Rebalancing the physician fee schedule towards primary care services

Ariel Winter and Kevin Hayes

November 2, 2017

MEDPAC

Outline

- Context and background
- Problems with how fee schedule pays for primary care
- Two approaches to rebalance the fee schedule towards primary care services

This year's agenda for work on clinician payment policy

- Merit-based Incentive Payment System
- Rebalancing fee schedule towards primary care
- Assessing payment adequacy for physician/other health professional services (March 2018 report)
- Advanced Alternative Payment Models and ACOs (Spring 2018)

Prior Commission recommendations to rebalance fee schedule towards primary care

- Create budget-neutral bonus for primary care services (2008)
  - Congress created Primary Care Incentive Payment (PCIP) program, 2011-2015 (not budget neutral)
- Repeal SGR and provide higher updates for primary care than specialty care (2011)
- Establish per beneficiary payment for primary care clinicians to replace PCIP (2015)
  - Fund payment at same level as PCIP (~$700 million)
  - Fund payment by reducing fees for all fee schedule services other than primary care

Prior Commission recommendations to improve accuracy of fee schedule payment rates

- Set annual numeric goal for CMS to reduce prices of overpriced services for 5 years (2011)
  - Congress set a numeric target for 3 years (2016-2018)
- CMS should regularly collect data on clinician volume and work time to establish more accurate work and practice expense relative values (2011)
  - Not adopted

What is primary care and who provides it?

- Five core elements of primary care: accessibility, continuity, comprehensiveness, coordination, accountability
- High-quality primary care essential for well-functioning health care system
- Primary care physicians: family medicine, internal medicine, geriatrics, pediatrics
  - 19% of professionals who billed Medicare in 2016
- Other primary care practitioners: advanced practice registered nurses, physician assistants
  - 21% of professionals who billed Medicare in 2016

Problems with how fee schedule pays for primary care

- Primary care services underpriced relative to other services
  - Time needed for procedures eventually declines due to changes in productivity, clinical practice, and technology
  - But rates not updated frequently enough to reflect reductions in time
  - Primary care services are labor-intensive, so time is less likely to decline
- FFS payment allows certain specialties to more easily increase volume of services than primary care clinicians
- Fee schedule is not well-designed to support primary care

CMS has reviewed potentially mispriced services since 2008 but fee schedule still unbalanced

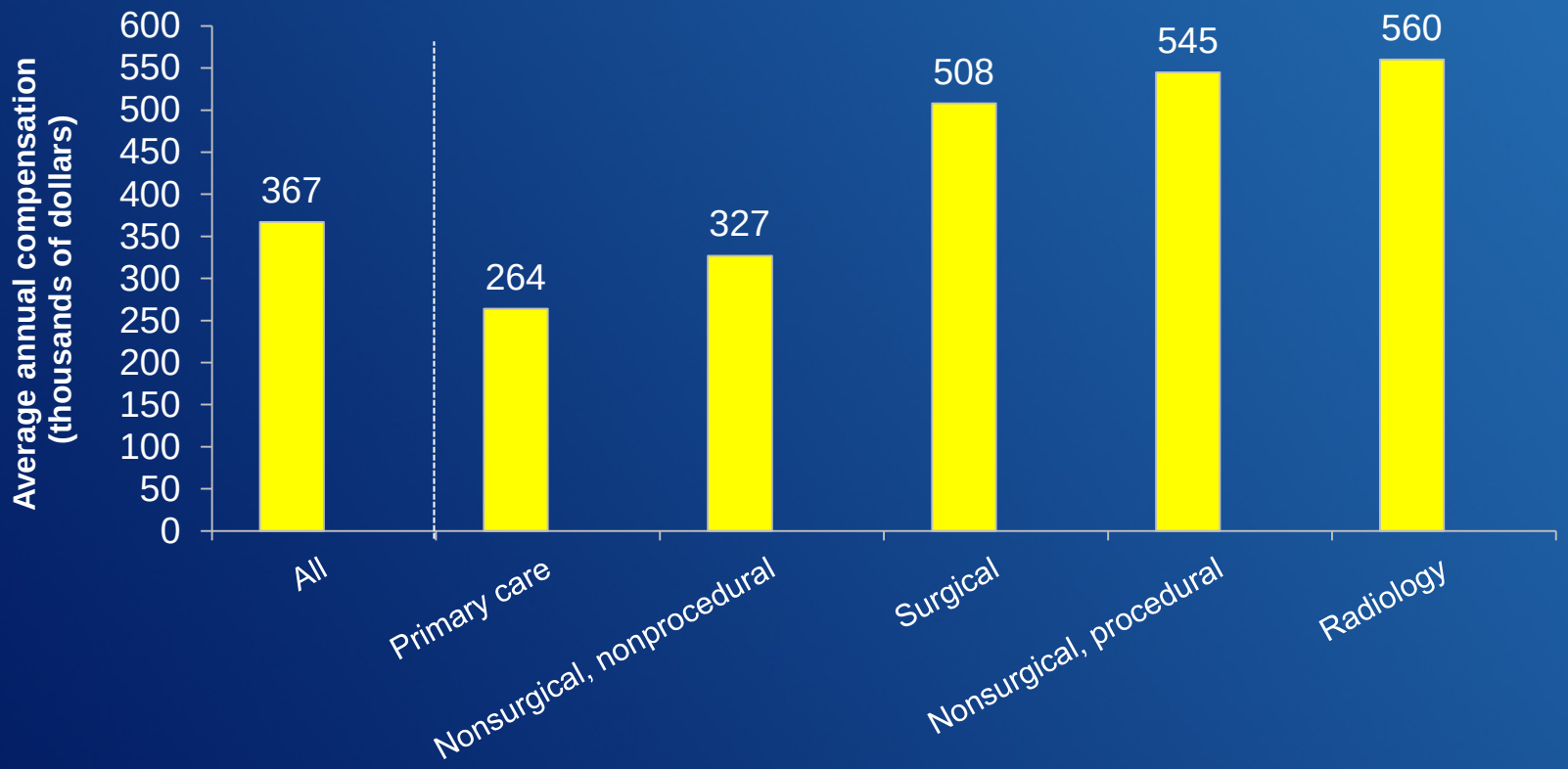
- Services that comprise 29% of fee schedule spending have not yet been reviewed
- RVUs for clinician work did not decline as much as time estimates
- Potential explanation: decreases in time were partially offset by increases in intensity

	Number of services revised, 2008-2016	**Average percent change**
Work RVUs	607	-9%
Time estimates	607	-18

Note: Reflects changes to RVUs adopted by CMS. Services had a decrease in work RVUs, time estimates, or both. Data are preliminary and subject to change.
Source: MedPAC analysis of physician time and RVU files from CMS.

MEDPAC

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.

MEDPAC

Data preliminary and subject to change.

Rebalancing the fee schedule towards primary care

- Prior incremental efforts to address underpricing of primary care services have not succeeded in rebalancing fee schedule
- Commission may wish to consider more significant changes
  - Should Medicare increase payment rates for primary care services provided by all specialties or just primary care clinicians?
  - Should payments also be increased for psychiatric services?
  - How much should payments be increased?
  - Should higher payments be distributed a per service or per beneficiary basis?

Approach 1: Increase fee schedule payments for primary care and psychiatric services provided by all specialties

- Budget-neutral change: higher payments for primary care and psychiatric services offset by lower payments for other services
- Payment increase paid on a per-service basis
- Primary care services include
  - E&M codes for office visits, home visits, visits to patients in long-term care settings
  - Chronic care management, transitional care management, welcome-to-Medicare visits, annual wellness visits
- Psychiatric services include
  - Same E&M codes as primary care services
  - Psychiatric diagnostic evaluation and psychotherapy

Share of fee schedule payments derived from primary care services, selected specialties, 2016

Specialty	Share of fee schedule payments from primary care services
All primary care specialties	54
Family medicine	70
Advanced practice registered nurse	60
Geriatric medicine	56
Pediatric medicine	47
Physician assistant	47
Internal medicine	45
Endocrinology	76
Rheumatology	68
Hematology/oncology	50
All specialties	**29**

Data are preliminary and subject to change.
Source: Analysis of claims data for 100% of Medicare beneficiaries, 2016.

Approach 1: Budget-neutral increase for fee schedule payments for primary care and psychiatric services

	Size of payment increase for primary care and psychiatric services		
	10%	**20%**	**30%**
Dollar increase	$2.7 billion	$5.4 billion	$8.1 billion
Budget neutral adjustment applied to other services	-4.5%	-9.0%	-13.4%
Net impact by specialty group			
Primary care	3.4%	6.8%	10.2%
Psychiatry	4.8	9.6	14.4
Surgical	-1.6	-3.2	-4.7
Nonsurgical, nonprocedural	-0.9	-1.7	-2.6
Nonsurgical, procedural	-0.4	-0.8	-1.3
Radiology	-4.4	-8.8	-13.2
Other practitioners	-0.8	-1.6	-2.4

Data are preliminary and subject to change.
Source: Analysis of claims data for 100% of Medicare beneficiaries, 2016.

Approach 2: Increase payments for primary care and psychiatric services provided by certain clinicians

- Clinicians would be eligible based on specialty designation (primary care or psychiatry) and their share of payments from primary care and psychiatric services
- Rationale for targeting certain specialties: they play unique role in delivery system, have lower compensation than many other specialties
- Uses same definitions of primary care and psychiatric services as approach 1 (slide 11)
- Primary care specialties include
  - Family, internal, geriatric, and pediatric medicine
  - Advanced practice registered nurses, physician assistants

Approach 2: Budget-neutral payment increase for primary care and psychiatric services provided by certain clinicians

Percent of payments from primary care/psych services to qualify clinicians for increase	Number of eligible primary care clinicians and psychiatrists	Size of payment increase (in billions)		Budget-neutral adjustment applied to other services	
		10% increase	30% increase	10% increase	30% increase
40%	263,057	$1.2	$3.6	-2.0%	-5.9%
75	224,441	1.0	3.0	-1.7	-5.0

Data are preliminary and subject to change.
Source: Analysis of claims data for 100% of Medicare beneficiaries, 2015 and 2016.

Options for distributing payment increase under approach 2

- Distribute on a service-by-service basis
  - Easier to administer
  - But rewards clinicians who provide more discrete primary care visits
- Distribute on a per beneficiary basis
  - Paying clinicians based on size of patient panel rather than number of visits could encourage non-face-to-face care coordination
  - As size of payment increases, questions about patient attribution, risk adjustment
- Consider a mix of both options (e.g., implement sequentially)

Key decision points for Commissioner discussion

- Should Medicare increase payment rates for primary care services provided by all specialties or just primary care clinicians?
- Should payments also be increased for psychiatric services?
- How much should payments be increased?
- Should higher payments be distributed on a per service or per beneficiary basis?