Mandated report on clinician payment in Medicare

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MEDPAC

Presentation overview

- Mandate overview
- Medicare's payment system for clinician services
- Long-term trends in payment adequacy indicators
  - New analysis: Impact of site-of-service shifts on clinician volume and spending
- Summary and conclusion

Statutory mandate: Medicare Access and CHIP Reauthorization Act of 2015

- Requires MedPAC to consider the effect of the statutory updates for 2015-2019 on:
  - Efficiency and economy of care
  - Supply
  - Access
  - Quality
- And make recommendations for future updates necessary to ensure beneficiary access to care

Medicare's payment system for clinician services

- Fee schedule of 7,000 discrete services delivered by clinicians in all settings
- Fee schedule updated through rulemaking each year, and a conversion factor translates relative values to payment rates
- Fee schedule payment updates
  - Annual updates of between 0% and 1% from 2011-2015
  - 0.5% each year from 2016-2018
  - 0.25% in 2019
  - No update from 2020-2025 (A-APM incentive payment for certain clinicians)
- Payment amounts vary by geographic adjustment factors, type of clinician, setting, and other characteristics

Considering payment adequacy indicators over a longer timeframe

- Access to Medicare clinician services is as good as or slightly better than access for individuals with private insurance
- The supply of clinicians in Medicare grew in absolute terms, assignment and participation rates remain high
- Volume of services has varied over time and by type of service
- Quality is indeterminate
- Medicare's payment rates average ~75% of private PPO payments for clinician services (decline from 80% in the past 5 years)

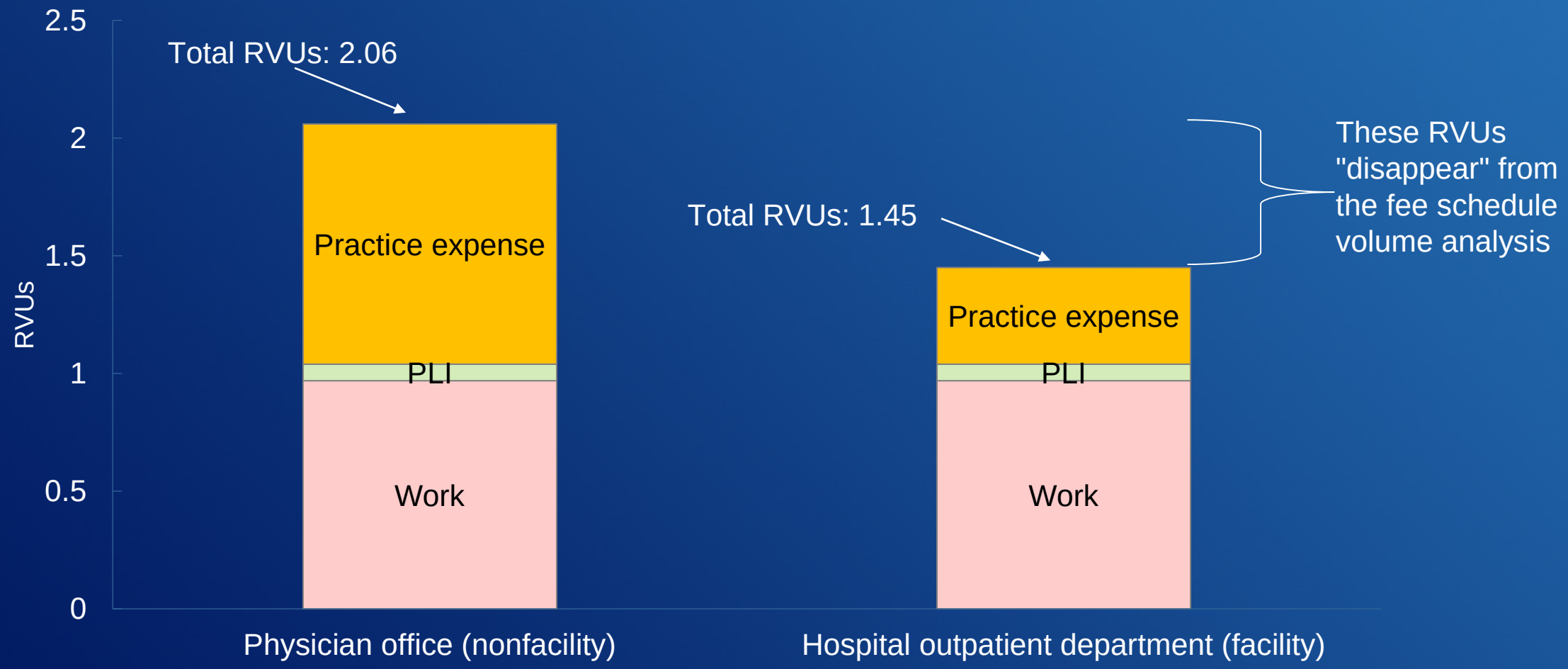
Considering the updates and the payment adequacy indicators

- To date, payment adequacy indicators have largely been stable in the presence of payment updates of between 0% and 1%
- We have monitored the payment adequacy indicators in the past and will continue to do so in the future
- When we identify problems with the payment adequacy indicators, we consider 1) whether Medicare policy is implicated; 2) if a change is necessary to the overall payment rate; or 3) if other Medicare changes may be necessary
- Examples
  - Ensuring an adequate supply of primary care physicians
  - Appropriate payment for advanced imaging
  - Adopting site-neutral policies

Fee schedule volume and spending in the context of site-of-service changes

- Services may shift settings due to changes in safety profiles, clinical practice, or payment differences
- Our measure of volume captures both units of service and intensity (measured as RVUs)
- Fee schedule volume and spending is sensitive to the site where the service is provided
- When services shift settings, the RVUs in the fee schedule can change (increase or decrease)

E&M service shifts from the physician office to the hospital outpatient department: Effect on RVUs



Note: PLI (professional liability insurance), RVU (relative value unit). This graphic shows the RVUs for 99213, a level 3 evaluation and management visit for an established patient in 2019 shifting to an on-campus OPD. Source: Centers for Medicare & Medicaid Services.

Results preliminary; subject to change

Our measure of volume growth would be higher if services had not changed settings over time

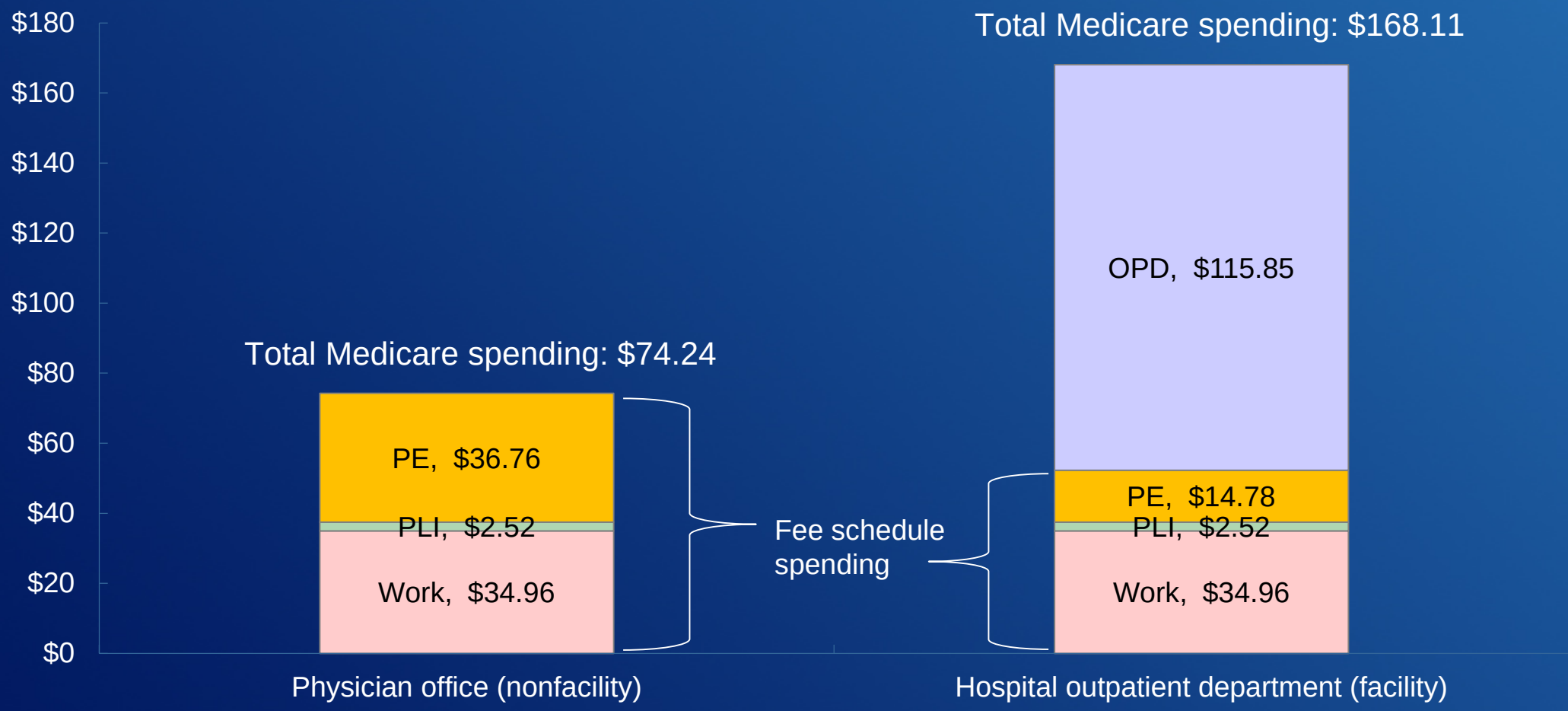
	Average annual volume growth (2012-2017)	Average annual volume growth, holding site-of-service constant (2012-2017)
All services	**1.1%**	**1.5%**
Evaluation and management	1.0	1.5
Imaging	0.1	1.2
Major procedures	2.2	1.5
Other procedures	1.5	1.9
Tests	0.2	1.0

+36% higher

Note: Our measure of volume growth is units multiplied by RVUs.
Source: MedPAC analysis of 100% FFS claims.

Results preliminary; subject to change

E&M service shifts from the physician office to the hospital outpatient department: Effect on spending



Note: OPD (outpatient department), PE (practice expense), PLI (professional liability insurance). This graphic shows the RVUs for 99213, a level 3 E&M visit for an established patient. Source: Centers for Medicare & Medicaid Services.

Results preliminary; subject to change

Overall, site-of-service shifts affect volume, fee schedule spending and total spending

- Services shifting from the physician office to the outpatient department can affect:
  - The number of RVUs for the service;
  - The units of service;
  - Our measure of volume growth;
  - Fee schedule spending; and
  - Total Medicare spending
- We plan to continue developing this analysis to give ongoing context for the measures in MedPAC's yearly payment adequacy assessment

Summary of mandate findings

- Medicare's payment updates for clinician services have generally been in the range of 0 to 1 percent for the past decade
- Payment adequacy indicators show generally stable trends over the same timeframe
  - Access remains steady (and as good as or slightly better among Medicare beneficiaries than privately-insured individuals);
  - Volume has been variable, and is sensitive to shifts in the site of service;
  - Quality remains indeterminate; and
  - Medicare's payment rates relative to private PPO payments have fallen slightly, but this has not resulted in any divergence between access for Medicare beneficiaries and privately-insured individuals

Note: PPO (preferred provider organization)

Results preliminary; subject to change

Considering future updates

- The mandate asks us to weigh in on any necessary future statutory updates needed to ensure access
- Going forward, we are best able to do so by considering the most up-to-date information each year via the payment adequacy assessment
- Most recently MedPAC finalized a recommendation for the 2020 payment update for clinician services

Next steps

- We plan to finalize this material as a chapter in the June Report to the Congress
- We welcome any questions about the mandate or new material