

CHAPTER

2

**Promoting the use
of primary care**

R E C O M M E N D A T I O N S

2A The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners. Primary-care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.

COMMISSIONER VOTES: YES 15 • NO 2 • NOT VOTING 0 • ABSENT 0

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2B The Congress should initiate a medical home pilot project in Medicare. Eligible medical homes must meet stringent criteria, including at least the following capabilities:

- furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services),
- conduct care management,
- use health information technology for active clinical decision support,
- have a formal quality improvement program,
- maintain 24-hour patient communication and rapid access,
- keep up-to-date records of beneficiaries' advance directives, and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

Medicare should provide medical homes with timely data on patient utilization. The pilot should require a physician pay-for-performance program. The pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

Promoting the use of primary care

Chapter summary

Patient access to high-quality primary care is essential for a well-functioning health care delivery system. Research suggests that reducing reliance on specialty care may improve the efficiency and quality of health care delivery. Areas with higher rates of specialty care per person are associated with higher spending but not improved access, quality, health outcomes, or patient satisfaction (Fisher et al. 2003a, Fisher et al. 2003b, Kravet et al. 2008, Wennberg 2006). Moreover, states with more primary care physicians per capita have better health outcomes and higher scores on performance measures (Baicker and Chandra 2004, Starfield et al. 2005).

Despite these findings, primary care services—which rely heavily on cognitive activities such as patient evaluation and management (E&M)—are undervalued and they risk being underprovided relative to procedurally based services. Indeed, the share of U.S. medical school graduates entering primary care residency programs has declined over the last decade, and internal medicine residents are increasingly choosing to subspecialize rather than practice as generalists (Bodenheimer 2006). Also, the Commission found that although a small

In this chapter

- The value of primary care
- Access and medical training concerns
- Fee schedule adjustment for primary care
- A medical home program in Medicare

share of beneficiaries reported looking for a new physician in 2007, those looking for a primary care physician were more likely to report problems finding one than those looking for a new specialist (MedPAC 2008).

Given signals that primary care is undervalued, the Commission has approached the problem in three ways. First, the Commission recommended improvements to the process for reviewing the relative value of physician services (MedPAC 2006). These recommendations sought to address concerns that cognitive services—mainly E&M services—were being devalued over time. Although the formal process for reviewing the service values has not changed, the physician work component of certain E&M codes increased substantially in 2007.

The second initiative is included in this chapter and concentrates on services furnished by practitioners whose practices focus mostly on primary care. The Commission recommends increasing Medicare Part B payments for primary care services furnished by such practitioners. This adjustment, administered in a budget-neutral manner, would help overcome the undervaluation of primary care services in the physician fee schedule.

Recommendation 2A

The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners. Primary-care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.

COMMISSIONER VOTES:

YES 15 • NO 2 • NOT VOTING 0 • ABSENT 0

The services selected for the adjustment—a subset of E&M services within the statutory definition of primary care—would be office visits, home visits, and visits to patients in certain nonacute facility settings (skilled nursing, intermediate care, long-term care, nursing home, boarding home, domiciliary, and custodial care). The adjustment would help to promote the use of primary care. To ensure that the adjustment reaches the intended physicians and other practitioners who are focused on primary care, it will be important to determine practitioner eligibility. Accordingly, the Commission recommends that the Secretary use claims data to confirm that practitioners

are meeting a minimum threshold for the percentage of services they furnish that are primary care services.

The third initiative, also introduced in this chapter, is to establish a medical home pilot program in Medicare. A medical home serves as a central resource for a patient's ongoing care. Other purchasers and payers have begun programs that recognize the value of having specified clinicians accountable for effectively managing patient care (Baron and Cassel 2008). Through a pilot project, Medicare could test the effectiveness of a medical home program to support and encourage care coordination across settings and among providers for complex patients—those with multiple chronic conditions. This pilot would include monthly, per beneficiary payments to qualifying medical practices for infrastructure and activities that promote ongoing, comprehensive care management. Beneficiaries would not incur any additional cost sharing for the monthly fees. Qualifying medical homes could include primary care practices as well as specialty practices that focus on care for certain chronic conditions, such as diabetes. To be eligible for these monthly payments, medical homes would be required to meet several stringent criteria. In rural areas, the pilot could test the ability of medical homes to provide high-quality, efficient care with fewer structural requirements.

The Congress should initiate a medical home pilot project in Medicare. Eligible medical homes must meet stringent criteria, including at least the following capabilities:

- *furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services),*
- *conduct care management,*
- *use health information technology for active clinical decision support,*
- *have a formal quality improvement program,*
- *maintain 24-hour patient communication and rapid access,*
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- *maintain a written understanding with each beneficiary designating the provider as a medical home.*

Medicare should provide medical homes with timely data on patient utilization. The pilot should require a physician pay-for-performance program. The pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued.

Recommendation 2B

COMMISSIONER VOTES:

YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

Although medical homes should offer their patients guidance on selecting appropriate specialty services, participating beneficiaries would retain their ability to see specialists and other practitioners of their choice, as they would remain in fee-for-service Medicare. While the medical home pilot would stress the importance of patient–clinician communication regarding service use outside the medical home, Medicare should also provide medical homes with timely data on patients’ Medicare-covered utilization outside the medical home, including services under Part A, Part B, and drugs under Part D. These data will assist medical homes in comprehensive care management.

A medical home pilot provides an excellent opportunity to test and implement physician pay for performance (P4P). Under the pilot project, the Commission envisions that the P4P incentives would allow for rewards and penalties based on performance in quality and efficiency. Efficiency measures should be calculated from spending on Part A, Part B, and Part D, and efficiency incentives could take the form of shared savings models similar to those under Medicare’s ongoing physician group practice demonstration. Bonuses for efficiency should be available only to medical homes that have first met quality goals and that have a sufficient number of patients to permit reliable spending comparisons. Medical homes that are consistently unable to meet minimum quality requirements would become ineligible to continue participation.

The medical home pilot should be on a large enough scale to provide statistically reliable results to test the hypothesis that medical homes can improve the quality and efficiency of care for patients with multiple chronic conditions. However, the pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued entirely.

Finally, policymakers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them. The Commission will examine medical training issues in the future. ■

The value of primary care

Patient access to high-quality primary care is essential for a well-functioning health care delivery system. Research suggests that reducing reliance on specialty care may improve the efficiency and quality of health care delivery. Areas with higher rates of specialty care per person are associated with higher spending but not improved access to care, higher quality, better outcomes, or greater patient satisfaction (Fisher et al. 2003a, Fisher et al. 2003b, Kravet et al. 2008, Wennberg 2006). Moreover, research has found that states with more primary care physicians per capita have better health outcomes and higher scores on performance measures (Baicker and Chandra 2004, Starfield et al. 2005). Cross-national comparisons have demonstrated that countries with greater dependence on primary care have lower rates of premature deaths and deaths from treatable conditions, even after accounting for differences in demographics and gross domestic product (Starfield and Shi 2002).

Undervaluation of primary care in the physician fee schedule

Despite research that suggests a need to increase the use of primary care services over specialty services, primary care services—which rely heavily on cognitive activities such as patient evaluation and management (E&M)—are undervalued (Ginsburg and Berenson 2007, Maxwell et al. 2007, MedPAC 2006). Unlike other services, primary care services do not lend themselves to efficiency gains. Instead, they are composed largely of activities such as taking the patient's history; examining the patient; and engaging in medical decision making, counseling, and coordinating care. These activities require the clinician's time both with the patient and before and after seeing the patient. Many Medicare patients need longer visits because they have multiple chronic conditions and some have a compromised ability to communicate with their physician.

By contrast, efficiency can improve more easily for other types of services, such as procedures, with advances in technology, technique, and other factors. For example, research on open heart surgery showed that advances in techniques and technology allowed physicians to become more proficient in performing procedures, taking less time per procedure (Cromwell et al. 1990). Ideally, when such efficiency gains are achieved, the fee schedule's relative value units (RVUs) for the affected services should decline accordingly, while budget neutrality would raise the RVUs for the fee schedule's primary care services.

The Commission recommended that CMS's process for reviewing the relative values of physician services be improved (MedPAC 2006). The three five-year reviews completed so far—in 1997, 2002, and 2007—led to substantially more recommendations for increases than decreases in the relative values of services, even though many services are likely to become overvalued as time passes. The Commission recognized the valuable contribution made by the Relative Value Scale Update Committee, but we concluded that CMS relies too heavily on physician specialty societies, which tend to identify undervalued services without identifying overvalued ones. The Commission found that CMS also relies too heavily on the societies for supporting evidence. In any case, because of these problems with the review process, the two-step sequence described above—lower RVUs for overvalued services and higher RVUs for primary care—tends not to occur, giving rise to concerns that primary care services are undervalued.

Although the formal process for reviewing the service values has not changed, the work component of certain E&M codes—including those most frequently billed (e.g., the midlevel office visit for established patients)—increased substantially in 2007. Practice expense values have also increased for E&M codes through CMS's new methods for calculating direct and indirect practice expense relative values.

Another issue that exacerbates the devaluation of primary care services relative to other types of services has been the constraint on payment updates for physician services. To the extent that the sustainable growth rate limits growth in aggregate physician spending, differences in the rate of volume growth across services means that certain types of services—such as imaging—are capturing a larger portion of Medicare physician spending at the expense of other services.¹ The Commission has expressed concern about primary care services, which have been found to be capturing a smaller portion of Medicare physician spending even though the overall relative value of E&M services has increased (MedPAC 2006). An Urban Institute analysis of changes in the relative values assigned to physician services and how those changes interact with growth in the volume of services sheds light on this dynamic (Maxwell et al. 2007).

In consideration of the devaluation of primary care services, the Commission is concerned that these services risk being underprovided, as physicians view them as less valued and less profitable. Yet, primary care services and—

**TABLE
2-1****Nearly one-third of physicians who regularly bill Medicare specialize in primary care, 2006**

Physician specialty	Number of physicians	Percent of total physicians
Primary care	152,929	31%
All other	344,143	69
Total	497,072	100

Note: Primary care specialties include family medicine, internal medicine, geriatric medicine, and pediatric medicine. Counts include allopathic and osteopathic physicians who billed for at least 15 Medicare patients during the year. Specialty information is from physicians' self-designation.

Source: MedPAC analysis of Health Care Information System data, 2006.

perhaps more importantly—primary care clinicians, are critical to delivering more coordinated, high-quality care to the Medicare population. Therefore, the Commission has undertaken three initiatives to promote the services, practitioners, and activities relevant to primary care. The first initiative was the Commission's 2006 recommendation (mentioned previously) to improve the process for reviewing the relative value of physician services. The second and third initiatives for promoting the use of primary care are introduced in this chapter: fee schedule changes to increase the value of primary care services provided by health professionals who focus predominantly on primary care, and the establishment of a medical home pilot project in Medicare. Before discussing these two initiatives in more detail, we present some background information on primary care and access issues.

What is primary care and who provides it?

Primary care is comprehensive health care provided by personal clinicians who are responsible for the overall, ongoing health of their patients. Primary care is often considered first-contact care that treats an array of health care needs, including preventive, acute, and chronic care (Grumbach and Bodenheimer 2002). Primary care providers are responsible for making and managing appropriate patient referrals to specialists and other caregivers. Comprehensive primary care involves teamwork that can include physician and nonphysician providers.

Physicians who specialize in primary care are trained in family medicine, internal medicine, geriatric medicine, or pediatrics. Of the almost 500,000 physicians who regularly treat Medicare beneficiaries, 31 percent specialize in

primary care (Table 2-1). Although osteopathic physicians make up only 8 percent of these primary care physicians, 46 percent of osteopaths specialize in primary care.² Osteopathic physicians are disproportionately more likely to be located in rural communities (Peters et al. 1999).

Nurse practitioners and physician assistants also provide primary care. Data on the number of nonphysician practitioners treating Medicare patients is compromised because they often do not bill Medicare directly; rather, supervising physicians frequently bill for their time.³ A recent report from the Government Accountability Office finds that about 83,000 nurse practitioners and 23,000 physician assistants are in primary care practice, and their numbers have grown faster than those of primary care physicians (GAO 2008b). These figures, however, are not specific to the Medicare population.

The Institute of Medicine noted the multidimensional nature of primary care, particularly for people with special needs and disabilities (IOM 1996). Although practitioners in certain specialties often provide primary care to their patients (e.g., endocrinologists for diabetes patients), this chapter mainly focuses on the physicians and other providers who specifically train in and provide primary care.

Beneficiaries value having a usual source of health care

Survey research suggests that most Americans value having a primary care physician who is familiar with their medical problems (Grumbach et al. 1999, Schoen et al. 2007). Medicare beneficiaries are more likely than their (typically) younger counterparts to report having a usual source of care. A "usual" source of care becomes even more important when considering that beneficiaries with chronic conditions typically see multiple health professionals during the year (Pham et al. 2007). Thus, initiatives to promote and sustain primary care as a usual source of care directly support beneficiary preferences for having a personal physician.

Survey results from the Medicare Current Beneficiary Survey (MCBS) suggest that most beneficiaries may already consider themselves to have a central source for their ongoing care—that is, a version of a medical home. Specifically, 95 percent report having a particular medical person or clinic that they usually go to when they are sick or want medical advice (Table 2-2). Most beneficiaries (86 percent) report their usual source of care to be a doctor's clinic, office, or group. About one-third report that they have been going to their usual source of care for

**TABLE
2-2**

Most beneficiaries report having a usual and thorough source of care, 2005

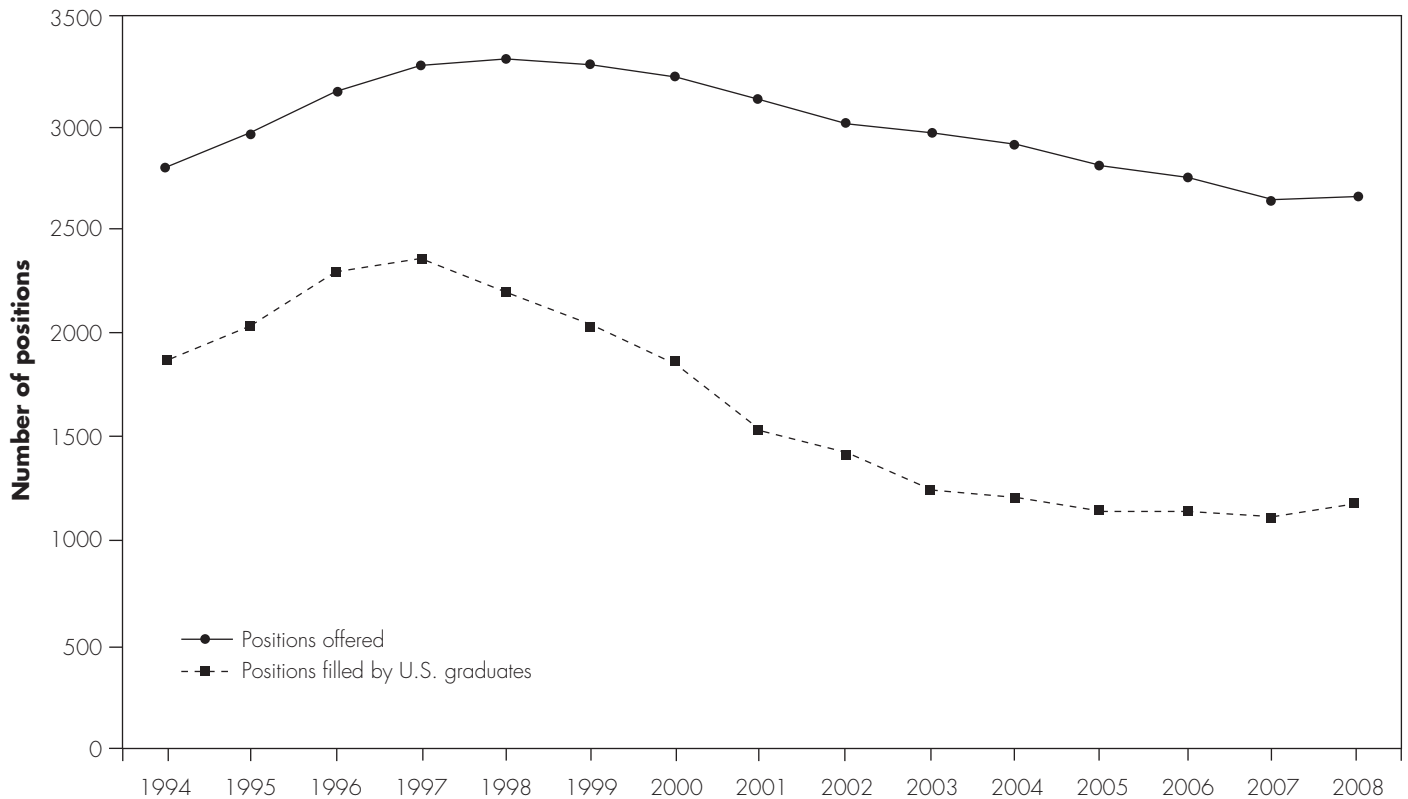
Question	Response percentage	Question	Response percentage
Is there a particular medical person or clinic you usually go to when you are sick or for advice about your health?		Your doctor (or usual clinician) is very careful to check everything when examining you.	
Yes	95%	Strongly agree or agree	91%
No	5	Strongly disagree or disagree	8
N/A	0	N/A	1
What kind of place do you usually go to when you are sick or for advice about your health?		You often have health problems that should be discussed with your doctor (or usual clinician) but are not.	
Doctor's clinic, office, group practice	86	Strongly agree or agree	9
Hospital emergency room	<1	Strongly disagree or disagree	89
Other	9	N/A	2
N/A	5	Your doctor (or usual clinician) has a good understanding of your medical history.	
How long have you been seeing this doctor or going to this usual place?		Strongly agree or agree	93
Less than 1 year	9	Strongly disagree or disagree	5
1-2.9 years	16	N/A	2
3-4.9 years	16	Your doctor (or usual clinician) often does not explain medical problems to you.	
5-9.9 years	20	Strongly agree or agree	10
10 or more years	33	Strongly disagree or disagree	89
N/A	5	N/A	1
If you usually see a particular doctor, what is that doctor's specialty?		Your doctor (or usual clinician) tells you all you want to know about your condition or treatment.	
Family medicine	19	Strongly agree or agree	91
General practice	37	Strongly disagree or disagree	8
Internal medicine	25	N/A	1
Cardiology	2	Your doctor (or usual clinician) answers all your questions.	
Other	7	Strongly agree or agree	95
N/A	8	Strongly disagree or disagree	4
Among those who reported NOT having a usual source of care (5%), reasons given (not mutually exclusive):		N/A	1
Seldom get sick	65		
Recently moved to area	12		
Doctor no longer available	15		
Like to go to different places	11		
Places are too far away	8		
Medical care is too expensive	16		

Note: N/A (not applicable). Beneficiaries living in nursing facilities are excluded. Totals may not sum to 100 percent due to rounding and nonresponses.

Source: Medicare Current Beneficiary Survey Access to Care file, 2005.

**FIGURE
2-1**

Share of U.S. medical school graduates filling family medicine residency positions has declined over the last decade



Source: National Resident Matching Program (AAMC 2008).

10 years or more, and more than half report going for at least the past 5 years. Among those who report having a particular doctor at their usual place of care, 81 percent report that their doctor is trained in a primary care field, such as family medicine (19 percent), general practice (37 percent), or internal medicine (25 percent).⁴

Beneficiaries appear relatively satisfied with the care and attention they receive from their usual source of care. For example, 91 percent report that their doctor is careful to examine everything during their appointment. Only 9 percent of beneficiaries reported that they have health problems that should be discussed with their doctor but are not. Also, 93 percent reported that their doctor has a good understanding of their medical history. Small shares of beneficiaries indicate that the clinicians at their usual source of care do not explain their medical problems (10 percent) or do not answer all their questions (4 percent).

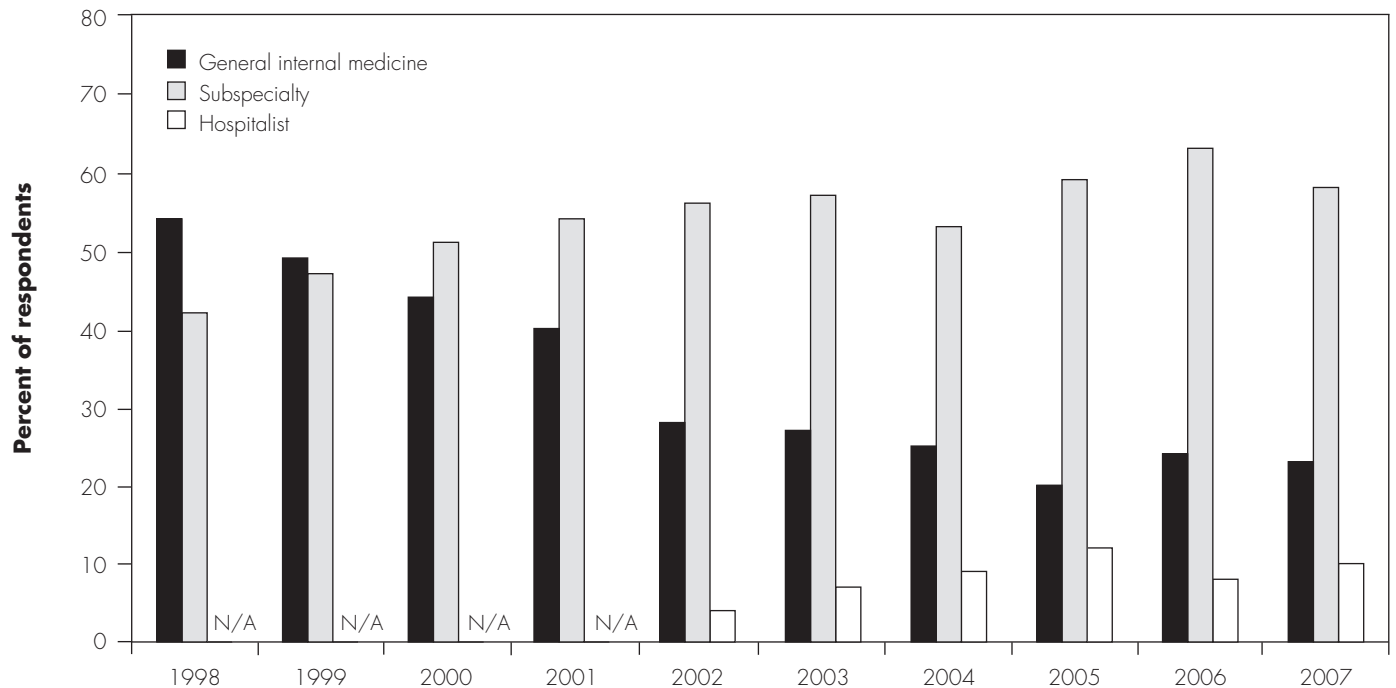
Among the small share of beneficiaries who reported not having a usual source of care (5 percent), the most common reason that they did not have a usual source of care was that they seldom get sick (65 percent). Other, less frequently cited reasons included medical costs, recently moving to the area, and their doctor no longer being available. A small share indicated that they preferred to seek medical care at different places rather than from a usual source. Because these results show that most beneficiaries strongly value having a usual source of care, signals that primary care is undervalued raise some concern about future access to primary care.

Access and medical training concerns

Although most beneficiaries report having a usual source of care, finding a new primary care physician

FIGURE 2-2

Proportion of third-year internal medical residents becoming subspecialists or hospitalists is growing



Note: N/A (not available).

Source: Bodenheimer, T. 2006. Primary care—Will it survive? *The New England Journal of Medicine* 355:861–864. Copyright © 2006 Massachusetts Medical Society. All rights reserved. Updated to include years 2006 and 2007, supplied by Thomas Bodenheimer, who obtained the relevant data from The American College of Physicians.

appears more difficult than finding a new specialist (MedPAC 2008). In our 2007 beneficiary access survey, the Commission found that among the small share of beneficiaries looking for a new primary care physician, 30 percent reported some difficulties finding one. Specifically, 12 percent reported “small” problems and 17 percent reported “big” problems.

In addition to some access problems among those looking for a new primary care physician, another signal that primary care services may be undervalued relative to specialist services is the decline in the share of U.S. medical school graduates entering family practice and primary care residency training programs in the last decade (Figure 2-1). In recent years, international medical graduates have been filling this gap, but the trend may not adequately meet growing demand in future years.

Also, the proportion of third-year internal medical residents becoming generalists is declining because a

growing share choose to subspecialize after residency or become hospitalists (Figure 2-2). Therefore, although the Government Accountability Office found that the number of physician residents in primary care training programs increased 6 percent over the last decade, it is important to understand that many of these residents do not remain in primary care practice (GAO 2008b).

The trend for medical students and residents to choose careers as specialists reflects a number of factors, including income prospects, lifestyle preferences (e.g., on-call schedules), student debt, and perceived prestige of specialists over generalists. Additionally, medical students may find family practice daunting because of perceived pressure to have vast knowledge about all health care problems. Policies to encourage medical training in primary care could improve primary care quality and access and thus promote beneficiary use of primary care services.

Medicare plays a large role in financing medical education and training. It provides two different payments to teaching hospitals: (1) graduate medical education (GME) payments toward the cost of resident and supervisory physician salaries, and (2) indirect medical education (IME) payments toward the higher cost of treating patients in a teaching hospital. These payments totaled about \$8.6 billion dollars, or 2.3 percent of total Medicare program spending in 2006.

By statute, GME subsidies for individual teaching hospitals are based on a number of factors including a calculated number of allotted residency training positions. Although Medicare limits the amount of this subsidy, there is no limit on the number of residents a hospital may choose to employ. In general, Medicare places no specialty requirements when calculating the number of subsidized residency positions, nor does it require specific competencies in training curricula. Under certain circumstances, residents may train in ambulatory settings outside the hospital, but the hospital remains responsible for the residents' salaries and supervision costs.

Policymakers could consider ways to use some of these GME and IME subsidies toward promoting training in primary care. For example, a portion could be targeted specifically to support medical residency positions in primary care. Similarly, allocating shares toward nurse practitioners and physician assistants—key professionals in managing patients' chronic conditions—could be useful for promoting primary care services use. Further, a share of GME and IME subsidies could be expressly directed toward training all medical residents on the importance of primary care and interdisciplinary teams, quality measurement, and clinical uses for information technology (IT). Encouragement of geriatric training opportunities in nonhospital settings (e.g., nursing facilities) may also be useful. Medical education subsidies could also be used to help pay student loans for clinicians committed to primary care specialties. Primary care providers generally earn lower salaries than their more procedurally based counterparts (AMGA 2007, MGMA 2007, Modern Healthcare 2007). Therefore, student loan subsidies could somewhat offset incentives for medical students to select higher paid specialties to help pay off their medical school debts more easily.

Fee schedule adjustment for primary care

To promote use of primary care and redistribute payments toward services furnished by primary care providers, the Commission recommends that Medicare's payment system for physician services—the physician fee schedule—include an adjustment for primary care. The adjustment would raise payments for selected primary care services furnished by physicians, advanced practice nurses, and physician assistants with practices focused on primary care. Services we defined as primary care are a subset of E&M services: office and home visits and visits to patients in certain nonacute facility settings (skilled nursing, intermediate care, long-term care, nursing home, boarding home, domiciliary, and custodial care).⁵

For the adjustment to occur, Medicare would append information to claims for payment submitted by physicians, advanced practice nurses, and physician assistants. Specifically, Medicare's claims processing contractors would attach a special code—known as a modifier—to billing codes for primary care services furnished by qualifying practitioners. Under the physician fee schedule, modifiers signify payment adjustments; for example, modifiers specify whether a service is eligible for a bonus payment because it was furnished in a health professional shortage area or a physician scarcity area. The presence of a primary care modifier on the claim would trigger an adjustment that would bring about a higher payment (Figure 2-3).

The adjustment would target practitioners who focus on primary care services. The Commission's recommendation identifies two options for identifying such practitioners. The first option is to consider both a practitioner's specialty designation—geriatric medicine, family practice, internal medicine, and others—and whether he or she furnishes mostly primary care services instead of other services, such as procedures, imaging, and tests. As we discuss later, a practitioner's specialty is self-designated, and administrative changes would be needed to make a practitioner's specialty a reliable factor in determining eligibility for the adjustment.

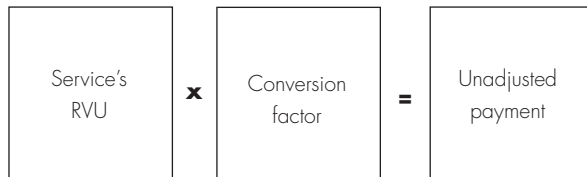
The second option is to consider only whether the practitioner furnishes mostly primary care services. This option would not consider specialty designation. Instead, it would make the adjustment available to practitioners who

**FIGURE
2-3**

Proposed payment adjustment for primary care could occur in two steps

Step 1

Practitioner submits claim that includes a billing code for a primary care service:



Step 2

A modifier code automatically appended to the billing code for the primary care service indicates that the service was furnished by a primary care practitioner:



Note: RVU (relative value unit).

focus on primary care services even if they specialize in, for example, endocrinology or rheumatology.

To make the adjustment budget neutral, it would be funded by a reduction in the conversion factor for other services. Thus, the adjustment would lead to lower payment rates for services furnished by practitioners other than those receiving the adjustment. Even for practitioners receiving the adjustment, payment rates would go down for the services they furnish that are not office visits, home visits, or visits to patients in certain nonacute facility settings. Structured in this way, the adjustment would redistribute payments and reward primary care. It would also support investment in IT and other resources needed for the medical home programs discussed later in this chapter.

Physicians in specialties not focused on primary care have raised concerns about budget neutrality. However, there are three points to consider as they pertain to the Commission's recommendation. First, the recommendation does not mean that services subject to the reduction for budget neutrality should have lower RVUs. The five-year review would continue to address the RVUs for those services, as appropriate. Rather, the reduction for budget neutrality would occur through the fee schedule's conversion factor. Second, the Commission's position should not be viewed as a statement on the supply of practitioners furnishing services other than primary care. On the contrary, questions have been raised about the supply of generalist physicians outside of primary care, such as general surgeons (Fischer 2007). Instead, the

Commission's position is that primary care is an overriding priority toward redesigning the health care delivery system in the long run. Third, the recommendation on the fee schedule adjustment is made in the context of other recommendations by the Commission for modest positive updates for physician services. For instance, the Commission has recommended an update for 2009 equal to the change in input prices for physician services less an adjustment for productivity, or about 1.1 percent (MedPAC 2008). By contrast, the preliminary estimate of the 2009 update under current law is -5.4 percent (see Appendix A, p. 243 of this report).

A rationale for the fee schedule adjustment is that primary care services appear to be undervalued in the fee schedule. In recommending improvements in the five-year review, the Commission expects that payments for primary care services and other E&M services will increase (MedPAC 2006). The fee schedule adjustment, however, is intended not just to increase payment for certain services but also to target the higher payments toward certain practitioners.

In addition to addressing concerns about the undervaluation of primary care, a fee schedule adjustment could augment other changes in policy that may help promote primary care. For instance, the Commission recommended that the Congress create an independent entity that would produce credible, empirically based information on comparative effectiveness—information that would help providers and patients make informed decisions about alternative services for diagnosing and

**TABLE
2-3****Some practitioners derive much of their fee schedule payments from primary care services**

Practitioner and specialty	Percent of allowed charges from primary care services
Physician	
Geriatric medicine	65.0%
Family medicine	62.5
Internal medicine	44.4
Pediatric medicine	36.5
Nurse practitioner	65.4
Physician assistant	34.8
All other	13.4

Note: Primary care services include office and home visits and visits to patients in certain nonacute facility settings (skilled nursing, intermediate care, long-term care, nursing home, boarding home, domiciliary, and custodial care). Analysis includes services billable under the physician fee schedule only.

Source: MedPAC analysis of 2006 claims data for 100 percent of Medicare beneficiaries.

treating common clinical conditions (MedPAC 2006). The Commission further discussed the option of allowing comparative effectiveness information to influence payment. For instance, a new set of budget-neutral RVUs that accounted for value as well as resource costs could be established in the fee schedule. To the extent primary care services are valued highly on their comparative effectiveness, they could garner higher payments through this policy change.

The fee schedule adjustment could have a meaningful impact on payments for the practitioners who receive it. Some practitioners derive a large share of their payments under the fee schedule from primary care services (Table 2-3). For instance, physicians with a specialty designation of geriatric medicine receive an average of 65.0 percent of their fee schedule payments from primary care services.

The fee schedule adjustment would also signal a major change in the purpose of the physician fee schedule. Currently, the fee schedule is intended only to account for differences in resource costs among services. By contrast, using the fee schedule as a vehicle for promoting primary care would be a very different role for the payment system. Instead of just accounting for current resource costs, a

payment system that includes a fee schedule adjustment for primary care could look ahead to resources the nation needs to achieve a reformed delivery system.

RECOMMENDATION 2A

The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners. Primary-care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.

RATIONALE 2A

A fee schedule adjustment for primary care would help overcome the undervaluation of primary care services. In addition, the adjustment could support investment in infrastructure—such as IT and staffing—between now and when medical home initiatives (discussed later in this chapter) are up and running. If commercial insurers, Medicaid programs, and other payers use Medicare’s physician fee schedule as a basis for their payment rates, the fee schedule adjustment could promote primary care throughout the health care system.

IMPLICATIONS 2A**Spending**

- As a budget-neutral policy, the fee schedule adjustment would not affect federal benefit spending relative to current law.

Beneficiary and provider

- For beneficiaries, the adjustment could improve access to primary care services.
- For physicians and other providers, the adjustment would have redistributive effects depending on the services they furnish.

The fee schedule adjustment raises certain issues. For one, it would require a decision about the level of the adjustment. Because there is no one formula or analytical approach to making the decision, judgment is required. In making that judgment, there are two precedents to consider. Currently, a 10 percent bonus is paid for services furnished in a health professional shortage area. There is also a 5 percent adjustment for services furnished in areas defined in the statute as physician scarcity areas.

For each of these policies, the Congress has already made a decision about the level of a fee schedule adjustment, albeit an adjustment with a purpose other than promoting primary care. In making a judgment about an adjustment for primary care, the Congress may wish to consider these precedents at least as a starting point for its deliberations.

Incentives are another issue. The adjustment is intended to give physicians and other practitioners an incentive to furnish primary care services. However, for beneficiaries without supplemental coverage, it could discourage use of primary care because their coinsurance is calculated as a percentage of allowed charges, and the fee schedule adjustment would raise allowed charges. Further work is necessary—perhaps in the design of the Medicare benefit package—to mitigate any mixed signals the fee schedule adjustment would send. We note also that the impact on beneficiary financial liability could be mitigated somewhat to the extent that primary care services are substituted for imaging, tests, and procedures.

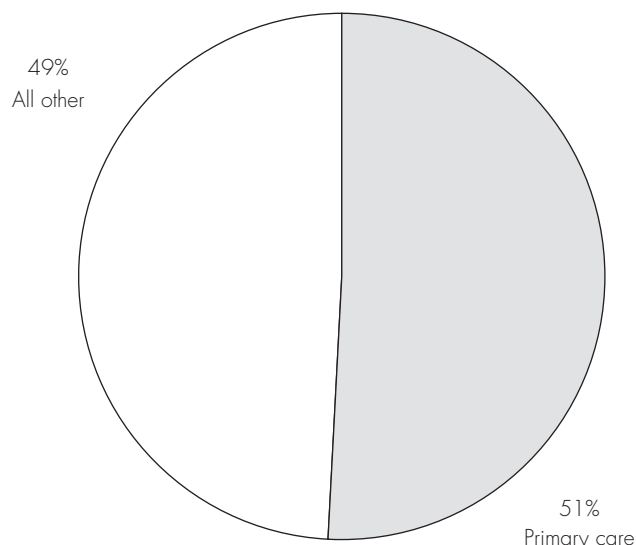
Other issues concern how the fee schedule adjustment would work administratively and its effects on payments to physicians and other practitioners. As we discuss below, the two options in the Commission’s recommendation—specialty designation plus claims patterns versus claims patterns only—have different effects and require different administrative processes. In general, we find that considering specialty designation and claims patterns would result in a more tightly targeted adjustment and a relatively modest reduction in payments for other services to maintain budget neutrality, but that specialty designation is a problem administratively. On the other hand, the second option—an adjustment that relies on a review of a practitioner’s claims pattern but not specialty designation—means that more physicians and a more diverse population of physicians would qualify for the adjustment and that the adjustment would be easier to administer. Nonetheless, this second option could require a larger reduction for budget neutrality or practitioners would have to meet a higher primary care services percentage threshold in order to qualify.

Targeting the adjustment with specialty designation and review of claims patterns

Targeting the fee schedule adjustment on the basis of specialty designation and a primary care services threshold would limit the adjustment to physicians with one of the designations often considered to be primary care: geriatric medicine, family practice, internal medicine, and pediatric medicine. The convention in Medicare is to also identify

FIGURE 2-4

Primary care practitioners account for just over half of allowed charges for primary care services



Note: Primary care practitioners are physicians with a specialty designation of internal medicine, family medicine, geriatric medicine, or pediatric medicine; advanced practice nurses; and physician assistants. Allowed charges for primary services are allowed charges for office and home visits and visits to patients in certain nonacute facility settings (skilled nursing, intermediate care, long-term care, nursing home, boarding home, domiciliary, and custodial care).

Source: MedPAC analysis of 2006 claims data for 100 percent of Medicare beneficiaries.

advanced practice nurses—such as nurse practitioners—and physician assistants as distinct specialties.

Targeting the adjustment in this way would support a goal of rewarding generalists furnishing primary care. The primary care practitioners listed above account for 51 percent of allowed charges for primary care services (Figure 2-4). Specialists—such as cardiologists and orthopedic surgeons—and other practitioners bill for the remainder.

There are problems, however, with the use of physician specialty designation to decide who can receive the adjustment. One problem is that some physicians have mixed practices. For instance, a physician may have a designation of internal medicine while practicing as a cardiologist. Or the opposite may be true: A physician with a designation of cardiology may practice as a general internist. Either way, the specialty designation in these cases does not accurately characterize the nature of the

physician's practice and whether he or she is a primary care physician.

Another problem is that physician specialty is self-designated. That is, physicians declare a specialty when they apply to bill Medicare. Further, they can change their status when they add a billing location or for some other reason. One concern is that they may change their specialty in response to the availability of a fee schedule adjustment for primary care. Another concern is how to accommodate new physicians. They, too, would have an incentive to designate themselves as primary care physicians—as is the intention of the fee schedule adjustment. However, the incentive might prove strong enough to lead to specialty designations that are not consistent with how physicians are actually practicing.

Some problems with specialty designation could be addressed administratively. For instance, to counter the incentive for physicians to change their specialty to qualify for the fee schedule adjustment, the Secretary could consider limits on the frequency with which physicians can change their specialty designation. The Secretary could also evaluate board certification in a primary care specialty as an option. Certification takes time and effort to achieve and maintain, thereby indicating a commitment to primary care practice. Nonetheless, other steps may be necessary. As we discuss next, coupling consideration of specialty designation with review of claims patterns, as recommended by the Commission, could help mitigate the problem with self-designation of specialty and further identify primary-care-focused practitioners.

Review of claims patterns

In reviewing claims patterns for the fee schedule adjustment, the Secretary would establish a minimum threshold for the percentage of services furnished that are primary care services.⁶ For example, the threshold could be that at least 65 percent of a practitioner's allowed charges must be for primary care services. A physician with one of the primary care specialty designations who meets the threshold would be deemed a primary care physician. The Secretary would then examine claims data—for example, over the past year—to confirm that the physician meets the threshold. Only those physicians at or above the threshold would receive the adjustment. The Secretary could institute such a procedure at the outset of implementing the fee schedule adjustment.

For new physicians, the Secretary could use a claim look-back as described above after each new physician's first

year of submitting claims to Medicare. Such a review would ensure that the chosen specialty designation is a fair representation of the physician's practice and the services furnished.

Effects of a fee schedule adjustment based on specialty designation and review of claims patterns

To approximate the effects of a fee schedule adjustment based on specialty designation and review of claims patterns, we used Medicare claims data to model changes in allowed charges that would occur depending on the level of the adjustment and the threshold primary care practitioners would have to achieve to qualify for the adjustment. We used 2006 claims data for 100 percent of Medicare beneficiaries to obtain national estimates of the changes in allowed charges. Part of the analysis, however, required physician-specific estimates—aggregated to the level of specialty designation—of allowed charges for primary care services at or above the threshold. To obtain those estimates, we used 2004 claims data for 100 percent of Medicare beneficiaries in six metropolitan statistical areas: Boston, Massachusetts; Greenville–Spartanburg, South Carolina; Miami, Florida; Minneapolis–St. Paul, Minnesota; Orange County, California; and Phoenix, Arizona. These data may not be fully representative of the nation, and, to help overcome any lack of representativeness, the estimates for each specialty derived from them were weighted accordingly with weights derived from the 2006 national data. We note also that the analysis does not include changes in the fee schedule's RVUs that occurred subsequent to 2006, which means that effects of the fee schedule adjustment on allowed charges are somewhat overstated.⁷

In the analysis, we considered two levels for the adjustment: 10 percent and 5 percent. We then varied the threshold that practitioners would have to meet to qualify as primary care focused. The range chosen was 40 percent to 75 percent. For example, if the threshold was 40 percent, at least 40 percent of a practitioner's allowed charges would have to be for primary care services to qualify for the adjustment. To show impacts for services and practitioners not eligible to receive the adjustment, we applied a reduction for budget neutrality.

The results indicate the minimum net change in allowed charges for services furnished by primary care practitioners (Table 2-4). For a 10 percent fee schedule adjustment, the net increase would range from 3.4 percent to 7.4 percent, depending on the level of the qualifying

**TABLE
2-4**

Effects of a fee schedule adjustment based on specialty designation and review of claims patterns

Threshold percentage of primary care services provided in practitioner's Medicare practice	Percent of allowed charges (all practitioners) eligible for fee schedule adjustment	Minimum net change in primary care practitioners' total allowed charges for all services		Budget neutrality reduction applied to services not eligible for adjustment	
		10 percent adjustment	5 percent adjustment	10 percent adjustment	5 percent adjustment
40	9.5%	3.4%	1.7%	-1.0%	-0.5%
50	8.8	4.5	2.3	-1.0	-0.5
60	7.6	5.7	2.8	-0.8	-0.4
65	6.8	6.2	3.1	-0.7	-0.4
75	4.7	7.4	3.7	-0.5	-0.2

Note: Analysis includes services billable under the physician fee schedule only. Net change in total allowed charges includes a reduction for budget neutrality applied to services other than primary care services. Analysis does not include changes in the fee schedule's relative value units that occurred subsequent to 2006.

Source: MedPAC analysis of 2006 claims data for 100 percent of Medicare beneficiaries and—for estimates of practitioners meeting claims pattern threshold—2004 claims data for 100 percent of beneficiaries in six metropolitan statistical areas (Boston, MA; Greenville-Spartanburg, SC; Miami, FL; Minneapolis-St. Paul, MN; Orange County, CA; and Phoenix, AZ).

threshold for furnishing primary care services. For a 5 percent fee schedule adjustment, the increase charges would range from 1.7 percent to 3.7 percent.

These increases illustrate the fee schedule adjustment's effect on allowed charges as a net impact. That is, a practitioner qualifying for the adjustment would receive an increase in payments for primary care services but also a decrease in payments—when a reduction for budget neutrality is applied—for services other than primary care.

The effects of the adjustment for a given practitioner would vary depending on whether he or she met the primary care services threshold and depending on the mix of primary care and other services the practitioner furnishes. For instance, a practitioner with a practice composed entirely of primary care services would see all of his or her services eligible for the adjustment. In other words, for such a practitioner, the impact of a 10 percent adjustment would be an increase in allowed charges of 10 percent. By contrast, a practitioner furnishing fewer primary services would see a proportionally smaller impact of the fee schedule adjustment.

The reduction for budget neutrality would also vary. Specifically, the analysis shows the inverse relationship between the threshold and the reduction for budget neutrality: the higher the level of the threshold, the lower the necessary reduction for budget neutrality because fewer services qualify for the adjustment. For instance,

with a 10 percent fee schedule adjustment and a 40 percent threshold, the estimated reduction for budget neutrality would equal -1.0 percent. By contrast, a 10 percent fee schedule adjustment with a 75 percent threshold would require a smaller reduction for budget neutrality: -0.5 percent. The reduction is smaller because fewer billings are affected by the adjustment when the threshold is higher.

Overall, modeling of this option for the fee schedule adjustment shows that the two components of such a policy—specialty designation and review of claims patterns—could complement each other. Considering specialty designation could help target the adjustment toward practitioners who are generalists. Review of claims patterns could help hold down the reduction necessary to make the adjustment budget neutral and help make the adjustment more focused on practitioners who concentrate on primary care.

Targeting the adjustment with review of claims patterns only

To simulate the effects of a fee schedule adjustment based on review of claims patterns only, we analyzed Medicare claims data in a manner similar to that described above. For this option, however, we assumed no requirements for a practitioner's specialty designation. Instead, any practitioner would be eligible for the adjustment if he or she met a threshold for furnishing primary care services.

**TABLE
2-5**

Effects of a fee schedule adjustment based on review of claims patterns only

Threshold percentage of primary care services provided in practitioner's Medicare practice	Percent of allowed charges (all practitioners) eligible for fee schedule adjustment	Minimum net change in qualifying practitioners' total allowed charges for all services		Budget neutrality reduction applied to services not eligible for adjustment	
		10 percent adjustment	5 percent adjustment	10 percent adjustment	5 percent adjustment
40	12.9%	3.1%	1.6%	-1.5%	-0.7%
50	11.1	4.4	2.2	-1.2	-0.6
60	9.1	5.6	2.8	-1.0	-0.5
65	8.0	6.2	3.1	-0.9	-0.4
75	5.5	7.4	3.7	-0.6	-0.3

Note: Analysis includes services billable under the physician fee schedule only. Net change in total allowed charges includes a reduction for budget neutrality applied to services other than primary care services. Analysis does not include changes in the fee schedule's relative value units that occurred subsequent to 2006.

Source: MedPAC analysis of 2006 claims data for 100 percent of Medicare beneficiaries and—for estimates of practitioners meeting claims pattern threshold—2004 claims data for 100 percent of beneficiaries in six metropolitan statistical areas (Boston, MA; Greenville-Spartanburg, SC; Miami, FL; Minneapolis-St. Paul, MN; Orange County, CA; and Phoenix, AZ).

We modeled effects of two levels for the adjustment: 10 percent and 5 percent. We allowed the primary care services threshold to range from 40 percent to 75 percent of allowed charges.

The analysis shows that an adjustment based on review of claims patterns only would have effects similar to those for an adjustment based on both specialty designation and claims patterns (Table 2-5). With an adjustment based on claims patterns only, the estimated reductions for budget neutrality are larger than they would be with the other type of adjustment, particularly at lower thresholds. For instance, with a threshold of 40 percent and a fee schedule adjustment of 10 percent, the estimated reduction for budget neutrality with claims patterns review only is -1.5 percent. With the same threshold and adjustment, estimated reduction for budget neutrality with both specialty designation and claims patterns review is -1.0 percent. With more practitioners capable of receiving the adjustment—practitioners in addition to primary care practitioners—the reduction for budget neutrality must be higher to offset the adjustment's effect on spending. The alternative is to set the primary care services threshold higher and maintain the reduction for budget neutrality at a given level.

To see why more practitioners would receive the fee schedule adjustment if it is based on claims patterns review but not specialty designation, consider two specialty designations: endocrinology and rheumatology.

In 2006, 49.7 percent and 45.2 percent, respectively, of these specialties' allowed charges were for primary care services. As we saw earlier (Table 2-3, p. 34), other specialty designations had percentages that were much higher. For instance, the values were 65.0 percent for geriatric medicine and 65.4 percent for nurse practitioners. Nonetheless, even with lower average allowed charges for primary care services, enough practitioners with specialty designations other than those considered to be primary care would qualify for the adjustment—if it is based solely on claims pattern review—to make a difference in the distribution.

Otherwise, effects of the fee schedule adjustment are not markedly different. At lower threshold percentages, estimated changes in allowed charges are lower under an adjustment based solely on claims pattern review because of the larger reduction for budget neutrality applied to services other than primary care services. For instance, with a threshold of 40 percent and an adjustment of 10 percent, the net change in allowed charges for qualifying practitioners is 3.1 percent when the adjustment is based on claims pattern review only versus 3.4 percent when the adjustment is based on both specialty designation and claims pattern review. At higher thresholds, however, the effects of the two options for the adjustment are the same.

We make two observations about the option of a fee schedule adjustment based on review of claims patterns only.

- It would make the adjustment available to those physicians who are specialists to some extent but who also have concentrated their practices in primary care services. An example might be a physician who first achieved board certification in internal medicine, then went on to gain certification in cardiology, but continued to focus mostly on primary care.
- In turn, to make the fee schedule adjustment budget neutral, the required reduction in payments would need to be somewhat larger or the minimum threshold of primary care services would need to be somewhat higher, although the differences are small.

A medical home program in Medicare

Medical home initiatives, which highlight care coordination from within a medical practice, have the potential to add value to the Medicare program, particularly for patients with multiple chronic conditions. Unlike the current fee-for-service (FFS) payment system, which emphasizes treatment for acute conditions and face-to-face care, medical home programs encourage practitioners to coordinate their patients' care between visits and among providers. In improving care continuity and coordination, medical homes can enhance the role of primary care practice. As discussed earlier, efforts to promote the use of primary care services can increase our health system's quality and efficiency.

Other purchasers and payers have begun programs that recognize the value of having someone accountable for effectively managing patient care (Baron and Cassel 2008). In fact, several different models of medical homes exist, some of which are discussed in a later section of this chapter. Jointly, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association recently released key medical home principles (AAFP et al. 2007). Under the Tax Relief and Health Care Act of 2006 (TRHCA), CMS will begin a medical home demonstration project in January 2009.

A medical home serves as a central resource for a patient's ongoing care. In many medical home programs, patients can designate the office of a physician or medical group as their medical home. Typically, patients choose medical homes that include their primary care practitioner, but in some cases patients may choose specialty practices

that manage their main chronic condition, such as endocrinology for patients with diabetes. A multispecialty group practice would be well suited to serve as a medical home because it could take full advantage of interactions and communications between primary care providers and other specialists within the same practice.

In Medicare, a medical home program would encourage beneficiaries to seek or remain with a physician who can manage their overall care. Under such a program, Medicare would direct monthly payments to medical homes to promote the important role that personal physicians and their health care team play in care delivery, particularly for patients with multiple conditions. A goal for medical homes is to improve patients' understanding of their conditions and medical advice and, in turn, reduce the use of high-cost settings such as emergency rooms and inpatient care. Ideally, through better care coordination, medical homes could also enhance communication among providers, thereby eliminating redundancy and improving quality.

In its June 2006 report, the Commission discussed the importance of care-coordination services—a major component of medical homes. Although the chapter did not explore medical homes per se, it examined many of the related activities and the organizational capabilities of entities that could serve as medical homes. Through literature reviews and interviews with a wide variety of experts and organizations involved in care-coordination programs, we found that two functions considered essential are: (1) a care manager (usually a nurse) to assist the patient in self-management and monitor patient progress; and (2) an information system to identify eligible patients, store and retrieve patient information, and share information with those who need it. Interviewees also noted that programs were more effective when integrated with the care the beneficiary receives from his or her physician. Further, most programs focus their efforts on beneficiaries at high levels of complexity, such as those with multiple chronic conditions or high users of health care services.

Care-coordination services appear to improve quality, but published research on cost savings is less clear. While most physician groups participating in Medicare's Physician Group Practice demonstration showed quality improvements, a smaller number achieved savings (GAO 2008a). Recent results from a CMS care-coordination pilot, Medicare Health Support (MHS), found that fees paid by CMS for care-coordination and disease

management services were not covered by reductions in Medicare spending in the program's first two years (CMS 2008a). However, a key difference between the MHS and a medical home program is that the MHS is operated by contractors—primarily private sector disease and care management service companies—that may act independently of the patients' physicians. In fact, the MHS evaluator found that only a small portion of physicians who treat the participating beneficiaries had formal relationships with the care-coordination contractors during the program's first year (RTI International 2007). In contrast, the Commission envisions a medical home model where the beneficiary's clinician would be the hub of care-coordination services for his or her Medicare patients.

The following section discusses functions that the Commission considers essential for a voluntary medical home program within Medicare. Some, but not all, of these capabilities are required in the Medicare demonstration project scheduled to start in January 2009.

Essential activities of a Medicare medical home

In addition to providing or coordinating appropriate preventive, maintenance, and acute health services, the Commission considers it essential for medical homes to provide the following activities:

- furnish primary care,
- conduct care management,
- use health IT for active clinical decision support,
- have a formal quality improvement (QI) program,
- maintain 24-hour patient communication and rapid access,
- keep up-to-date records of beneficiaries' advance directives, and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

Furnish primary care

Medical practices that provide primary care services—either exclusively or as part of their practice—would be eligible to participate in a Medicare medical home program. Thus, primary care, multispecialty, and geriatric medicine practices are natural candidates for medical home programs that manage beneficiaries' overall health

care. Patients could choose a specialty practice as their medical home if that practice manages their main chronic condition—such as endocrinology for patients with diabetes or nephrology for patients with renal disease. However, like all practices participating in the medical home program, these practices would need to provide the full range of primary care services (preventive, maintenance, and acute care) to their medical home patients.

As part of its function to deliver primary care, a Medicare medical home would be responsible for monitoring its patients' medications. Medical homes should conduct periodic reviews of a patient's regular medications in addition to reviews immediately after an acute event, such as a hospitalization. These medication reviews should assess for medical necessity, dosage appropriateness, actual or potential adverse drug reactions or interactions, and missing medications (Hepler and Strand 1990). Ideally, these medication reviews would be coordinated with a pharmacist. Part D, the Medicare drug benefit, requires that participating insurers administer a medication therapy management program for at least their high-cost beneficiaries.⁸ Medical homes also could coordinate with these drug plans to review patients' medication use. Additionally, Medicare should require drug plans to provide drug utilization data to their enrollees' medical homes, as discussed later in this chapter.

Conduct care management

Essential functions of medical homes include following up on patients and coordinating care among providers between appointments and health events. In particular, communication among practitioners during transitions out of the hospital should be a high priority (Coleman and Williams 2007). Care management also involves assessing patient adherence to treatment plans, conducting patient education on self-care, coordinating patient referrals for health and community services, and keeping track of results from tests and referral services through communication with other providers. Many of the services encompassing care management do not require the patient to be on site; instead, services such as conferring with other specialists on test results can be accomplished by telephone, electronic communications, or mail.

The function of care management requires an adequate ratio of clinical staff to patients. Physician offices with a relatively small patient panel, for example, may manage care with the help of only one nurse or nurse practitioner, but an office with a larger patient panel may require more

clinical staff to conduct appropriate care management. On the one hand, larger multispecialty practices may be better able to make initial investments (e.g., in staff and IT) to coordinate care; on the other hand, staff in smaller offices may be more familiar with their entire patient panel and may have developed successful, but perhaps less technical, mechanisms for monitoring patients.

Use health IT for active clinical decision support

Health IT has the potential to improve the quality, safety, and efficiency of health care (MedPAC 2006, MedPAC 2005, Shortell and Schmittiel 2004). Medical homes should have the capability to use health IT to support their clinical decisions and functions. (The Commission does not consider health IT for the sole purpose of streamlining coding and billing processes to be clinically relevant.) Larger medical practices, such as multispecialty practices, are much more likely to have clinical health IT in place (Gillies et al. 2006, Hing et al. 2007).⁹ However, smaller offices are increasingly adopting it in their practices. The medical home pilot should be careful to find a balance between ensuring that all medical homes participating in the pilot have important health IT functionality and not setting the bar so high that many primary care practices find it impossible to participate.

Below are several health IT functions medical homes could use to improve care. A number of these tools are components of electronic health systems described in an analysis by the Massachusetts General Hospital's Institute for Health Policy (Blumenthal 2008).

- Electronic medical records (EMRs) store and track patient demographic and clinical information such as diagnoses and treatments, prescribed medications, and clinical notes. EMRs help practices receive and organize patient encounters, referrals, test results, and follow-up.
- Patient registries keep track of patients by specified medical conditions or other characteristics and alert clinicians when a patient is due for an examination or test.
- E-prescribing facilitates beneficiary access to medications and physician records of patients' medication use.
- Clinical decision support tools at the point of service assist health professionals with conducting and ordering appropriate tests and procedures.

- A system for patients to access their personal health information in a timely manner promotes better patient–clinician communication.

Future technological innovation should make it increasingly possible for physicians in smaller practices to use IT. As with larger practices, smaller physician offices could use IT to connect to patients and other physicians as well as to facilitate effective clinical management. However, in less populated areas of the country medical practices are less likely to have health IT but may conduct more personalized care coordination—not only with the patients but also with other medical providers in the community. The medical home pilot could allot some funding for these medical homes to test their ability to provide high-quality, efficient care coordination with somewhat modified structural requirements.

Have a formal QI program

Medical homes should design and implement their own QI programs. This activity engages the practice in determining appropriate quality goals and measures. It requires data collection and analysis and, in return, provides medical homes with timely feedback on their ability to meet their own goals (Audet et al. 2005). It can also help guide medical homes in areas for improvement. Practices could develop their QI programs around several indicators, including outcome measures based on lab values, process measures based on services provided, patient satisfaction measures based on patient surveys, and efficiency measures based on spending and time expended.

The QI programs would be a requirement for participating medical homes. However, these programs would be internal and thus separate from a Medicare-sponsored pay-for-performance (P4P) program in a medical home pilot (discussed later in this chapter).

Maintain 24-hour patient communication and rapid access

Medical homes need to be accessible and promptly responsive to patient inquiries 24 hours a day. That is, during regular office hours, medical homes need to schedule timely appointments and have clinicians available to reply to patients' questions about their health care. Some medical practices have found secure e-mail communication an effective and efficient care management tool (Zhou et al. 2007). Further, patients with Internet access report interest in communicating with their doctors by e-mail (Cummings 2006). During nonregular office

hours, medical homes must have mechanisms in place for prompt clinician–patient contact to respond to patients’ urgent and emergent needs. Accordingly, the clinician-based response is a key feature of this 24-hour-a-day criterion.

Keep up-to-date records of beneficiaries’ advance directives

Medical homes are a natural place to keep signed copies of patients’ advance directives—documents that convey patients’ wishes and decisions about end-of-life care. Requiring medical homes to keep their patients’ up-to-date advance directives strongly encourages patients and their personal physician to have a discussion to clarify patients’ desires for health care in the last months of life. With this information, medical home physicians can monitor their patients’ status and ensure that they receive the kind of end-of-life care they expressly want.

Medical home certification or accreditation in the future

With respect to the above criteria, CMS would need to determine a mechanism for verifying that medical homes are, in fact, furnishing these activities and meeting these criteria. P4P measures will help establish a way to encourage medical homes to provide high-quality care. If the pilot is successful, and thus is expanded nationwide, it may be useful for medical homes to undergo an accreditation or certification process conducted by an external accrediting body. Private insurers and employers are working to establish a process for assessing and identifying medical homes. These initiatives as well as Medicaid primary care case management are further discussed in the text box (pp. 44–45).

Our discussion focuses on medical homes in the context of Medicare FFS, but, in many cases, Medicare Advantage plans may develop or already be incorporating a medical home model in their plans. A certification or accreditation process that recognizes FFS medical homes may also be used for medical homes in Medicare Advantage.

Qualifying beneficiaries

Early medical home initiatives in Medicare should target beneficiaries with at least two chronic conditions. These individuals, who typically see multiple health professionals in various settings, have the most immediate care-coordination needs and account for the greatest share of Medicare spending, compared with their healthier counterparts (Anderson and Horvath 2002, Wolff et al.

2002). About 60 percent of the FFS Medicare population has two or more chronic conditions (CMS 2007). The most common conditions include heart disease, diabetes, arthritis, congestive heart failure, osteoporosis, depression, chronic obstructive pulmonary disease, and Alzheimer’s and related disorders.

A medical home program that targets this beneficiary population will, in turn, target the physicians, nurse practitioners, and physician assistants who manage their care. As discussed earlier, clinicians in geriatric practice will be major candidates for medical home programs. Although increasing the eligibility pool to include all Medicare patients would encourage physicians and beneficiaries to establish relationships early in their Medicare enrollment, it is useful to focus the initial stage of the medical home program on a smaller, targeted population: those with multiple chronic conditions. In doing so, Medicare learns about the program’s successes and challenges before opening up the program to a larger population.

Further work is needed to address particular beneficiary circumstances. For example, participation adjustments may be needed for beneficiaries in nursing homes, those in hospice care, and those who spend part of the year away from their medical home (“snowbirds”). Further consideration is also needed to select the chronic conditions that would qualify for medical home eligibility.

Other beneficiary responsibilities and rights

Participating beneficiaries would select a single medical home. The Commission recommends that beneficiaries sign a document—jointly with their main clinician—designating their selection and triggering Medicare’s monthly fee to go to that medical home. The document would outline beneficiaries’ responsibilities and rights in the medical home program and would encourage beneficiaries to consult with their medical home before or instead of seeking new specialists. Under these principles, the medical home serves as a resource to improve care continuity and help patients and families navigate through the health system to select optimal treatments and providers. Participating beneficiaries and medical homes would need to renew this understanding annually to ensure that each patient–clinician relationship was ongoing for each medical home. Medical homes would maintain this document.

Although medical homes should offer their patients guidance on selecting appropriate specialty services,

participating beneficiaries would retain their ability in FFS Medicare to see specialists and other health practitioners of their choice. This right would be outlined in the signed agreement described earlier.

When launching the medical home pilot to the beneficiary population, Medicare should engage in a public information campaign on the potential benefits of comprehensive primary care. These potential benefits include improvements in health and more judicious use of discretionary services. In fact, such public education efforts may be worthwhile regardless of the implementation of a medical home program. Because some people may have negative connotations associated with the term “home” in a medical context, Medicare might also explore alternative names for “medical home” that may appeal more to beneficiaries, such as a “designated medical practice.”

Per beneficiary monthly payments to medical homes

In addition to receiving payments for the Medicare-covered fee schedule services they provide, qualifying medical homes would receive monthly payments for medical home infrastructure and care-coordination activities. Specifically, these monthly fees would be for medical home activities and expenses that exceed the pre- and post-visit time and expenses currently allocated in the physician fee schedule. Beneficiary cost sharing would not apply to these medical home monthly fees.

A number of implementation details regarding medical home payments need to be addressed. For example, an amount would need to be determined for the monthly fee. This amount must be sufficient to encourage participation and pay practices adequately for the desired activities but within the bounds of affordability for the Medicare program. Another consideration is whether the medical home fee would go to the practice or to the beneficiary’s individual practitioner. Providing payments to the individual clinician encourages individual accountability. However, the concept of medical home is meant to promote comprehensive teamwork in health care delivery. Accordingly, directing payments to the practice (i.e., the medical group) rather than to individual physicians could foster this objective.

P4P component for quality and efficiency

In previous reports, the Commission has recommended that Medicare initiate P4P programs for physicians to encourage improvements in care quality and efficiency. A

medical home pilot provides an excellent opportunity to implement and test physician P4P with payment incentives based on quality and efficiency. Under the pilot project, the Commission envisions that the P4P incentives allow for both rewards and penalties based on performance.

Improving care quality

Commercial insurers have focused quality incentives on primary care physicians, who make up the largest share of physician specialties experiencing P4P financial incentives (Cross 2007). A predominant reason for this focus is that the performance measures used in P4P programs often concentrate on primary care (e.g., flu shot rates). In 2006, the Commission surveyed physicians and found that larger practices, particularly multispecialty practices (which include a greater proportion of nonproceduralists than single-specialty practices), are more likely than smaller practices to take part in P4P programs from non-Medicare insurers (MedPAC 2007a).

In contrast to the Physician Quality Reporting Initiative, which pays physicians to report quality information, a P4P program would reward medical homes that met specified quality goals or that showed improvement toward those goals. P4P incentives would not be reward only; financial incentives would include both rewards and penalties. Thus, a high-performing medical home would receive the monthly fee plus a P4P bonus payment. Also, medical homes that did not attain specified goals or did not demonstrate improvement toward them would be penalized. Financial penalties could include either a portion of the medical home’s monthly fee or a small percentage of the medical home’s FFS billing. Additionally, medical homes that are consistently unable to meet minimum quality requirements would be ineligible to continue participation in the pilot.

Measures for determining medical home performance could largely rely on Medicare claims. Thus, providers would not experience an additional administrative burden when participating in the P4P component. As the Commission has stated, claims-based indicators can provide both process and outcome measures (MedPAC 2006). Process measures assess whether clinically indicated services were provided and include items such as eye exams for people with diabetes. Outcome measures assess resulting health status indicators and include items such as emergency room visits. Other measures could assess beneficiary experience. An existing survey instrument designed by the Consumer Assessment of Healthcare Providers and Systems for primary care

Medical home initiatives among private payers and Medicaid programs

Some private health insurance payers have announced they are planning or have recently implemented medical home pilot programs for their covered populations. Also, two major nonprofit accreditation organizations have launched medical home recognition and certification programs. Third, North Carolina and other state Medicaid programs have used primary care case management (PCCM) programs, which incorporate medical home concepts, for a number of years as part of their Medicaid managed care programs. These programs are explored briefly here.

Private health insurers' medical home programs

In August 2007, UnitedHealth Group, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association, and the American College of Physicians announced a medical home pilot program in Florida. The program will have approximately six selected primary care practices serving UnitedHealthcare commercially insured members. UnitedHealthcare states that it will support the participating practices with quality improvement and care management functions, including 24/7 nurse triage, identification of and outreach to plan members who may need clinical interventions, and educational tools and assistance to help patients manage their conditions.

In January 2008, two New York health insurers—Group Health and Health Insurance Plan of New York—announced they were launching a medical home program as a two-year pilot. Participants will

be randomly assigned into a supported group and a comparison group, each consisting of 25 adult primary care physician practices. The total number of participants in the supported group is expected to include about 100 physicians and 20,000 patients. The University of Connecticut Health Center will conduct a formal program evaluation under a grant from the Commonwealth Fund.

Medical home recognition programs

Earlier this year, Bridges to Excellence (BTE) launched a medical home physician practice recognition program. BTE is a not-for-profit organization that develops programs to recognize and reward health care providers for selected goals. For the medical home recognition program, physicians assess their practices using a scoring tool to determine whether they meet specified performance standards, such as level of health information technology functionality and ability to identify and contact at-risk patients. This assessment is subject to independent, third-party verification. Practices may also use the scoring tools developed by the National Committee for Quality Assurance (NCQA) and described in the next paragraph. Once a physician practice has achieved BTE recognition, it is eligible to receive incentive payments from the health plans and purchasers that participate in BTE. These medical home payments would be made to the practice by a patient's health plan or employer and would be in addition to the payments made to the practice under regular contracted provider compensation arrangements.

(continued next page)

providers collect patient responses to questions on topics such as appointment wait times and follow-up communication for test results. Measures regarding care transitions (i.e., medical home communication with hospital clinical and discharge planning staff) would also be important to capture (Coleman and Williams 2007). Improvements in this area are key potential benefits of a medical home and can reduce hospital readmissions—an objective discussed in Chapter 4.

Promoting efficiency

In conjunction with quality incentives, a medical home pilot also offers an opportunity to examine ways to encourage medical practices to improve the efficiency of their patients' resource use. The Commission has recommended that Medicare begin confidentially informing physicians of their resource use and ultimately begin payment incentives that reward efficiency (MedPAC 2008).

Medical home initiatives among private payers and Medicaid programs (cont.)

NCQA announced a medical home recognition program earlier this year, called Physician Practice Connections–Primary Care Medical Home. According to NCQA, this model’s standards emphasize the use of systematic, patient-centered, coordinated care management processes (NCQA 2008). Practices seeking recognition complete a web-based data collection tool and provide documentation to NCQA to validate their responses to it. It is not known how health plans will use the NCQA medical home designation, but they have used other NCQA recognition programs to designate providers in directories, to qualify providers for tiered provider networks, and as part of pay-for-performance programs.

North Carolina Medicaid medical home program

North Carolina’s Medicaid program has had a medical home program for adults under age 65 and for children since 1991; according to the state’s evaluations, it has achieved successful access, quality, and financial outcomes. The state is developing a pilot program to expand its medical home model to Medicaid recipients in the aged, blind, and disabled eligibility categories.

The program, called Community Care of North Carolina (CCNC), is a Medicaid PCCM program authorized by CMS. The North Carolina Department of Health and Human Services initiated the program in 1991 as a pilot in five counties in conjunction with the state’s Office of Rural Health and Community Care. It became statewide in 1998. A key feature of the program is its use of physician-led community networks, which are private not-for-profit entities that contract with the

state to provide many of the operational functions for the medical home program. Fourteen of these networks are operating currently, with each covering a different region of the state. Every primary care provider participating in CCNC joins his or her local community network. The responsibility for managing the care of the enrolled population falls to the community network, while management of resource use and quality of care for individual CCNC enrollees is the responsibility of each enrollee’s designated primary care provider.

In addition to their fee-for-service payments, primary care providers participating in a community network are also paid a per member per month management fee. The network in which the primary care provider is enrolled also receives a management fee based on the number of Medicaid recipients enrolled with the network. The community networks develop and disseminate condition-specific initiatives designed to assist primary care providers in improving health outcomes for enrollees. Examples of these initiatives include disease management for asthma, congestive heart failure, and diabetes; reduction in emergency department use; and case management of high-risk and high-cost patients.

In addition to North Carolina, 9 other states had PCCM programs with at least 250,000 enrolled Medicaid recipients as of mid-2006 (the most recent date for which data are available), ranging from about 268,000 enrollees in Massachusetts to nearly 1 million in Texas. About 6.5 million total Medicaid beneficiaries were enrolled in PCCM programs in the United States in 2006 (CMS 2006). ■

In the first year, the pilot could measure patient resource use and confidentially share feedback on these results with the medical home. Medicare could also provide data feedback from the medical practice’s previous year to help medical homes understand their practice pattern relative to that of their peers. In the second year, the pilot could begin assessing medical homes based on resource use. Because medical homes are designed to be central resources for

managing enrollees’ overall care, they are well suited for these measures and incentives.

The pilot might also explore different kinds of efficiency measures, such as type of service, care setting, or episode of care (MedPAC 2007b). Detailed reports that feed back information on all care that enrollees received, including from other providers, would greatly enhance the ability of medical homes to improve care coordination over

time. Nevertheless, CMS would have to evaluate the appropriateness of more detailed efficiency measures given the characteristics of physician practices that choose to participate, such as their number of enrollees, the number of conditions those enrollees had, and the extent to which their enrollees used services outside the medical home. The National Committee for Quality Assurance has begun measuring resource use among health plans for selected medical conditions.

Efficiency incentives could take the form of shared savings models similar to those under Medicare's ongoing physician group practice demonstration. Bonuses for efficiency should be available only to medical homes that have met quality goals and that have a sufficient number of patients to permit reliable spending comparisons. Although less individually targeted, another mechanism for encouraging efficiency would be to distribute a portion of any realized aggregate savings among all the medical home providers. In any case, measuring resource use across the entire medical home pilot is important to test the premise that medical home programs can improve care and promote more judicious use of discretionary services.

Notification of beneficiary service use outside the medical home

For comprehensive care management, medical homes need information on beneficiary service use outside the medical home. After referring patients to a specialist, medical homes should actively follow up on results, treatment, and recommendations. Moreover, medical homes should strongly encourage their patients to notify them of health care use outside the medical home. This objective can be addressed during the beneficiary enrollment and designation process.

In some cases, however, the medical home may not be aware of its patients' use of services outside the medical home. For example, patients may be admitted to the hospital for an acute event. Ideally, hospitals should notify patients' medical homes upon admission and discharge (as discussed in Chapter 4), but Medicare should also supply medical homes with timely data on patients' service use, which would provide the medical home with a backup method for keeping track of patients' health care utilization.

To this end, the Commission recommends that Medicare provide medical homes with a timely, periodic report that lists all the Medicare-covered services each of its medical home patients received in the previous month. Medicare's

claims processors could compile these reports and send them to Medicare or to the medical home directly. The services to be included in the reports would include those in both Part A and Part B services. Medicare should also supply medical homes with patients' prescription drug use data under Part D. It may be more efficient to require contracted drug plans to provide this information to the medical homes directly. Similarly, Medicare should encourage all providers of Medicare-covered services to notify their patients' medical homes of their service use. Data on Medicaid service use would also be helpful for medical home providers who treat beneficiaries covered by Medicaid.

Recent efforts by Medicare to streamline FFS claims processing could facilitate this data-reporting activity. Specifically, Medicare is transitioning to single contractors (Medicare administrative contractors (MACs)) for processing both Part A and Part B claims. Using MACs rather than relying on separate entities for Part A (fiscal intermediaries) and Part B (carriers) should make FFS claims processing more efficient and can improve Medicare's ability to analyze beneficiary spending and utilization trends. MACs could assist in providing medical homes with data to help them understand their patients' service use. Under this premise, the medical home pilot could include—but not be limited to—areas where MACs are in place. Currently, three MACs have begun processing FFS claims in 14 states.¹⁰ By 2010, the MAC program will be fully implemented, with 15 MACs responsible for all FFS claims processing.

Patient privacy concerns will need to be addressed before a MAC or Medicare can provide individual patient information to medical homes. Each participating beneficiary would need to sign a privacy agreement that allows Medicare to supply medical homes with information on his or her Medicare-covered utilization. This agreement could be a requirement for beneficiary participation in the medical home program. Additionally, medical homes would need to be held accountable for safeguarding patient information.

Advantages of a pilot project

The Commission considers the medical home concept a promising intervention for beneficiaries with multiple chronic conditions. Complex patients need care coordination and education—neither of which is currently fostered or rewarded by fee-for-service payment. Medical practices led by physicians, nurse practitioners, and physician assistants are a logical place to turn for these

services, particularly practices with strong nursing and other dedicated staff support, as well as information technology to assist in clinical monitoring. Medicare has invested considerable effort and money in programs to engage external third-party disease management companies and private health plans in coordinating care for such beneficiaries. Yet, the results from these efforts have been equivocal. The Commission believes it is now time to test patients' clinician-centered care coordination on a large-scale basis.

It is appropriate to test new policies before fully committing Medicare to them, but it is not without problems. It often takes three to five years to move from initial conception through implementation of the test to final evaluation, with legislation authorizing program-wide implementation adding another year or more. If the test is small scale, the cycle is longer because small numbers make it more difficult to attain statistically meaningful results. Thus, the test must run longer to help compensate.

A long test cycle is problematic when the costs of the current payment system, both in dollars and substandard care, are so large. It is imperative, then, that we seek ways to hasten the testing process. We see two opportunities to do so: first, to increase the scale of the project so we determine more quickly whether the intervention works (and can test more variations); second, to reduce the amount of time it takes to advance a successful intervention into program-wide implementation.

We are recommending that the medical home program take the form of a pilot project rather than a demonstration project in order to accelerate the testing of this promising concept. The Commission envisions a medical home pilot that would be about four times larger than the TRCHA medical home demonstration. (Some of the added resources would need to go to CMS to implement this complex project.) This scale would allow CMS to determine more quickly how the intervention affects quality and spending. We also recommend that the Congress establish, in advance, clear, measurable objectives for the project and authorize the Secretary of the Department of Health and Human Services to implement the program nationwide, without further legislative action, if those objectives are met.

The Commission recognizes that there are legitimate concerns about moving quickly to a large-scale pilot. First, the cost of a failed test is larger. More money would have been spent, and the constituency lobbying for continuation of the unsuccessful intervention would be more powerful. Second, the opportunity for a potentially

sound intervention may be lost if the test is developed and implemented too hastily.

We acknowledge those risks, but going slower has its own. Given Medicare's pressing problems with cost and quality, especially for beneficiaries with multiple chronic illnesses, the status quo is itself extremely risky. After weighing one set of risks against the other, the Commission believes it is prudent to move as quickly as practicable to a large-scale pilot test of the medical home model.

Determining whether the pilot is successful: Efficiency and quality

Medicare should evaluate the medical home pilot using efficiency and quality measures to determine its overall success. These aggregate measures can be obtained largely through claims data. Measures for determining the success of the pilot could encompass:

- total spending and episode spending,
- outcome quality measures (e.g., rates of potentially avoidable hospitalizations and emergency room visits),
- process quality measures (e.g., rates of selected clinically necessary tests for a given condition), and
- structural measures (e.g., health IT functionality).

The pilot's success could be measured by aggregate changes from baseline in spending and quality over a specified time period. Alternatively, spending and quality assessments could be made relative to a comparison group. If the results do not meet predetermined thresholds for improvement, the pilot should be discontinued. However, if results show improvement, then the Secretary should begin implementing a medical home program in Medicare nationwide. To capture any savings and quality improvements that build over time, it would be important for the pilot to run for multiple years.

RECOMMENDATION 2B

The Congress should initiate a medical home pilot project in Medicare. Eligible medical homes must meet stringent criteria, including at least the following capabilities:

- **furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services),**
- **conduct care management,**

- **use health information technology for active clinical decision support,**
- **have a formal quality improvement program,**
- **maintain 24-hour patient communication and rapid access,**
- **keep up-to-date records of beneficiaries' advance directives, and**
- **maintain a written understanding with each beneficiary designating the provider as a medical home.**

Medicare should provide medical homes with timely data on patient utilization. The pilot should require a physician pay-for-performance program. The pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued.

RATIONALE 2B

The Commission considers the medical home concept a promising intervention to test, particularly for the treatment of beneficiaries with multiple chronic conditions. Medical home initiatives encourage improved care coordination and have the potential to add value to the Medicare program through efficiency and quality gains. Ideally, medical home programs can enhance communication among providers, thereby eliminating redundancy and improving quality. Medicare payments to medical homes would promote the important role of personal physicians, nurse practitioners, and physician assistants in delivering care to patients with multiple chronic conditions. The Commission recommends that medical homes meet several stringent criteria to be

eligible to participate in the pilot. Additionally, the pilot should be on a large enough scale to provide statistically reliable results.

IMPLICATIONS 2B

Spending

- The pilot will require up-front costs, primarily in the form of monthly fees to medical homes and CMS resources. In general, the Commission envisions that the pilot would be about four times larger than the TRHCA medical home demonstration, which the Congressional Budget Office estimated to be about \$100 million over three years. In the first year of the pilot, costs would be in the range of \$50 million to \$250 million. In a five-year window, costs would be in the range of \$250 million to \$750 million. Savings are not included in these estimates.

Beneficiary and provider

- Medical home initiatives will help sustain beneficiaries' relationship with their primary clinician because they will support ongoing, comprehensive care. With increased resources going to medical homes, this recommendation is also designed to enhance access to primary care and improve care coordination.
- Participating providers who specialize in primary care and in certain chronic conditions will receive additional Medicare resources for serving as patients' medical home and providing beneficiaries with comprehensive, ongoing care. ■

Endnotes

- 1 The sustainable growth rate determines the spending target for physician services. It is composed of growth rates for enrollment in Medicare fee-for-service, input prices for physician services, physician services spending due to changes in law and regulations, and—as an allowance for volume increases—real gross domestic product per capita.
- 2 Graduates of allopathic medical schools receive doctor of medicine (MD) degrees. Graduates of osteopathic medical schools receive doctor of osteopathic medicine (DO) degrees. Both are considered physicians.
- 3 When nonphysician practitioners bill Medicare directly for a physician service, they receive 85 percent of the Medicare physician fee schedule rate. Thus, medical practices have a financial incentive to consider the services of nonphysician practitioners as being under the supervision of physicians.
- 4 The MCBS uses different categorical variables than Medicare claims to describe physician specialty. We include “general practice” for reporting MCBS results, but not for our physician-designated claims analyses in the rest of the chapter.
- 5 To define primary care services, we started with the definition of primary care services in the Social Security Act (Sec. 1842(i)(4)) and then focused on a subset of E&M services within that definition. The definition in the statute includes three other categories of services typically furnished by specialists and not by primary care physicians and omitted from the discussion here. One is emergency department visits. Another is intermediate and comprehensive office visits for eye examinations and treatments. The third is monthly end-stage renal disease services.
- 6 In reviewing claims patterns, the Secretary could consider not just the services furnished but also the diagnoses of patients reported on claims and whether they are broad-based versus concentrated in a narrow range of conditions or otherwise characteristic of continuous and coordinated patient care. In the Commission’s *Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System*, generalist physicians in specialties such as family medicine and internal medicine were reported to treat many types of episodes of care. By contrast, specialists—such as dermatologists and urologists—were reported to focus their practices on only a few different types of episodes (MedPAC 2007b).
- 7 The effects are overstated because of increases in RVUs for primary care services that have occurred since 2006. For instance, the RVUs for physician work went up for many primary care services as a result of the most recent five-year review. With those increases, it is likely that more physicians would have met the threshold for furnishing primary care services—at a given level of the threshold—in a year subsequent to CMS’s use of those RVUs for payment in 2007. With more physicians meeting the threshold, the percent of allowed charges eligible for the fee schedule adjustment would go up, the reduction for budget neutrality would be larger, and the minimum net change in qualifying practitioners’ allowed charges would go down.
- 8 Specifically, insurers must design a medication therapy management program for enrollees with annual spending at or above \$4,000.
- 9 CMS is currently implementing a five-year Medicare demonstration project that will encourage small- to medium-sized primary care physician practices to use electronic health records (EHRs) to improve the quality of patient care. By the end of the second year of the demonstration, participating physician practices must be using an EHR to perform specific minimum core functionalities that include clinical documentation, ordering and recording lab tests, and recording prescriptions. CMS expects to announce the locations of 4 of the expected 12 sites for the EHR demonstration by the end of 2008, with the remaining 8 announced in 2009 (CMS 2008b).
- 10 The first MAC is processing claims in Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming. The second MAC is processing claims in Colorado, New Mexico, Oklahoma, and Texas. The third MAC is processing claims in Iowa, Kansas, Missouri, and Nebraska.

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