

CHAPTER

5

**Per beneficiary payment
for primary care**

Per beneficiary payment for primary care

Chapter summary

The Commission has a long-standing concern that primary care services are undervalued by the Medicare fee schedule for physicians and other health professionals (“the fee schedule”) compared with procedurally based services. That undervaluation has contributed to compensation disparities such that average compensation for specialist practitioners can be more than double the average compensation for primary care practitioners. For example, radiologists’ average annual compensation in 2010 was \$460,000, while the average for primary care physicians was \$207,000. Such disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided. While Medicare beneficiaries generally have good access to care, as shown in both patient and physician surveys, access for beneficiaries seeking new primary care practitioners raises more concern than access for beneficiaries seeking new specialists (Medicare Payment Advisory Commission 2014).

With the goals of directing more resources to primary care and rebalancing the fee schedule, the Commission made a recommendation in 2008 for a budget-neutral primary care bonus payment, funded by a reduction in payments for non–primary care services. The Patient Protection and Affordable Care Act of 2010 created a bonus program, but it was not budget neutral and thus required additional funding. The program provides

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- Experience with primary care bonus payment
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- Conclusion

a 10 percent bonus payment for primary care services provided by primary care practitioners from 2011 through 2015.

The Commission has also become increasingly concerned that the fee schedule is an ill-suited payment mechanism for primary care. The fee schedule is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, primary care services ideally are oriented toward ongoing, non-face-to-face care coordination for a panel of patients. Some patients in the panel will require the coordination of only preventive and maintenance services. Others will have multiple complex chronic conditions and will require extensive care coordination. The fee schedule is not well designed to support these behind-the-scenes activities, and it is precisely these activities that will be crucial in the move to a more coordinated and efficient health care delivery system of the future.

The primary care bonus program expires at the end of 2015. The Commission believes that the additional payments to primary care practitioners should continue. While the amount of the primary care bonus payment—an average of \$3,938 per eligible practitioner in 2012—is not large and will probably not drastically change the supply of primary care practitioners, it is a step in the right direction. The Commission is considering the option of continuing the additional payments to primary care practitioners, but in the form of a per beneficiary payment. Replacing the primary care bonus payment with a per beneficiary payment could help to move away from a fee-for-service, volume-oriented approach and toward a beneficiary-centered approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination.

This chapter explores a per beneficiary payment for primary care and considers several design issues: requirements that practices must meet to receive the payment, mechanisms for attributing beneficiaries to practitioners or practices, and methods to fund the payment. Specific to funding, we considered two methods. One method is to fund a per beneficiary payment by reducing the payments of all services that are not eligible for the current primary care bonus payment by an equal percentage. A second method is to reduce the payments of services specifically identified as overpriced, service by service, and fund the per beneficiary payment with the savings. ■

Primary care physician perspectives on care coordination: Findings from focus groups

The Commission conducts annual focus groups in select markets aimed at providing more qualitative descriptions of primary care physician and beneficiary experiences with the Medicare program. We conduct focus groups in markets where Medicare beneficiaries have reported experiencing relatively poor access to routine, specialty, and needed care on the Consumer Assessment of Healthcare Providers and Systems® survey. In selecting from the markets where Medicare beneficiaries report relatively poor access to care, we also factor in geographic and urban/rural diversity. In 2012 and 2013, Commission staff conducted focus groups in the following markets: the Bronx, NY; Greenville, SC; Chicago, IL/Gary, IN; and Richmond, VA. In each market, we held two focus groups with primary care physicians and three focus groups with Medicare beneficiaries. Each focus group consisted of 9 to 11 individuals. The primary care physicians who participated in the focus groups included solo practitioners, those organized in small group practices or large group practices, and those employed within hospital-based practices. Some of the primary care physicians were also part of care coordination initiatives, including medical homes. In each market, Commission staff also visited health systems, hospitals, physician offices, and other providers. Many of the providers we visited were also part of care coordination initiatives.

During the focus groups, primary care physicians reported numerous challenges to coordinating beneficiaries' care. Communication breakdowns between the primary care physicians and other providers (usually specialists) and between primary care physicians and hospitals were described as main impediments to care coordination. For example, some primary care physicians reported having to delay

primary care appointments when specialists did not provide reports on referred patients. Some primary care physicians also said that when one of their patients was in the hospital, they were rarely notified, if at all, of the patient's admission—even if that physician had privileges in that hospital.

Many of the primary care physicians in the focus groups stated that care coordination activities could help improve quality of care. Primary care physicians and other providers already participating in patient-centered medical homes said care coordination activities did improve the way they practice. Care coordination activities included more team-based care, increased face-to-face time with patients, follow-up with patients after primary care visits (e.g., through phone calls), checking in with patients after a hospital stay, improved communication with specialists, increased preventive care, and increased patient education.

However, primary care physicians and other providers reported that significant financial investments are required to implement and maintain a fully developed care coordination model. For example, many providers had to hire new staff or delegate new responsibilities to existing staff to implement the care coordination activities that resulted in the above improvements. Some primary care physicians in the focus groups stated that those financial investments are impediments to developing care coordination activities and pursuing initiatives such as medical homes. This sentiment was more common among the solo practitioners and those in small group practices. Moreover, several primary care physicians reported having looked into the process of being certified as a patient-centered medical home, but decided it was not worth pursuing for financial reasons. ■

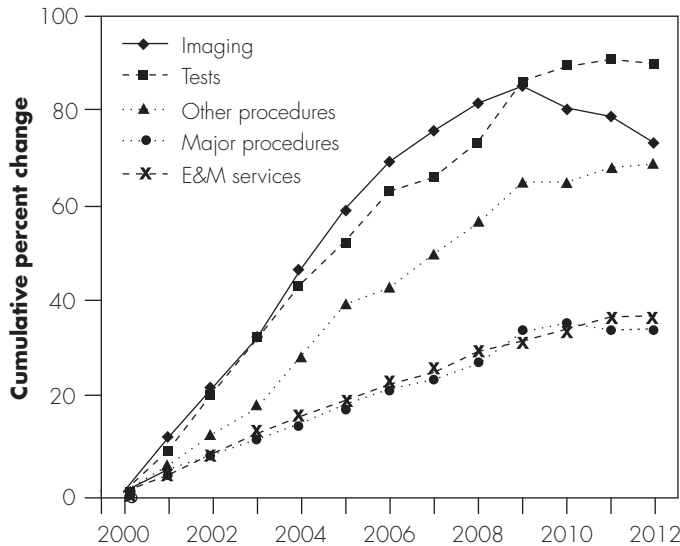
Background

Primary care is essential to delivery system reform, but the current Medicare fee schedule for physicians and other health professionals undervalues it relative to specialty care and does not explicitly pay for non-face-to-face care coordination (see the text box for a discussion of physician perspectives on care coordination). Those shortcomings

of the fee schedule have contributed to compensation disparities between primary care practitioners and specialists such that average compensation for some specialties can be more than double that of primary care practitioners. Faced with such compensation disparities, practitioners may increasingly opt for specialty practice over primary care practice, exposing beneficiaries to an increasing risk, in the long run, of impaired access to primary care.

FIGURE 5-1

Growth in the volume of procedurally based services generally exceeds that of E&M services, 2000–2012



Note: E&M (evaluation and management). Volume growth for E&M from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2011, 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 1.70 percent and the 2010 to 2011 growth rate of 2.00 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

The Commission has made several recommendations to address the inadequacies of the fee schedule. To rebalance the fee schedule, the Commission has proposed identifying overpriced services and pricing them appropriately, replacing the sustainable growth rate (SGR) formula with payment updates that are higher for primary care than specialty care, and establishing a primary care bonus payment funded from non-primary care services. To advance support for coordinated care, the Commission recommended establishing a medical-home pilot. A variant of the recommendation to identify overpriced services and price them appropriately was established under the Protecting Access to Medicare Act of 2014. Variants of the recommendations for a primary care bonus payment and a medical-home pilot were established under the Patient Protection and Affordable Care Act of 2010 (PPACA).

The primary care bonus program created by PPACA expires at the end of 2015. This chapter explores the option of replacing the primary care bonus payment, after it expires, with a per beneficiary payment for eligible primary care practitioners. In establishing a per beneficiary

payment for primary care, several design issues need to be considered, including requirements that practices must meet to receive the payment, mechanisms for attributing beneficiaries to practitioners or practices, and methods to fund the payment.

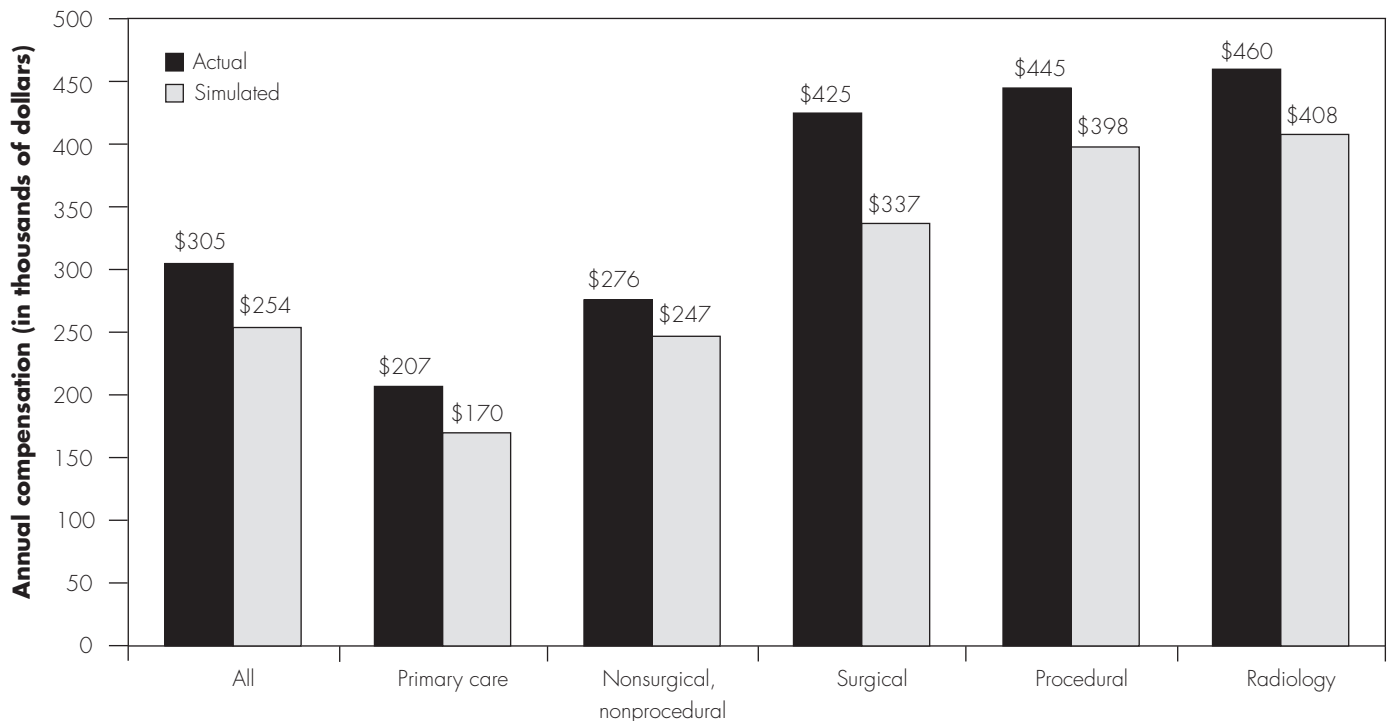
The fee schedule provides inadequate support for primary care

The fee schedule undervalues primary care relative to procedurally based services, leading to compensation disparities between primary care and specialty care. Those compensation disparities may, in the long run, expose beneficiaries to an increased risk of impaired access to primary care.

Undervaluation of primary care services

The undervaluation of primary care services stems from at least two problems with the fee schedule. First, the payment per primary care service is undervalued relative to payments per procedurally based services. Second, the volume of procedurally based services can be increased more readily than the volume of primary care services. Payment for services is based on an assessment of how much time and effort services require relative to one another. Over time, those assessments can get out of balance as the amount of time and effort required for procedurally based services declines due to advances in technology, technique, and other factors. Primary care services—generally defined as a subset of evaluation and management (E&M) services that include office visits, nursing facility visits, and home visits—tend to be labor intensive and so do not lend themselves to similar reductions in time and effort. Because those changes in relative time and effort are not quickly reflected in the fee schedule, procedurally based services become overpriced relative to primary care services over time. For those same reasons, procedurally oriented specialties can more easily increase the volume of services they provide (and therefore their revenue from Medicare), while other specialties—particularly those that spend most of their time providing labor-intensive primary care services—have limited ability to increase their volume.

Figure 5-1 groups procedurally based services into the categories of imaging (e.g., chest X-rays), tests (e.g., hemoglobin counts), major procedures (e.g., aneurysm repair), and other procedures (e.g., minor dermatological procedures). From 2000 to 2012, the growth in the

FIGURE 5-2**Disparities in physician compensation were widest when primary care was compared with proceduralists and radiologists, 2010**

Note: Simulated compensation is compensation as if all services were paid under the Medicare physician fee schedule.

Source: Urban Institute and Medical Group Management Association (MGMA) analysis of 2010 data from the MGMA's Physician Compensation and Production Survey on behalf of the Commission. The analysis is an update of earlier work performed on behalf of the Commission (for a description of the original analysis see Berenson et al. 2010).

volume of procedurally based services (other than major procedures) exceeded that of E&M services. Over that time period, cumulative growth in the volume of imaging, tests, and other procedures totaled 73 percent, 90 percent, and 69 percent, respectively, surpassing the cumulative growth in the volume of E&M services of 37 percent (Figure 5-1).

Compensation disparities between primary care and specialty physicians

The undervaluation of primary care services leads to compensation disparities between primary care and specialty care. Based on an analysis of 2010 data, actual physician compensation averaged about \$305,000 (Urban Institute and Medical Group Management Association (MGMA) analysis of 2010 data from the MGMA's Physician Compensation and Production Survey on behalf of the Commission) (Figure 5-2).¹

Compensation was much higher for some specialties than it was for others. The specialty groups with the

highest compensation were the procedural group and radiology. (The procedural specialties in this analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.) Actual compensations for the procedural group and radiology were about \$445,000 and \$460,000, respectively—more than double that of the \$207,000 average for primary care physicians.^{2, 3}

Differences between Medicare's fees and the fees of other payers do not explain the disparities. Simulated compensations were also calculated as if all services provided by physicians were paid under Medicare's fee schedule. Simulated annual compensation for all specialties averaged about \$254,000—17 percent lower than average actual compensation. Simulated, average annual compensation was about \$408,000 for radiologists and about \$398,000 for procedural physicians. Simulated compensation at those levels was still more than double that of the average simulated compensation for primary care physicians of \$170,000. Under some pricing mechanisms, such disparities in compensation could be

**TABLE
5-1**

Average bonus payments per eligible primary care practitioner, 2011 and 2012

	Total bonus payment (in millions)	Eligible practitioners	Average bonus payment per eligible practitioner	Average bonus payment per eligible practitioner in top quartile of the bonus distribution
2011	\$558	156,673	\$3,562	\$9,900
2012	\$664	168,685	\$3,938	\$9,300

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries, Centers for Medicare & Medicaid Services 2013a, Centers for Medicare & Medicaid Services 2012b.

based on differences in the value of services provided. However, these factors are not taken into account in the prices set under the Medicare fee schedule. A primary goal of the fee schedule is for payment to reflect the time and effort required to provide services without regard to specialty designation—in other words, to provide equal payment for equal work across specialties (Berenson et al. 2010).⁴

Access to primary care services

Such disparities in compensation can deter medical students from choosing primary care specialties and deter current practitioners from remaining in primary care practice, exposing beneficiaries to an increased risk in the long run of impaired access to primary care. Medicare beneficiaries generally have good access to care. However, access to primary care could become more difficult in the future as the newly insured seek care and as the baby-boom generation ages into retirement, increasing the number of Medicare beneficiaries and decreasing the number of practitioners.

Commission’s recommendations to support primary care

In response to these trends in the primary care workforce and the importance of primary care to both coordinated care and future payment reforms to improve the delivery of care, the Commission has made a number of recommendations to address the undervaluation of primary care services in the fee schedule relative to other services.

The Commission made recommendations that the Secretary identify overpriced services and collect data to improve the estimates of work and practice expense in the fee schedule (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2006a).

A variant of that recommendation was enacted into law in April of this year under the Protecting Access to Medicare Act. The Commission also made a recommendation that CMS establish a medical-home pilot project (Medicare Payment Advisory Commission 2008). A variant of that recommendation was enacted into law in 2010 under PPACA. The Commission’s recommendation for replacing the SGR system would provide higher updates for primary care relative to specialty care (Medicare Payment Advisory Commission 2011). Finally, the Commission made a recommendation to establish a budget-neutral primary care bonus payment, funded by a reduction in payments for non–primary care services. PPACA created a bonus program, but it was not budget neutral and thus required additional funds (Medicare Payment Advisory Commission 2008).

Experience with primary care bonus payment

The primary care bonus program enacted into law in 2010 under PPACA (named the Primary Care Incentive Payment program) establishes a 10 percent bonus payment for eligible primary care services provided by eligible primary care practitioners. Eligible primary care services are a subset of E&M services made up primarily of office visits, nursing facility visits, and home visits. Visits to hospital inpatients and emergency department care are not considered eligible primary care services. Eligible primary care practitioners include practitioners who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner, clinical nurse specialist, or physician assistant and for whom eligible primary care services account for at least 60 percent of allowed charges under the fee schedule (excluding hospital inpatient care and emergency department visits from the calculation). Practitioners do

Medicaid fee increase for primary care

Under a provision in the Patient Protection and Affordable Care Act of 2010, states are required in 2013 and 2014 to pay certain primary care physicians (and nonphysicians under their supervision) Medicaid fees that are at least equal to Medicare fees for primary care services. The physicians eligible are those with a specialty designation of family medicine, general internal medicine, and pediatric medicine and those with a subspecialty within the three primary care categories. The federal government is funding the full cost of the fee increase, up to the difference between Medicaid fees as of July 1, 2009, and Medicare fees in 2013 and 2014 (Kaiser Commission on Medicaid and the Uninsured 2012).

CMS estimated that it would increase federal spending by \$5.8 billion in 2013 and \$6.1 billion in 2014 (Centers for Medicare & Medicaid Services 2012a).

On average, Medicaid fees for primary care services were expected to increase by 73 percent in 2013 (Zuckerman and Goin 2012). However, depending on the state, the estimated effect on Medicaid fees would have varied. Average primary care fees were expected to more than double in six states—Florida, New Jersey, Michigan, California, New York, and Rhode Island—and to increase more than 50 percent in a dozen more states (Zuckerman and Goin 2012). ■

not apply for the bonus. It is paid automatically based on the provider's specialty and claims history. The program began in 2011 and expires at the end of 2015. (See the text box for another primary care provision in PPACA—set to expire at the end of 2014—that raises Medicaid fees to equalize them with Medicare's.)

Bonus payments totaled \$558 million in 2011 and \$664 million in 2012 (Table 5-1) (Centers for Medicare & Medicaid Services 2013a, Centers for Medicare & Medicaid Services 2012b). About 157,000 practitioners were eligible for the bonus in 2011, and about 169,000 were eligible in 2012, or about 17 percent of all practitioners billing Medicare in those years. On average, eligible practitioners received an annual bonus of about \$3,600 in 2011 and \$3,900 in 2012. However, practitioners who provided more primary care services to a greater number of fee-for-service (FFS) Medicare beneficiaries received much more than the average. The average bonus for practitioners in the top quartile of the bonus distribution was about \$9,900 in 2011 and \$9,300 in 2012.

Converting the primary care bonus payment to a per beneficiary payment

The Commission is considering the option of replacing the primary care bonus payment after it expires with a per beneficiary payment for eligible primary care practitioners. Replacing the primary care bonus payment

with a per beneficiary payment could help Medicare move away from the volume-oriented FFS payment approach and toward a beneficiary-centered payment approach that encourages care coordination, including the non-face-to-face activities that are critical components of care coordination. Of course, a per beneficiary payment in itself will not guarantee an increase in care coordination activities because practitioners could use the additional funds for other purposes, but it may be a step in the right direction. Separately, CMS has recently created FFS billing codes for some non-face-to-face activities (see text box, p. 81) even though FFS payment has typically focused on face-to-face activities.

In converting the primary care bonus payment to a per beneficiary payment, primary care practitioners would be defined as those practitioners enrolled in Medicare with a primary specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner, certified clinical nurse specialist, or physician assistant and for whom eligible primary care services account for at least 60 percent of allowed charges under the fee schedule (excluding hospital inpatient care and emergency department visits from the calculation). Eligible primary care practitioners would receive monthly payments based on the number of FFS Medicare beneficiaries who received eligible primary care services.

For example, eligible practitioners provided primary care services to 21 million FFS beneficiaries in 2012, for which practitioners received an average of \$31 per beneficiary

**TABLE
5-2**

Converting primary care bonus payment to per beneficiary payment, 2011 and 2012

	Total bonus payment (in millions)	Number of beneficiaries provided eligible primary care services by eligible practitioners (in millions)	Average bonus payment per FFS beneficiary	Monthly per beneficiary payment
	[a]	[b]	[c] = [a]/[b]	[d] = [c]/[12]
2011	\$558	20.4	\$27.35	\$2.28
2012	\$664	21.3	\$31.17	\$2.60

Note: FFS (fee-for-service).

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries; Centers for Medicare & Medicaid Services 2013a; Centers for Medicare & Medicaid Services 2012b.

in that year under the primary care bonus program (Table 5-2). This amount would equal a monthly, per beneficiary payment of about \$2.60. (Results based on 2011 data are similar and shown in Table 5-2.) Medicare, Medicaid, and the private sector do have programs testing per beneficiary payments (text box, pp. 82–83). In those programs, monthly per beneficiary payments range from a low of \$1.50 to as much as \$30.00.

Based on the example of a monthly, per beneficiary payment of \$2.60, eligible practitioners would receive about \$3,900 in additional Medicare revenue per year, on average. Practitioners who provided primary care services to more FFS Medicare beneficiaries than the average practitioner would earn more. To extend the example, consider a primary care practitioner with a panel of 1,400 patients of which 280 (20 percent) are FFS Medicare beneficiaries. A \$2.60 monthly, per beneficiary payment would provide \$8,700 in additional Medicare revenue per year.

Design considerations for a per beneficiary payment

In establishing a per beneficiary payment for primary care, several design issues—including practice requirements, beneficiary attribution, and funding mechanisms—need to be considered. Those considerations depend on the goals behind the per beneficiary payment. Goals could include increasing the compensation of primary care providers, directing more resources to primary care services, or redesigning the delivery of primary care. The goals that can be attained are in turn dependent on the amount of funding for the per beneficiary payment. A small per

beneficiary payment—such as the example just discussed of \$2.60 per beneficiary per month—may not seem like it would provide practitioners with the resources and incentives to undertake rigorous practice transformation. However, Medicare is not working in isolation. Other payers also are providing per beneficiary payments and other types of support for primary care (see text box, pp. 82–83). Even if Medicare contributes only modestly, the Commission believes it is worthwhile to do so, and allowing the Medicare primary care bonus to expire without a replacement would send a poor signal to primary care practitioners.

Practice requirements

Should any additional criteria be required of primary care practitioners to be eligible for the per beneficiary payments? Having practice requirements could provide a specific return for the additional funds directed toward primary care. For example, in return for a per beneficiary payment, practices could be required to improve access. Improved access could take many forms: increasing office hours, maintaining 24-hour phone coverage, and offering other opportunities for patient–caregiver communication such as e-mails or texting. Practices could be required to engage in care coordination activities such as employing a care manager and developing care plans. Practices also could gain eligibility for the per beneficiary payment by meeting specified outcomes or performance thresholds, for example, based on the appropriate use of services.

However, evidence concerning the effect of practice requirements on reducing health care spending and improving quality is not clear. Practice requirements could add to costs and may not increase value. Practice

Fee-for-service billing codes for non-face-to-face activities

While fee-for-service (FFS) payment has typically focused on face-to-face activities, CMS has recently created FFS billing codes for some non-face-to-face activities—transitional care management codes and a chronic care management code.

Transitional care management codes

CMS established two new transitional care management billing codes in the 2013 fee schedule final rule. Starting January 1, 2013, the Medicare program pays for 30 days of transitional care provided to beneficiaries recently discharged from a hospital, skilled nursing facility, or other facility to a community setting. The two codes correspond to higher and lower intensity medical decision making. The payment is designed to cover activities required to provide comprehensive transitional care management as beneficiaries return home.⁵ Use of the new codes has been relatively low because of claims processing issues and because there is often a lag for clinicians to adopt new billing conventions. CMS has released new guidance for billing and has modified its payment processes to clarify when providers should bill for the service, which should increase the number of paid claims (Centers for Medicare & Medicaid Services 2013b).

Chronic care management code

CMS will be creating a new code under the fee schedule for non-face-to-face chronic care management services for the 2015 fee schedule. The new separately payable code will be for non-face-to-face chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to

last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS finalized the establishment of the new code in the 2014 fee schedule final rule, but CMS plans to finalize some remaining design elements as part of the 2015 rulemaking (Centers for Medicare & Medicaid Services 2013b).

The requirement when billing for chronic care management services will be that at least 20 minutes of those services be provided over a 30-day period, and CMS will pay only one practitioner per beneficiary for each 30-day period. Before a practitioner can furnish or bill for chronic care management services, the eligible beneficiary must provide his or her written agreement to have the services provided, and the beneficiary will be charged cost sharing.

As part of the scope of chronic care management services, CMS will require practitioners to provide 24-hours-a-day, 7-days-a-week access to health care providers in the practice. CMS is developing practice standards for furnishing chronic care management services. Potential standards could include requiring the practice to use electronic health records that meet meaningful use standards, to employ at least one or more advanced practice registered nurses or physician assistants to provide chronic care management services, to demonstrate the use of written protocols in providing chronic care management services, and to ensure that all practitioners involved in providing chronic care management services have access to the beneficiary's electronic health record. ■

requirements could also limit practitioner participation, especially among small practices. Finally, requirements would also necessitate some sort of process to ensure that practices are in compliance, creating additional costs for practices and the Medicare program.

Beneficiary attribution

Unlike the service-based primary care bonus payment, a per beneficiary payment necessitates attributing a beneficiary to a practitioner to ensure that the right practitioner gets paid and that Medicare does not make

duplicate payments to multiple practitioners on behalf of the same beneficiary. In an ideal world, a Medicare beneficiary would designate her primary care practitioner. The designated primary care practitioner would provide the majority of the beneficiary's primary care for that year and for years to come, fostering a strong relationship and continuity of care. However, attributing a beneficiary to the right practitioner could be complicated in practice.

A beneficiary may not make a designation either because she is unaware of the need to do so, does not understand the purpose of making a designation, or feels the time

Examples of per beneficiary payment programs

Per beneficiary payments have been used for some time by government health programs to reimburse physicians for engaging in activities that are not directly reimbursable under the fee schedule, such as coordinating care for complex patients or developing a patient-centered medical home (PCMH). These programs have traditionally focused on Medicaid beneficiaries. Under the Patient Protection and Affordable Care Act of 2010 (PPACA), the Center for Medicare and Medicaid Innovation (CMMI) within CMS has developed several programs designed to promote primary care that also have a per beneficiary payment component. This text box outlines a few government-sponsored examples of these programs, including parameters like eligible beneficiaries and providers, practice requirements, and the size of the payments associated with them. Private payers like Blue Cross Blue Shield and Aetna also use this payment model in primary care, but little information about these programs is available because it is considered proprietary.

Medicaid

State Medicaid programs have varying requirements for providers to qualify for per beneficiary payments, and payment amounts can range from as little as \$1.50 per beneficiary per month to as much as \$30 per beneficiary per month. Most fall between \$3.00 and \$7.00. Requirements often include some degree of medical home certification, limitations on the severity and/or complexity of the patients who qualify, and in many cases practice requirements like 24-hour access, same-day appointments, or additional provider training. Often, the amount of the per beneficiary payment is determined, not by an estimate of costs to meet practice requirements, but by the funds available to the program for that purpose.

Alabama Patient 1st Program: Alabama provides a multicomponent case management fee, at a maximum of \$2.60 per beneficiary per month, to providers who agree to serve as the designated primary care practitioner for Medicaid beneficiaries in the state, in addition to the regular Medicaid fee-for-service (FFS) fees for providing specific medical services.

To receive this fee, providers must offer access to office resources 24 hours per day and use health information technology in some way. One use of this technology is

“in-home monitoring,” in which Patient 1st enrollees with certain chronic conditions like diabetes or hypertension can monitor their conditions at home by transmitting readings to a centralized database. Providers can receive higher payments by completing training modules on topics like health literacy and medical homes. Performance is measured and providers share in savings with the state. The program has been in place since 2004.

Outside evaluation of this ongoing program will include analysis of Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) surveys for change in patient experience within each community network pilot and before-and-after financial analysis. Key outcomes of interest for the community network pilots will include improved clinical outcomes, improved patient satisfaction, and Medicaid cost containment. Specific measures that will be used include CAHPS survey results, emergency department use by persons with asthma, HbA1C measures for persons with diabetes, inpatient hospitalization rates, immunization rates, and average number of office visits.

Community Care of North Carolina (CCNC): This program has been in place since 1998 and has been statewide since 2002. All Medicaid beneficiaries are eligible, including dual eligibles. In 2011, Medicare beneficiaries in seven counties also became eligible as part of a multipayer demonstration project (see below). The current per beneficiary per month payment is \$5 for aged, blind, and disabled patients and \$3 for all others.

Practices qualify if they agree to participate in the state’s primary care patient coordination system and provide, coordinate, or authorize all necessary medical care for the practice’s enrollees. A regional CCNC entity assists in care management, including identifying resources, collecting performance data, and providing feedback to practices. The feedback includes monthly and quarterly reports on utilization in comparison with peer group practices.

Center for Medicare and Medicaid Innovation (CMMI)

CMMI has introduced primary care-focused demonstration projects that use per beneficiary

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Examples of per beneficiary payment programs (cont.)

payments in several different configurations, for both Medicare and Medicaid beneficiaries.

Comprehensive Primary Care Initiative: The Comprehensive Primary Care Initiative (CPCI) is a multipayer initiative fostering collaboration between public and private health care payers to strengthen primary care. In August 2012, CMS announced the selection of almost 500 primary care practices in 7 localities, which include 2,347 providers serving an estimated 315,000 Medicare beneficiaries, to participate in the CPCI. The CPCI will test innovations in both service delivery and payment. Comprehensive primary care is characterized as having the following five functions: risk-stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the “medical neighborhood.” The per beneficiary payments in this initiative are to be used to further those goals.

The payment model includes a monthly care management fee paid to the selected primary care practices on behalf of their FFS Medicare beneficiaries and, in years 2 through 4 of the initiative, the potential to share in any savings to the Medicare program. In years 1 and 2, the average per beneficiary per month amount is \$20, and in years 3 and 4 it drops to \$15. Practices also will receive compensation from other payers participating in the initiative, including private insurance companies and other health plans, which will allow them to integrate multipayer funding streams to strengthen their capacity to implement practice-wide quality improvement.

Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration: Under this demonstration, CMS will participate in multipayer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified use and expenditures; improve the safety, effectiveness, timeliness, and efficiency of health care; increase patient decision making; and increase the availability and delivery of care in underserved areas. The care management fee, which is less than \$10 but varies by state, is intended to cover care coordination, improved

access, patient education, and other services to support chronically ill patients.

- **Michigan Primary Care Transformation Project:** This program covers commercial, Medicaid, and Medicare patients at participating practices. These practices, which must be medical homes certified either by the National Committee for Quality Assurance (NCQA) (level 2 or 3) or Blue Cross Blue Shield, receive a three-part payment for completing different activities: \$3 per beneficiary per month for care management, \$1.50 for practice transformation support, and up to \$3 for performance improvement. Medicare pays up to \$2 more for its beneficiaries. The project began late in 2011.
- **Rhode Island Chronic Care Sustainability Initiative Project:** This pilot program covers all insured adults, including Medicare beneficiaries, with chronic illnesses. The pilot sites agree to seek NCQA medical home recognition, to participate in training in the Chronic Care Model, and to hire a nurse care manager. In exchange, sites receive a \$3 per beneficiary per month payment for implementing medical home features and an additional \$0.80 per beneficiary per month for on-site care management activities. The program initially focuses on beneficiaries with coronary artery disease, diabetes, depression, and smoking cessation. Performance measures include cost and utilization measures for emergency department services, prescription drugs, and hospital admissions. This project began in 2008 and was included in the MAPCP in 2011.

Federally Qualified Health Center (FQHC) demonstration: The 473 participating FQHCs are expected to achieve level-3 patient-centered medical home recognition, help patients manage chronic conditions, and actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, the demonstration will pay them a \$6 monthly care management fee for each eligible Medicare beneficiary receiving primary care services. This demonstration began November 1, 2011, and will run until October 31, 2014. ■

and effort involved is too burdensome. Also, a beneficiary could designate one practitioner as her primary care practitioner, but be furnished care by another primary care practitioner throughout the year. In that case, the per beneficiary payment would not be well targeted. A beneficiary may also switch primary care practitioners from year to year, increasing the administrative complexity of designation for both the beneficiary and CMS. Finally, a beneficiary could feel pressured to sign designation forms if asked to do so by a practitioner at an office visit.

As an alternative, CMS could assign beneficiaries to primary care practitioners based on who furnished the majority of their primary care services in a year. An advantage of this option is that it would be easier to administer. Like the primary care bonus payment, the practitioner would receive payment automatically without extra paperwork requirements on behalf of practitioners and beneficiaries. This option requires a decision as to whether beneficiaries would be attributed prospectively or retrospectively.

In prospective attribution, beneficiaries are attributed to practitioners at the beginning of the performance year based on the majority of primary care services furnished in the previous year. In this case, the practitioner could be paid throughout the year and may be better positioned to make front-end investments in infrastructure and staffing that facilitate care coordination. However, practitioners could also be paid for beneficiaries no longer under their care.

In retrospective attribution, beneficiaries are attributed to practitioners at the end of the performance year based on the majority of primary care services furnished in that year. In this case, the practitioner would be paid only for beneficiaries under his or her care. But, the per beneficiary payment would have to be paid after year's end, which could make it more difficult to make front-end investments in the practice. Of course, for practitioners who see the same number of Medicare beneficiaries from year to year, annual per beneficiary payments would be similar under prospective and retrospective attribution.

Hybrids of the three approaches—designation, prospective attribution, and retrospective attribution—also could be considered. For example, CMS could assign beneficiaries prospectively and adjust for errors retrospectively. Alternatively, beneficiaries could be asked to designate their primary care practitioners, but if beneficiaries have not made designations after a period of time, CMS

could attribute them to practitioners prospectively or retrospectively.

Data on the number of primary care practitioners seen annually by beneficiaries could help determine how to attribute beneficiaries to practitioners. Medicare FFS beneficiaries typically do see multiple practitioners and even multiple primary care practitioners in a year (Medicare Payment Advisory Commission 2006a, Pham et al. 2007). However, for the per beneficiary payment, we are concerned with attributing beneficiaries who received eligible primary care services to the eligible primary care practitioners who provided those services. Limiting to that set of beneficiaries, services, and practitioners greatly reduces the number of practitioners seen by beneficiaries in a year: In 2012, 69 percent of beneficiaries received eligible primary care services from only one eligible primary care practitioner, and 90 percent of beneficiaries received eligible primary care services from one or two eligible primary care practitioners.

It also would be useful to know the extent to which beneficiaries switch primary practitioners from year to year. A 2007 study of 2000–2001 claims data found that 20 percent of Medicare beneficiaries had a change in the primary care practitioner who performed the majority of their primary care services (Pham et al. 2007). We plan to investigate this issue further with more recent claims data.

Finally, beneficiaries may be receiving primary care services from multiple practitioners at the same practice. In that case, it may be more appropriate to attribute beneficiaries to practices rather than to individual practitioners. We will investigate this concept in future work.

Funding

Funding the per beneficiary payment for primary care can address two goals: increase support for primary care and rebalance the fee schedule. These goals can be achieved by reducing payments for overpriced services and redistributing the savings to the per beneficiary payment. One funding method is to apply an equal percentage reduction to the payments of those services most likely to be overpriced: services in the fee schedule except those eligible for the primary care bonus. Another funding method is to reduce the payments for services specifically identified as overpriced on a service-by-service basis and fund the per beneficiary payment with the savings. This method would require a change in the current policy on redistribution of savings from overpriced services. Under both funding methods, we are assuming that beneficiaries

are not charged cost sharing to fund the per beneficiary payment for primary care.

Reducing fees of services not eligible for the primary care bonus payment

As discussed in the section on undervaluation of primary care services and illustrated in Figure 5-1 (p. 76), primary care services are composed largely of activities that require a practitioner's time—taking the patient's history; examining the patient; and engaging in medical decision making, counseling, and coordinating care. Those labor-intensive activities do not lend themselves to reductions in time and effort. By contrast, other services—especially procedurally based services—tend over time to become overpriced relative to primary care services due to advances in technology, technique, and other factors.

If primary care services are protected while payments are reduced for all other services, the specific payment reduction required would depend on the amount of the per beneficiary payment. As explained earlier, the current primary care bonus payment is equivalent to a per beneficiary payment of \$2.60 per month. With that payment amount as an example, one option would be to reduce fees for the 90 percent of the fee schedule not eligible for the primary care bonus payment. Under this option, the reduction would be 1.1 percent (Figure 5-3).

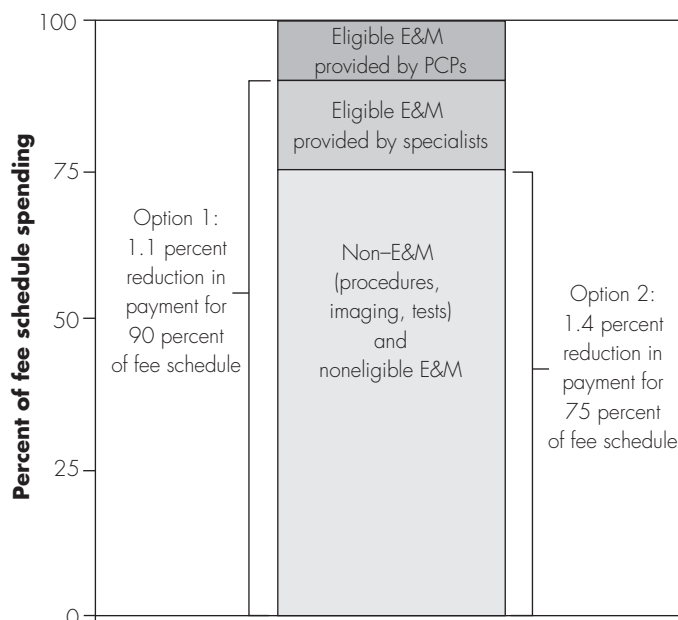
Another option would be to protect all bonus-eligible E&M services from fee reductions, regardless of a practitioner's specialty designation and regardless of whether primary care services account for at least 60 percent of the practitioner's allowed charges. In this case, funding would come from about 75 percent of the fee schedule. Because the funding would be coming from a smaller portion of the fee schedule, the reduction would be larger: 1.4 percent.

Reducing the fees of overpriced services

The Commission has made a series of recommendations on identifying and reducing payments for overpriced services (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2006b). Most recently—in our October 2011 letter on repeal of the SGR—the Commission recommended that the payment reductions should achieve an annual numeric goal for each of five consecutive years of at least 1 percent of the fee schedule. Redistributing 1 percent of the fee schedule each year from overpriced services would fund per beneficiary

FIGURE 5-3

Two options for funding the per beneficiary payment from services not eligible for the primary care bonus payment



Note: E&M (evaluation and management), PCPs (primary care practitioners). Eligible E&M services are E&M services eligible for the primary care bonus payment.

Source: MedPAC analysis.

per month payments of roughly \$2.60, \$5.20, \$7.80, \$10.40, and \$13.00 in years 1, 2, 3, 4, and 5, respectively.⁶

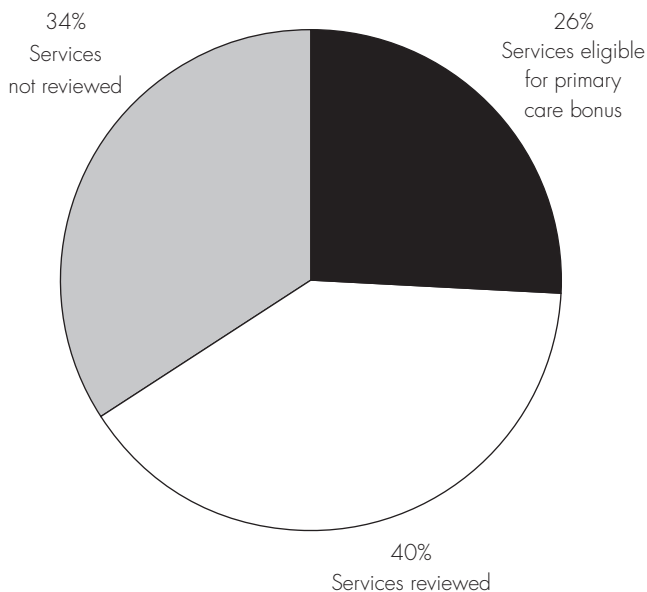
Achieving savings from overpriced services sufficient to fund a per beneficiary payment for primary care will require a concerted effort. It will require, first, review of the accuracy of the fee schedule's relative value units (RVUs), either as part of a process of validating the RVUs—a PPACA requirement that is taking some time to fulfill—or in the meantime as part of a current initiative to review RVUs. Second, it will require a targeting of savings from overpriced services to the per beneficiary payment. Current policy is to distribute such savings to all services equally as a percentage adjustment to fee schedule payments.⁷

- **Validating the RVUs of overpriced services**—Under a provision in PPACA, the Secretary is required to establish a process to validate the fee schedule's RVUs. The validation process is to include a sampling of services that meet criteria such as rapid growth,

**FIGURE
5-4**

**Further savings are possible
under potentially misvalued
services initiative, 2014**

**Services by review status
(as a percent of estimated allowed charges)**



Note: Percentages are each category's share of total fee schedule allowed charges. Services reviewed are those listed in fee schedule final rules for 2009 to 2014 as new, revised, or potentially misvalued.

Source: CMS final rules and utilization file for 2014 impacts.

use of new technologies, and substantial changes in practice expenses or that meet other criteria for identifying services that may be misvalued. The process is to consider work elements such as time, mental effort, and other factors.

As part of the validation process, the law gives the Secretary the authority to make appropriate adjustments to the RVUs for practitioner work. CMS sees validation of RVUs as a new requirement and one that would complement the ongoing efforts of the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) to provide recommendations on the valuation of fee schedule services.⁸

The fee schedule's RVUs for the work of physicians and other health professionals offer an example of how validation could occur.⁹ The statute defines this work as consisting of time and intensity—the amount

of time it takes to furnish a service and the intensity of work effort per unit of time. As a measure of the time component of this definition, CMS has a time estimate for each service with a work RVU.

Studies have shown that CMS's time estimates are inaccurate. Contractors working for CMS and the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services have found that the time estimates are too high for some services (Cromwell et al. 2007, Cromwell et al. 2004, McCall et al. 2006). The Government Accountability Office has found that the fee schedule does not adequately account for efficiencies that arise when a practitioner provides multiple services for the same patient on the same day (Government Accountability Office 2009).

To support validation of the time estimates and RVUs generally, the Commission recommended that the Secretary regularly collect data to establish more accurate RVUs (Medicare Payment Advisory Commission 2011). Further, to help assess whether Medicare's fees are adequate for efficient care delivery, the Commission recommended that the Secretary collect the data from a cohort of efficient practices rather than a sample of all practices. The Commission has worked with contractors to give the Secretary advice on how to collect the data.¹⁰

CMS is taking steps to fulfill the PPACA requirement on validating RVUs. First, the agency has established a contract with the RAND Corporation for development of a model to predict work RVUs and the components of those RVUs—time and intensity. The contractor will use a model design informed by statistical methodologies and an approach used to develop the RVUs initially. The contractor then will test the model with a representative set of CMS-provided billing codes. During the project, the contractor will consult with a technical expert panel for advice on model design issues and interpretation of results. Second, CMS has established a contract with the Urban Institute for collection of time data from several physician practices. As part of the project, the contractor will use the data collected to develop objective time estimates. The contractor will then convene groups of physicians from a range of specialties to review the new time data and their implications for the fee schedule's work RVUs.

- **Reviewing RVUs under the current potentially misvalued services initiative**—Pending validation of the fee schedule’s RVUs, there is an initiative concerning potentially misvalued services now underway that can serve as a source of savings to fund a per beneficiary payment for primary care. Under this initiative, CMS is working with the RUC to identify and review services that meet certain screening criteria (e.g., high volume growth).

It has been argued that this potentially misvalued services initiative already has captured most of the potential savings from overpriced services (Madara 2013). The assertion is that the services not yet reviewed represent low-volume services or services with moderate RVUs and, therefore, that their review would not have a high impact on fee schedule spending.

There are several reasons why the potentially misvalued services initiative remains an important source of savings. First, the services not yet reviewed do account for a meaningful share of fee schedule spending: 34 percent (Figure 5-4). Second, while the initiative has produced savings, further savings are possible even among those services already reviewed. According to an AMA progress report, a total of 1,451 services have been reviewed (American Medical Association 2014). Work RVUs were reviewed for 1,085 services, practice expense RVUs were revised for 119 services, and billing codes were deleted for 247 services. Among the services whose work RVUs were reviewed, the RVUs were decreased for 531 services, but they were increased (120 services) or maintained (434 services) for another 554 services. Further examination of the services whose work RVUs were increased or maintained could lead to additional decreases in work RVUs.

One further source of savings concerns a factor in the fee schedule’s definition of the work of physicians and other health professionals. Recall that the statute defines this work as consisting of the time spent providing a service and the intensity of work effort per unit of time. Over the course of the potentially misvalued services initiative, estimates of the time professionals spend providing services have gone down for a number of services. However, their work RVUs have not gone down as much: The time estimates decreased by an average of 18 percent,

TABLE 5-3

Time estimates have decreased more than work RVUs, 2008-2014

	Number of services	Average percent change
Work RVUs	499	-7%
Time estimates	499	-18

Note: RVU (relative value unit). Services had work RVUs and time estimates in 2008 and 2014 and had a decrease in work RVUs, a decrease in work time estimate, or both.

Source: MedPAC analysis of physician time and RVU files from CMS.

but the work RVUs decreased by an average of 7 percent (Table 5-3). Such a disparity could arise if the RUC is offsetting some of the decreases in time by increasing intensity. (Inflation in the time estimates for some services could also have a small effect on the disparity.¹¹) Further review of the RVUs for these services could lead to decreases more in line with decreases in time estimates and, therefore, could increase the savings available to fund the per beneficiary payment for primary care.

- **Targeting savings from overpriced services**—When the fee schedule’s RVUs are changed, the Medicare statute requires that the effect on spending must be budget neutral.¹² Specifically, if decreases (or increases) in the fee schedule’s RVUs would have an impact of \$20 million or more on spending, CMS must make a compensating payment adjustment. The current policy is to redistribute the savings to all other services. Underpriced, accurately priced, and overpriced services all receive the same budget-neutrality adjustment.

Under the funding mechanism discussed here, the budget-neutrality policy would be revised and savings from overpriced services would be redistributed solely to the payment for primary care. In addition to providing a funding source, doing so would help rebalance the fee schedule.

Conclusion

The Commission remains concerned that—within Medicare’s fee schedule for the services of physicians

and other health professionals—primary care remains undervalued. Moreover, such FFS payment is ill suited as a payment method for the non-face-to-face activities in primary care. Those activities are necessary to achieve care coordination for Medicare beneficiaries, especially those with multiple chronic conditions. Expiration of the primary care bonus at the end of 2015 provides an opportunity to revisit the structure of payment for primary

care and to consider the alternative of a per beneficiary payment. The Commission plans to continue work on these issues, including design considerations for a per beneficiary payment: the payment amount, requirements that practices must meet to receive the payment, mechanisms for attributing beneficiaries to practitioners or practices, and methods for funding a per beneficiary payment. ■

Endnotes

- 1 The analysis of physician compensation is an update of earlier work performed on behalf of the Commission (for a description of the original analysis, see Berenson et al. 2010).
- 2 The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.
- 3 To account for differences among specialties in hours worked per week, the contractor's earlier analysis for the Commission—with MGMA data for 2007—included comparisons of hourly compensation. The results were similar to those from the analysis of the 2010 data on annual compensation: hourly compensation for procedural specialties and radiology was more than double the hourly compensation rate for primary care. Analysis of hourly compensation was not possible with the 2010 data because the newer MGMA survey did not include questions about hours worked.
- 4 Fee schedule payments also include an estimate for practice expenses, but compensation, in the analysis discussed here, is calculated net of practice expenses.
- 5 The transitional care management code requires one face-to-face visit (not paid separately) as well as the non-face-to-face time required to deliver the transitional care.
- 6 The Protecting Access to Medicare Act of 2014 limited the funding that could be redistributed from overpriced services to the per beneficiary payment. The law set a target for reduced payments from overpriced services equal to 0.5 percent of fee schedule expenditures. If the target is not met in any one year—2017 through 2020—the savings from reduced payments for overpriced services will not be redistributed to all other services in the fee schedule as they would be otherwise. With this provision, the law claimed \$4 billion in savings over 10 years (2014–2024) to help fund a temporary (one-year) increase in fee schedule payment rates through March 31, 2015. This increase overrode a 24.1 percent reduction in rates that would have occurred on April 1, 2014, under the SGR formula.
- 7 The Protecting Access to Medicare Act of 2014 modified current policy. The law created the exception for any year in which the 0.5 percent target for savings from overpriced services is not met.
- 8 The RUC website is at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/the-rvs-update-committee.page>. The Commission's March 2006 report (http://medpac.gov/publications%5Ccongressional_reports%5CMar06_Ch03.pdf) also has a discussion.
- 9 In addition to RVUs for work, the fee schedule has RVUs for practice expense and for professional liability insurance.
- 10 Options for collecting the data were discussed in a 2012 Commission comment letter on CMS's proposed rule on the physician fee schedule (http://medpac.gov/documents/08312012_PartB_comment.pdf).
- 11 Methods for assessing the accuracy of time estimates are described in the Commission's 2012 comment letter on CMS's proposed rule on the physician fee schedule (http://medpac.gov/documents/08312012_PartB_comment.pdf).
- 12 The statutory requirement reads as follows: “the adjustments (to fee schedule RVUs) for a year may not cause the amount of expenditures under (the fee schedule) for the year to differ by more than \$20,000,000 from the amount of expenditures under (the fee schedule) that would have been made if such adjustments had not been made.”

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