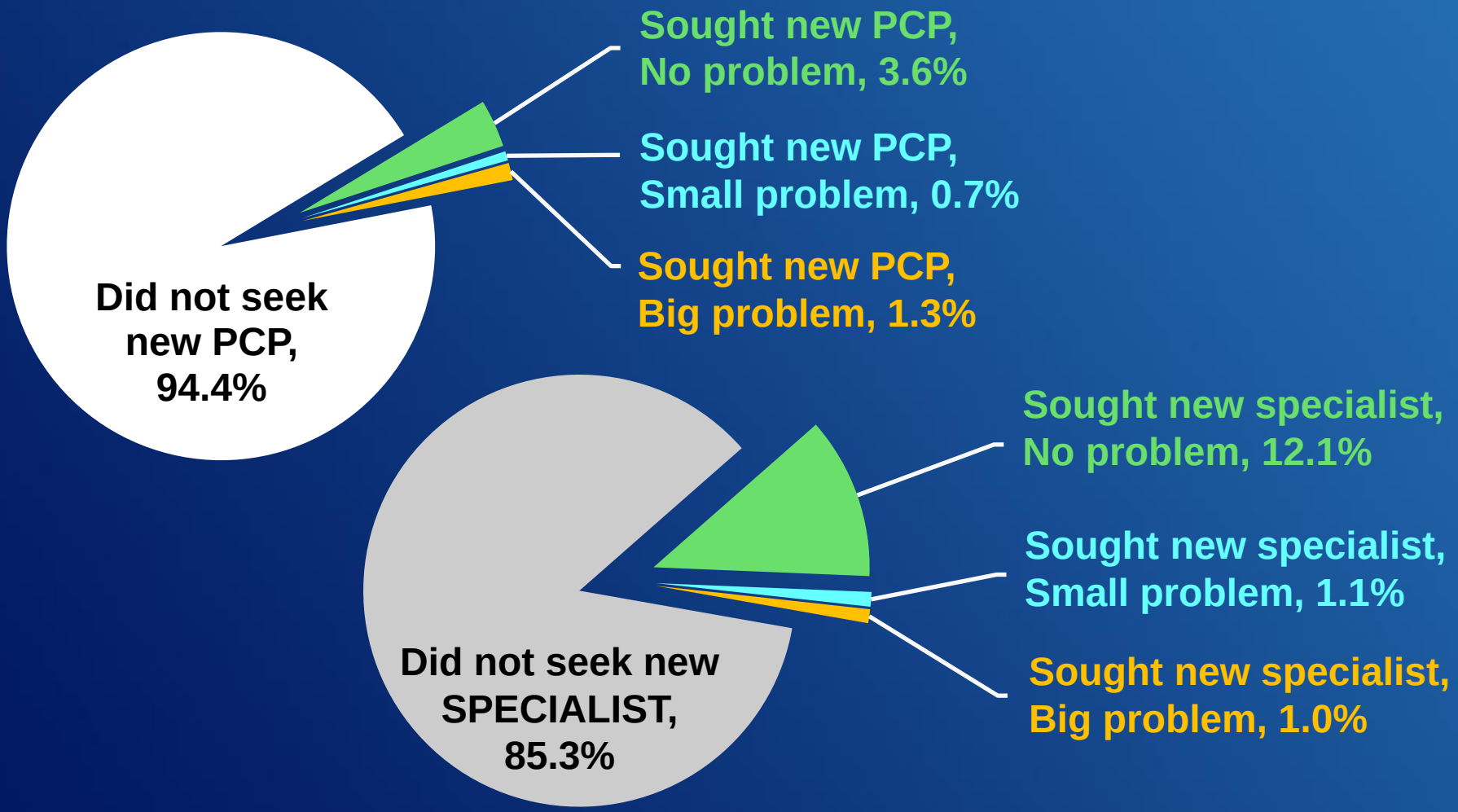
Payment adequacy analysis indicators

- 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 and focus groups of patients and physicians
  - Volume growth
- Quality – ambulatory care measures
- Ratio of Medicare to private PPO fees
- Indirect measures of financial performance

MedPAC 2011 physician access survey: Beneficiaries (age 65+) and privately insured individuals (age 50-64)

- Most Medicare beneficiaries are able to get timely appointments and can find a new physician when they need one
- Small shares of patients are looking for a new physician in the past year
  - **PCP:** 6% of Medicare beneficiaries and 7% of privately insured individuals
  - **Specialist:** 14% of Medicare beneficiaries and 16% of privately insured individuals
  - For both groups, among those looking for a new physician, finding a new PCP was more difficult than finding a new specialist

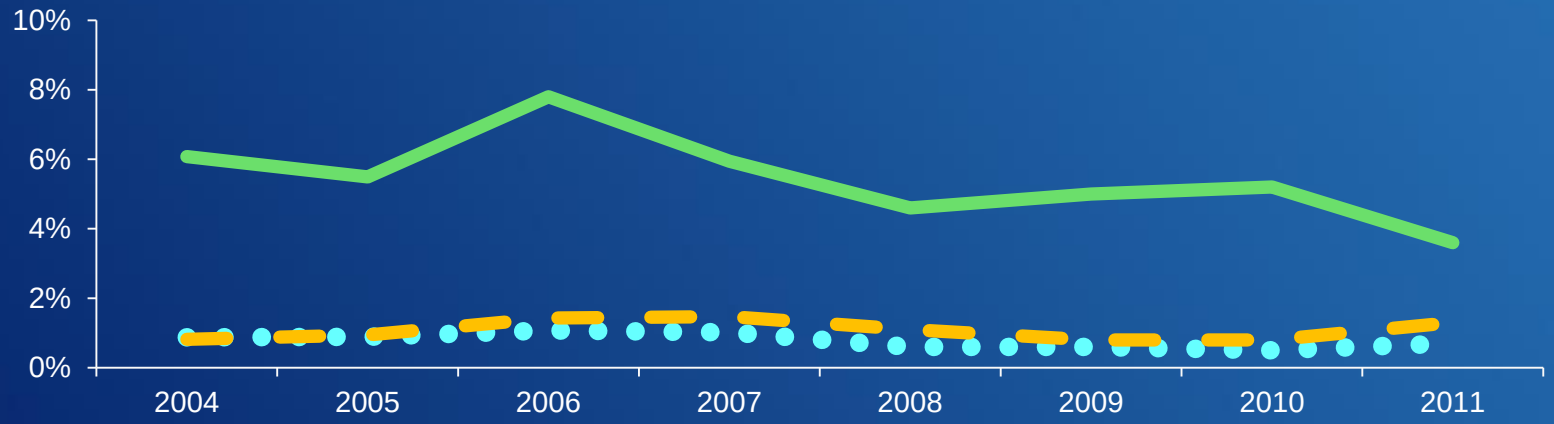
Most beneficiaries did not seek a new physician in the past year, but some reported problems when looking



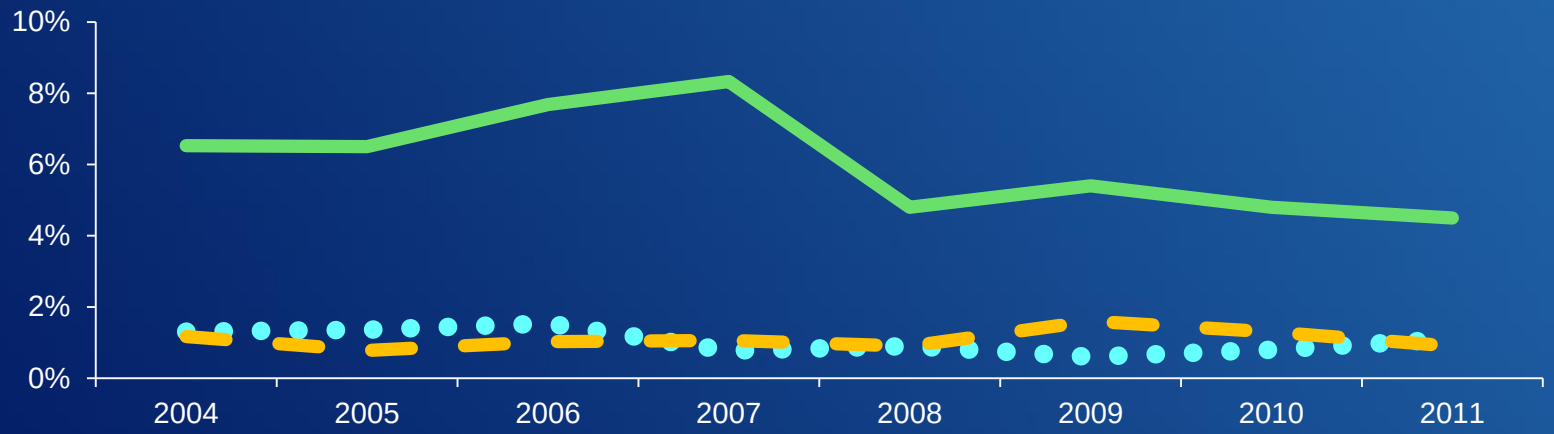
Note: Numbers may not sum to 100% because of rounding and missing responses. Numbers are preliminary and subject to change.
Source: MedPAC-sponsored telephone survey, 2011.

Overall ease of access finding a new PCP fluctuates annually, but trend is going downward

% of Medicare beneficiaries (age 65+)



% of privately insured (age 50-64)



No problem Small problem Big problem

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Note: The remaining percent of respondents in the survey did not seek a new primary care physician. Numbers are preliminary and subject to change. Source: MedPAC-sponsored telephone surveys, 2004-2011.

Other findings on access

- Minorities in both insurance groups experienced more access problems than whites
- Share of minority beneficiaries reporting problems finding a specialist increased
  - Potential future survey questions to understand more about this decline and possible policy options
- In rural areas, Medicare beneficiaries reported better access than privately insured
- ~1/3 of beneficiaries and privately insured saw an NP or PA for some or all of their primary care

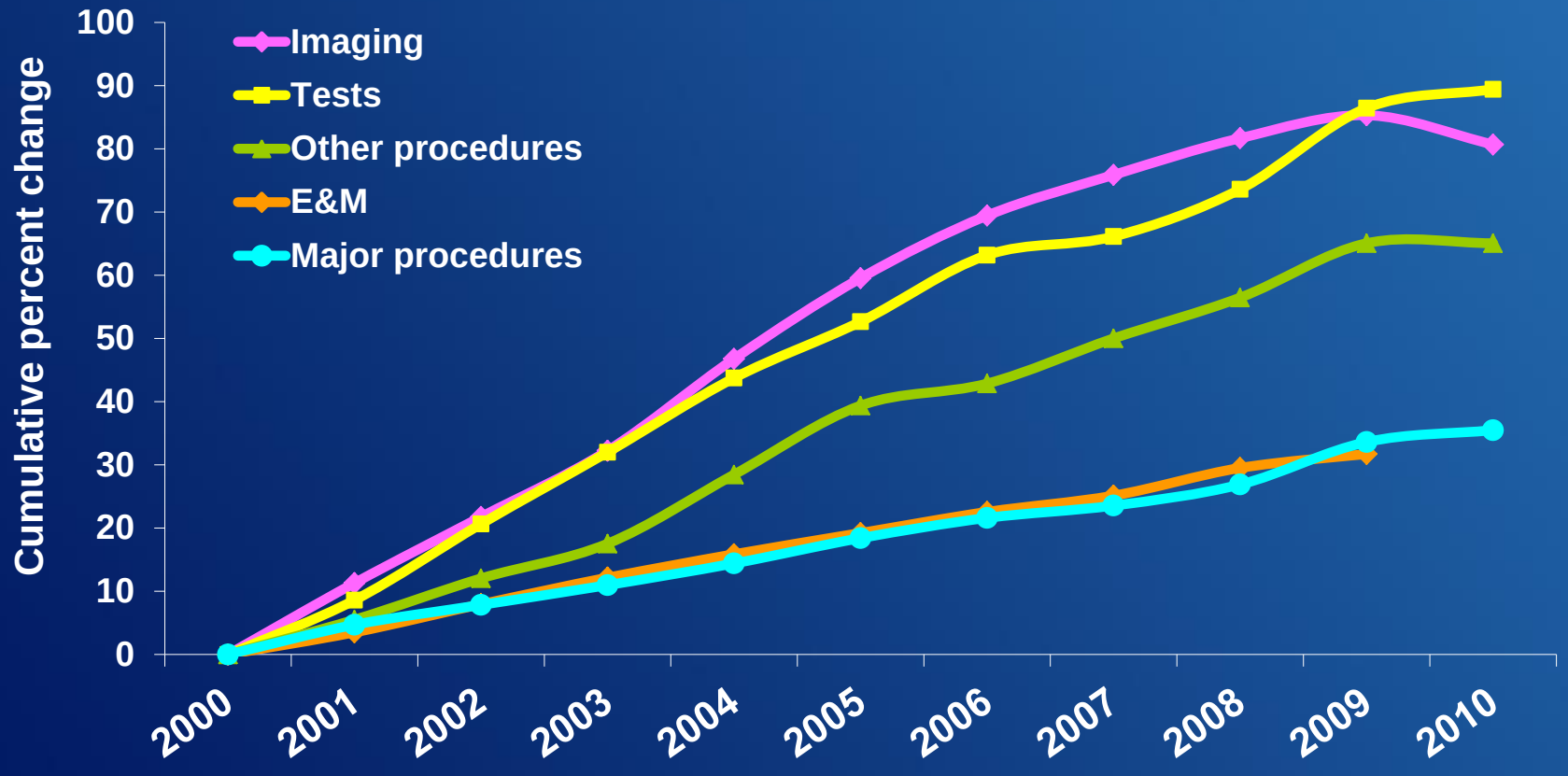
Other patient surveys

- **CAHPS-FFS, 2011**
  - 88% of beneficiaries: “always” or “usually” able to schedule timely appointments for routine care
- **MCBS, 2009**
  - 95% of non-institutional FFS beneficiaries have a usual source of care (doctor’s office or doctor’s clinic for vast majority); 5% said they had trouble getting care in past year
- **Commonwealth Fund, 2007**
  - Medicare beneficiaries (65+) reported fewer problems accessing medical care (from doctor or other medical health professional) 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

- **NAMCS, 2009**
  - 90% of physicians accepted (at least some) new Medicare patients
    - 82% of primary care physicians; 96% of specialists
- **Center for Studying Health System Change, 2008**
  - 86% of physicians accepted at least some new Medicare patients; 74% accepted “all” or “most.” Higher rates for privately insured patients.
  - Practice types more likely to accept new Medicare patients:
    - Medical and surgical specialists, rural practices, new physicians, group practices
- **Medical Group Management Association, 2010**
  - 92% of medical group practices accept new Medicare patients
  - 7% limit Medicare patients to established patients aging into Medicare
  - 1% do not accept any Medicare patients

Growth in the volume of fee schedule services per beneficiary, 2000-2010



Note: (E&M Evaluation and management). Volume growth for E&M is through 2009 only due to change in payment policy for consultations implemented in 2010.
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

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Changes in service use in 2010

- Decreases in service use not limited to Medicare
- Small imaging decrease after decade of rapid growth
  - 85 percent increase in service use from 2000 to 2009
  - 2.5 percent decrease in 2010
- Decrease in use of imaging occurred amid concerns about appropriateness

Repeat diagnostic testing in Medicare

- Geographic variation in use of imaging and other diagnostic services such as upper GI endoscopy
  - Correlation between how frequently a test is initiated and how frequently it is repeated
- Raises questions about necessity, use of imaging guidelines
- Raises further questions about how clinicians spend their time

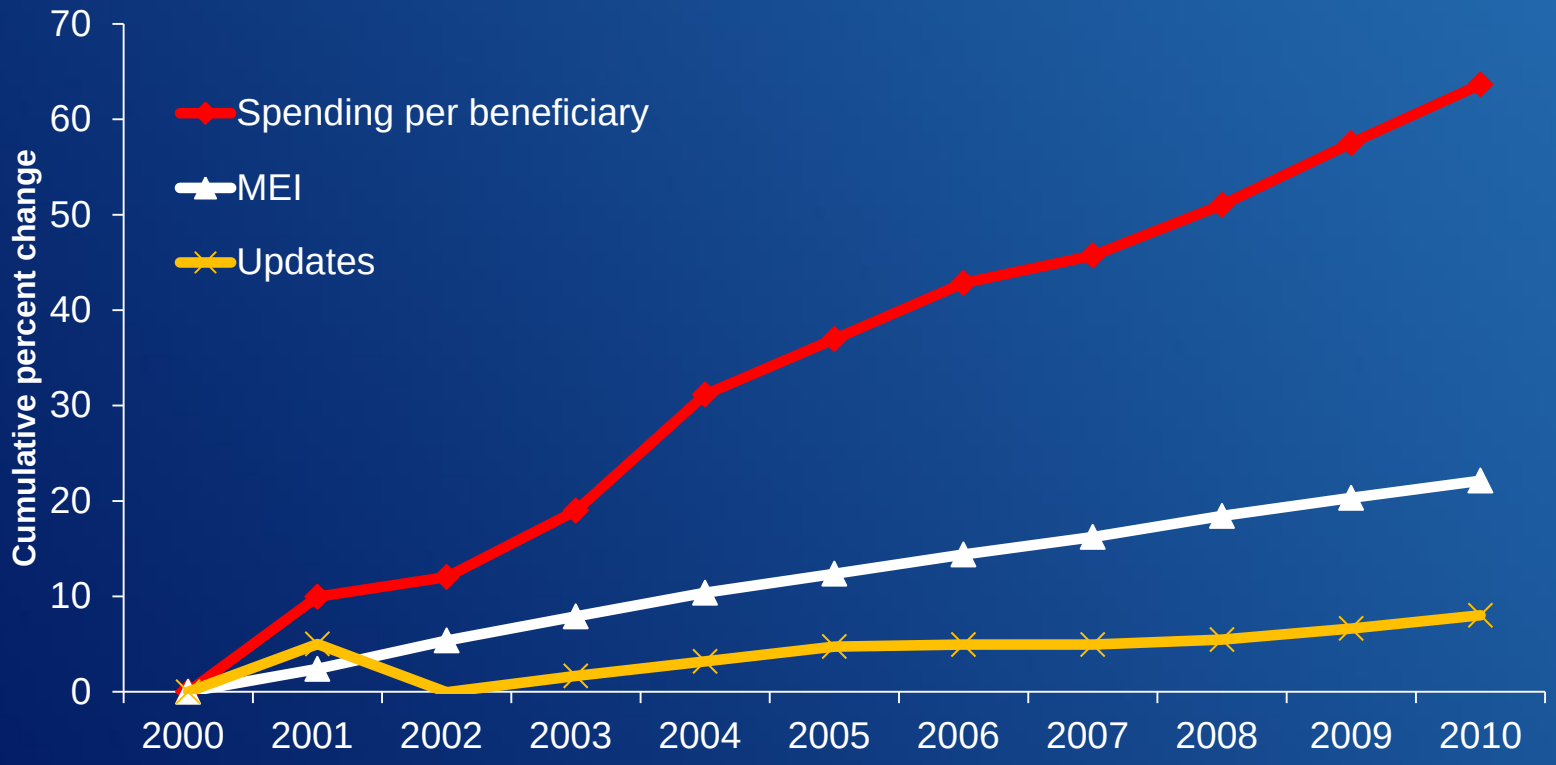
Most quality indicators were stable or improved from 2008 to 2010

- 30 out of 38 claims-based, ambulatory quality measures (for the elderly) improved or were stable
- Among the measures that declined,
  - Decreases were small
  - Most were process measures (rather than health outcome measures)
  - Matched findings in the private market (e.g., mammography screening)

Other indicators

- Ratio of Medicare to private PPO rates continued at 80% for 2010 – same as in previous year
- Among physicians and other practitioners billing Medicare, 95% are “participating” (accept Medicare’s fee schedule amounts as payment in full for all Medicare services)
- 99% of allowed charges were paid “on assignment” in 2010

Spending has grown faster than input prices or the updates



Note: MEI (Medicare Economic Index).
Source: 2011 trustees' report, Global Insight 2010q4 MEI forecast, and OACT 2011.

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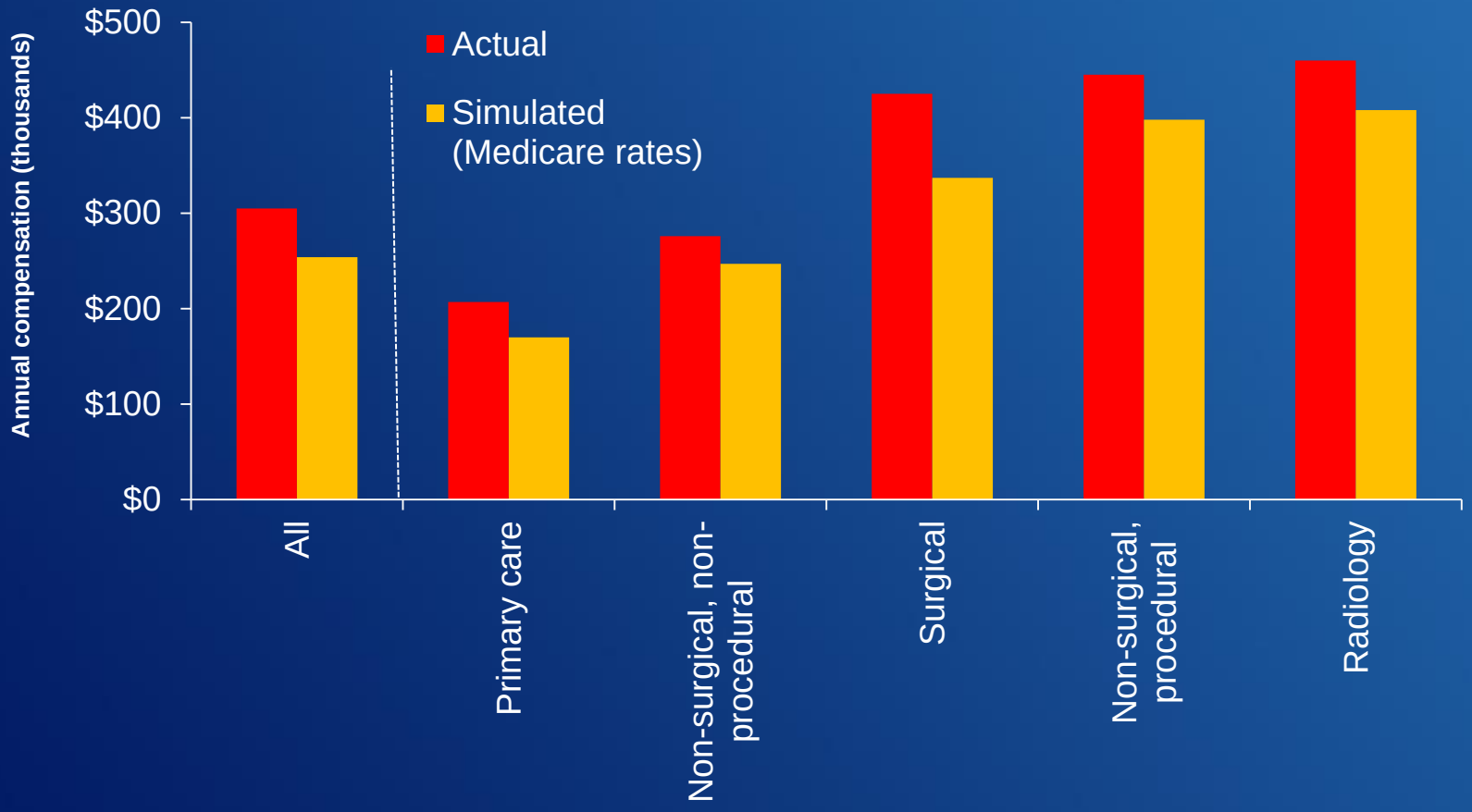
Disparities in compensation widest when primary care is compared to non-surgical proceduralists and radiologists



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

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Important facts about ASCs

- Medicare payments in 2010: $3.4 billion
- Beneficiaries served in 2010: 3.3 million
- Number of ASCs in 2010: 5,316
- 90% have some degree of physician ownership
- Will receive payment update of 1.6% in 2012

Measures of payment adequacy

- Access and supply
- Access to capital
- Medicare payments
- No cost or quality data

Access to ASC services and supply of ASCs have been increasing

	Avg annual increase, 2005-2009	Increase, 2009-2010
FFS beneficiaries served	2.7%	0.9%
Volume per FFS beneficiary	7.6%	1.6%
Number of ASCs	214 (4.6%)	99 (1.9%)

Numbers are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims and Provider of Services file from CMS, 2005-2010.

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Access to capital has been at least adequate

- Capital is required to establish new ASCs
- Number of ASCs grew at an annual rate of 4.6% over 2005-2009
- Growth has slowed: 1.9% in 2010
  - Economic downturn and slow recovery may have reduced access to capital

Services may have migrated from HOPDs to ASCs, but rate has slowed

- From 2005-2009, volume per beneficiary grew 6.1%/year in ASCs, no growth in HOPDs
- In 2010, volume grew 1% in both settings

Benefits and concerns over migration

- 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

Summary of payment adequacy

- Access to ASC services continues to increase
  - Number of beneficiaries served
  - Volume per FFS beneficiary
  - 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, 2011)
  - ASCs begin to submit quality data 10/2012

CMS adopted quality reporting program for ASCs for 2012

- ASCs will begin reporting 5 claims-based measures in Oct. 2012
- ASCs that do not report measures will receive lower annual update in 2014
- CMS does not have statutory authority to adopt value-based purchasing (VBP) program for ASCs

MedPAC's general criteria for performance measures

- Should be evidence-based and well-accepted
- Collecting data should not be unduly burdensome
- Should not discourage providers from taking riskier patients
- Most providers should be able to improve on measures
- Should send consistent signals across different provider types and settings

Potential measures for VBP program for ASCs

- Small set of measures primarily focused on outcomes
  - Patient safety measures (e.g., patient fall, patient burn)*
  - Hospital transfer or admission after ASC procedure*
  - Surgical site infection
- Some process, structural, patient experience measures

* Included in ASC Quality Reporting Program

Other design principles

- Medicare should reward ASCs both for attaining quality benchmarks and improving care over time
- Funding for VBP payments should come from existing ASC spending