Next steps in primary care

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MEDPAC

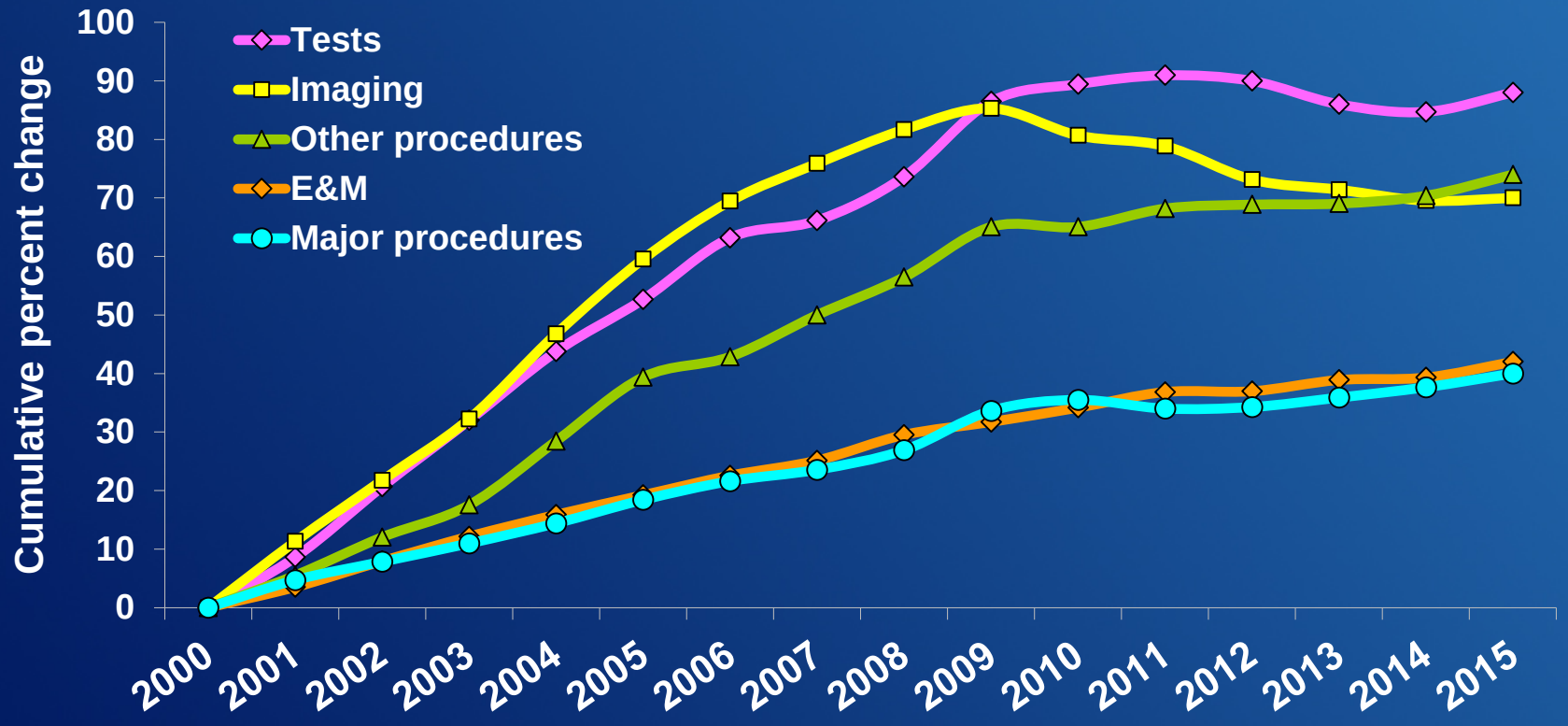
Outline

- Primary care services underpriced in fee schedule
- Prior Commission recommendations to improve payment for primary care
- 3 options to better support primary care
- Design issues

Primary care services underpriced in fee schedule

- Primary care is labor intensive, which limits potential for efficiency gains and volume growth
- For services other than primary care, efficiency gains are more likely due to advances in technique, technology, other factors
  - RVUs should decline for these services over time
  - Under budget neutrality rule, RVUs should go up for other services, including primary care
  - But process often does not account for efficiency gains
- Some specialties can increase the volume of services more easily than primary care clinicians

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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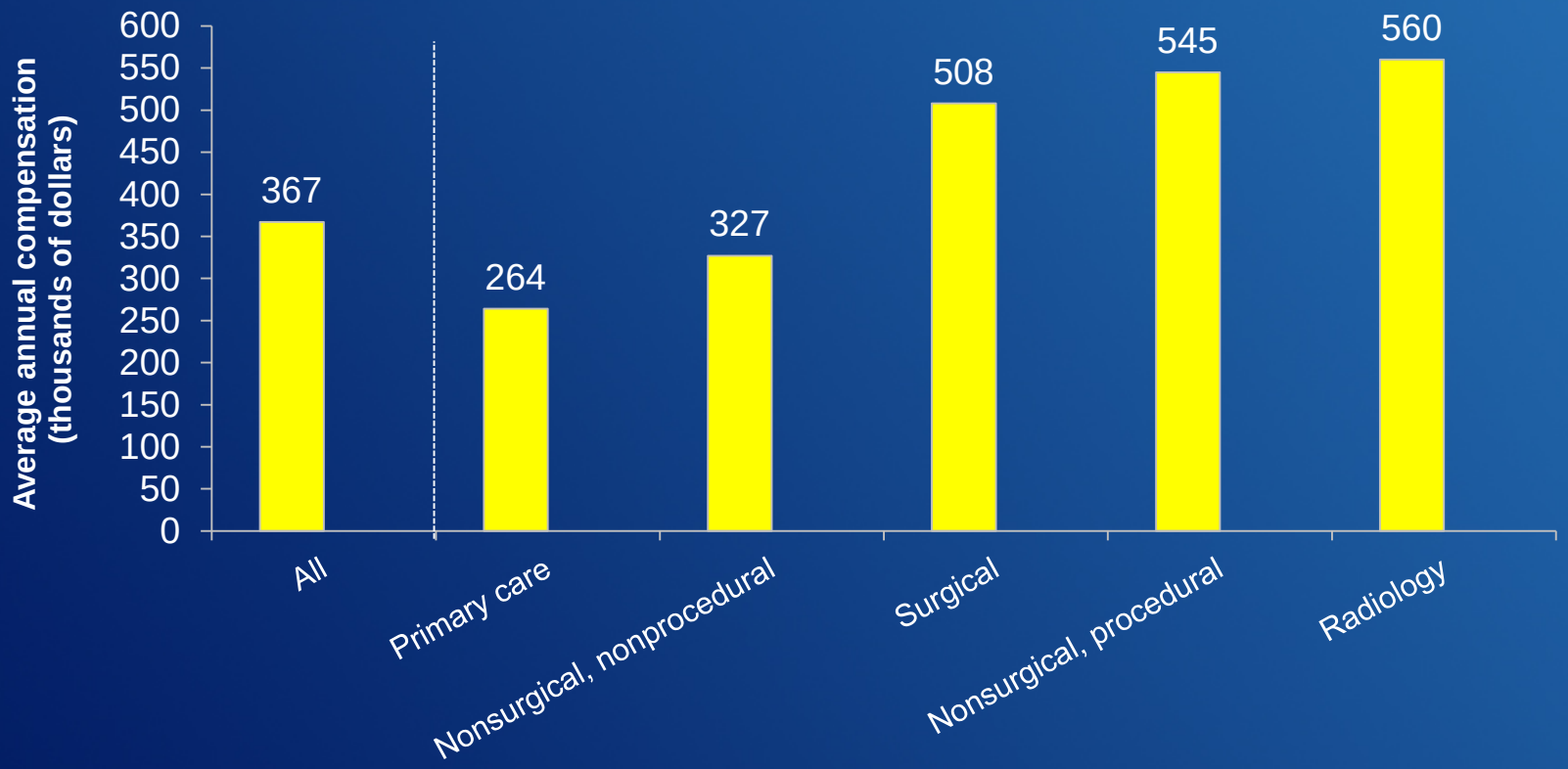
Data preliminary and subject to change.

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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Fee schedule not well-designed to support primary care

- Oriented towards discrete services
- Billable services have definite beginning and end
- Primary care requires ongoing, non-face-to-face care coordination
- Such care is crucial to a more coordinated and efficient health care system

Prior Commission recommendations to rebalance fee schedule and support primary care

- Create budget-neutral bonus for primary care services (2008)
  - PPACA created Primary Care Incentive Payment (PCIP) program, 2011-2015 (not budget neutral)
- Repeal SGR and provide higher updates for primary care (2011)
- Identify overpriced services and price them accurately (2011)
- Establish per beneficiary payment for primary care (2015)

Recommendation to establish per beneficiary payment for primary care

- Intended to replace expiring PCIP program but would retain certain elements of PCIP
- Initially, funding for per beneficiary payments should be equal to PCIP payments (~$700 million in 2015)
- Should be budget neutral: funded by reducing fees for all fee schedule services other than primary care visits furnished by any clinician
- Goal: move primary care from service-based payment to beneficiary-centered payment

3 options to better support primary care

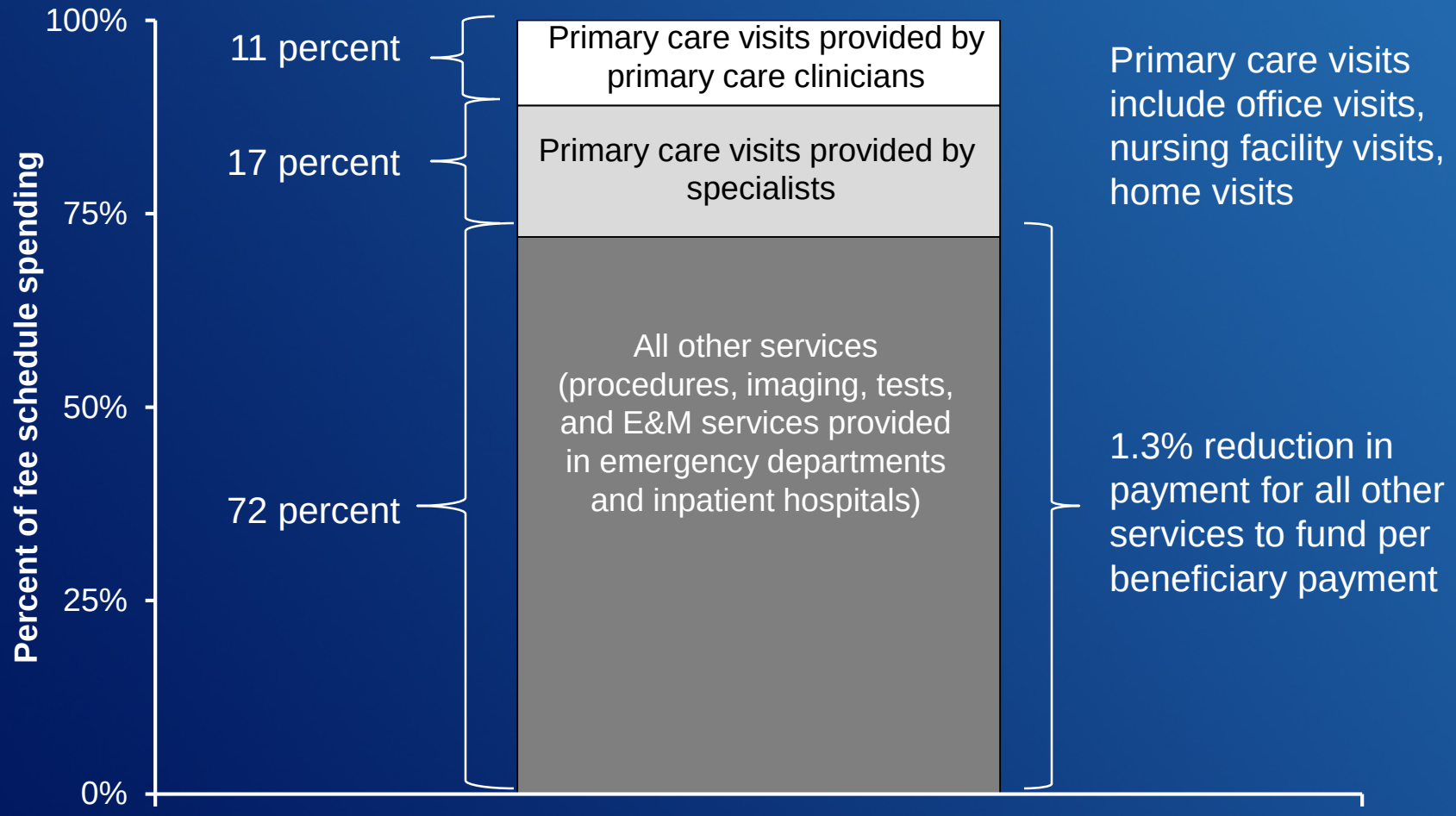
- Option 1: Maintain recommendation to establish per beneficiary payment for primary care based on amount of PCIP payments (~$700 million)
- Option 2: Increase per beneficiary payments to $1.2 billion ($700 million from option 1 + $500 million from MIPS exceptional performance bonus)
- Option 3: Allow primary care practitioners in all 2-sided ACOs to receive portion of payments for primary care visits as upfront payment, in addition to per beneficiary payment from option 2

Option 1: Per beneficiary payment for primary care based on amount of PCIP payments

- Per beneficiary payment: ~$28/year (almost $3,600 per clinician, on average)
- Funded by reducing fees by 1.3% for all services other than primary care visits
- Would help rebalance fee schedule between primary care and specialty care
- No beneficiary cost sharing

Data preliminary and subject to change.

Option 1 funded by reducing fees for all services other than primary care visits



Source: MedPAC analysis of Medicare claims data from 2015.

Data preliminary and subject to change.

Option 2: Increase per beneficiary payments to $1.2 billion

- $700 million from option 1 + $500 million from MIPS exceptional performance bonus
- Issues with MIPS
- Shift $500 million from MIPS to primary care
- Per beneficiary payment: ~$49/year (~$6,000 per clinician, on average)
- No beneficiary cost sharing

Data preliminary and subject to change.

Design issues with options 1 and 2

- Risk adjustment
- Alternatives for attributing beneficiaries to primary care providers
  - Based on plurality of primary care visits received in prior year
  - Beneficiaries designate a main primary care provider
- Practice requirements
- Incentive to refer attributed patients to other providers for primary care visits

Option 3: Allow PCPs in all 2-sided ACOs to receive portion of payments for primary care visits as upfront payment

- PCPs would also receive per beneficiary payment from option 2
- Partial capitation: PCPs would receive part of payments for primary care visits as upfront payment, part on FFS basis
- Upfront payment would be financed by reducing FFS payments for each primary care visit
- Upfront payment would give providers more flexibility to invest in care coordination
- No change in beneficiary cost sharing

Illustration of option 3: Upfront payment = 20% of FFS payments for primary care visits

Annual upfront payment based on 20% of FFS payments, per beneficiary	$81
	+
Annual per beneficiary payment from option 2	$49
Total per beneficiary payment (row 1 + row 2)	$130

- Assuming average number of beneficiaries per clinician (126), total per beneficiary payments per clinician would be ~$16,000.

Note: Annual per beneficiary payment amounts are based on the number of beneficiaries who received a primary care visit in 2015 (24.3 million).
Source: MedPAC analysis of Medicare claims data from 2015.

Rationale for only allowing partial capitation for PCPs in 2-sided ACOs

- Attribution would be simpler (beneficiaries would be attributed to ACOs based on current methods)
- Reduces need for risk adjustment because ACOs with higher historical spending on primary care visits would receive higher per beneficiary payments
- Reduces need for practice requirements because ACOs are accountable for quality and spending
- Limits incentive to refer patients to other providers for primary care because ACO is accountable for total spending

Summary

- Goals
  - Rebalance fee schedule by increasing spending on primary care
  - Give PCPs more resources and flexibility to invest in care coordination
- Options
  - Option 1: Per beneficiary payments based on amount of PCIP payments (~$700 million)
  - Option 2: Increase per beneficiary payments to $1.2 billion
  - Option 3: Allow PCPs in 2-sided ACOs to receive portion of payments for primary care visits as upfront payment + per beneficiary payment from option 2

Discussion questions

- How large should per beneficiary payment be?
- How should it be financed?
- Should Medicare offer partial capitation for primary care to PCPs in 2-sided ACOs?