Advising the Congress on Medicare issues

Per-beneficiary payment for primary care

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MEDPAC

Recap of Commission's November 2013 Meeting

- Per-beneficiary payment for primary care
- Concern about support for primary care
  - Essential to delivery system reform
  - Fee schedule shortcomings
    - Undervalues primary care relative to specialty care
    - Does not explicitly pay for care coordination
    - Creates compensation disparities
    - Incentivizes medical residents to choose specialty care over primary care
  - Long-run: beneficiary access is at risk

Commission's recommendations to address fee schedule inadequacies

- Rebalance fee schedule
  - Overpriced services – identify them and price them appropriately
  - SGR - replace with higher updates for primary care relative to specialty care
  - Primary care bonus – establish one and fund from non primary care services
- Support coordinated care
  - Establish medical home pilot project

Agenda for today

- Primary care bonus
  - Established by PPACA
  - Expires at end of 2015
- Continuing support for primary care
  - Extend primary care bonus, or
  - Establish per-beneficiary payment
    - Design issues
    - Funding

Primary care bonus experience, 2012

- 10 percent bonus to primary care practitioners
- Bonus payments totaled 1 percent of fee schedule spending
- 200,000 practitioners eligible (20 percent)
- Bonus payment per practitioner
  - $3,400 on average
  - $9,300 average for top quartile of distribution

Options to support primary care after bonus expires in 2015

- Extend existing primary care bonus
  - Simple program to administer and infrastructure in place
  - But still based on fee schedule
- Replace with per-beneficiary payment
  - Explicit payment for care coordination
  - Design issues and funding

Per-beneficiary payment, experience

- Per-beneficiary payment programs exist across the country
  - Medicaid, Medicare, private payers
- Majority of programs pay between $3-$7
  - Can be much higher and can depend on complexity of patient and practice standards
- Practice requirements often include
  - 24/7 access
  - Care manager/care coordination processes
  - Medical home certification

Implementing a per-beneficiary payment

- Design issues
  - Payment amount
  - Attributing a beneficiary to a practitioner
  - Practice requirements
- Funding source
- Depends on goals
  - Direct more resources to primary care services, or
  - Redesign the delivery of primary care

Design issue: payment amount

- Depends on goals and available funding
- Use same funding level as primary care bonus – an example
  - $664 million
  - 21.3 million beneficiaries
  - $31.17 per beneficiary
  - $2.60 per beneficiary per month
- Beneficiary would not pay cost sharing

Design issue: beneficiary attribution

- Unlike the service-based primary care bonus, a per-beneficiary payment necessitates attributing a beneficiary to a practitioner
- How to do so?
  - Written consent of beneficiary, or
  - Attribute to practitioner who furnished majority of primary care

Design issue: beneficiary attribution

- Written consent of beneficiary
  - Encourages beneficiary-practitioner dialogue
  - But beneficiary may feel pressured to sign
- Attribute to practitioner who furnished majority of primary care
  - Simple to administer
  - But payment likely made at year's end

Design issue: practice requirements

- Types of requirements
  - Improving access
  - Adopting a team-based approach to care
- Potential to improve quality of care
  - But can limit participation
- Achieving compliance
  - Attestation
  - Verification

Funding source: other fee schedule services

- From other fee schedule services – to rebalance
- Recall from primary care bonus

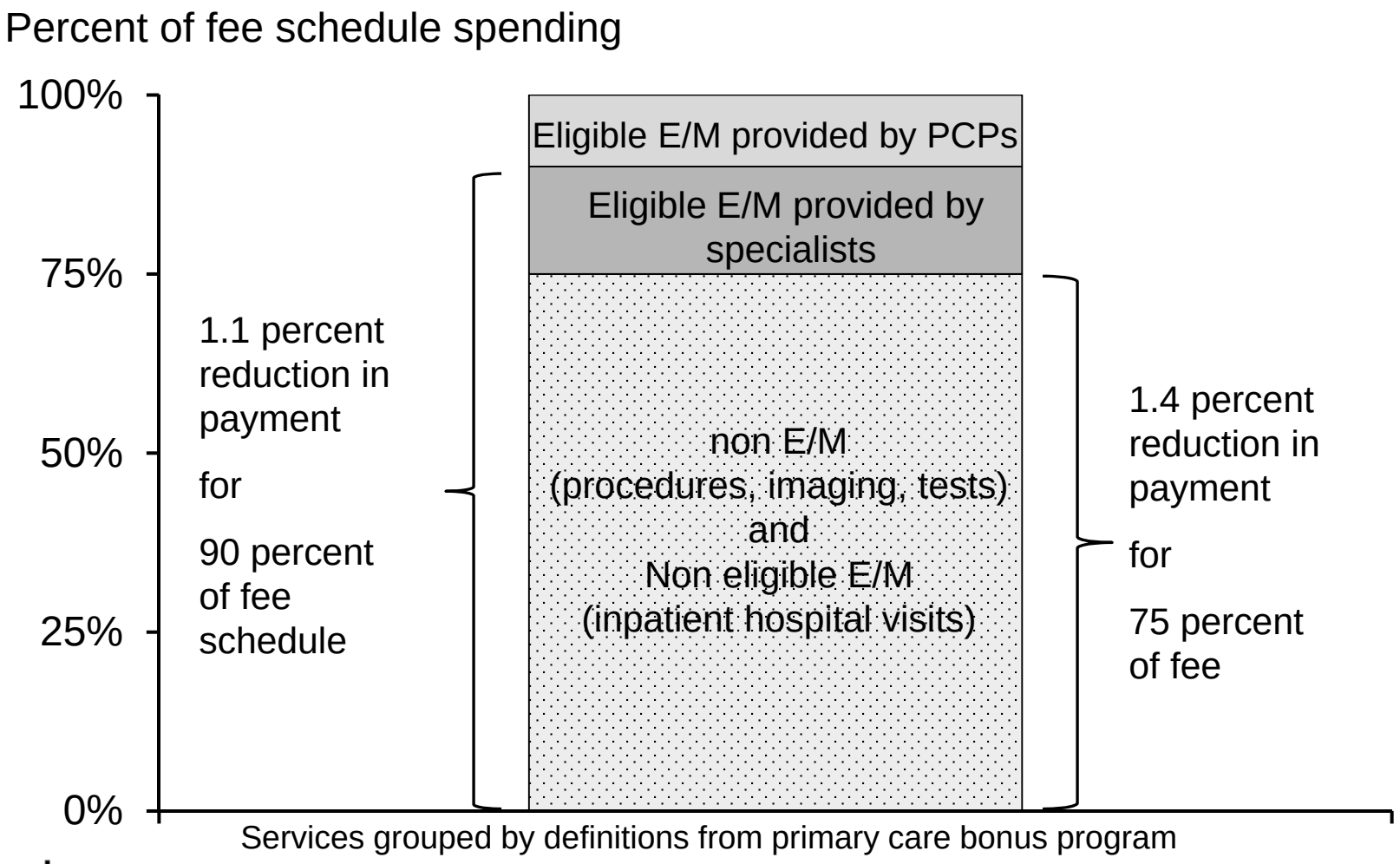
Eligible primary care services

- Subset of Evaluation/Management services (E/M)
- Office visits, nursing facility visits; excludes visits to inpatients

Eligible primary care practitioners

- Certain specialties (e.g., family practice, nurse practitioner)
- At least 60 percent of allowed charges from eligible primary care services

Funding source: for monthly, per-beneficiary payment of $2.60



MEDPAC Note: E/M (evaluation/management services), PCPs (eligible primary care practitioners).

Funding source: overpriced services

- Series of Commission recommendations
  - Identify & reduce payments of overpriced services
  - Achieve reductions of at least 1.0 percent of fee schedule spending each year for 5 years
- Could fund monthly, per-beneficiary payments rising annually over 5 years

Year 1	Year 2	Year 3	Year 4	Year 5
$2.60	$5.20	$7.80	$10.40	$13.00

Funding source: reducing payments for overpriced services

- PPACA requires validation of the fee schedules' RVUs
- Studies have found some time estimates to be highly inaccurate
- RUC reduced time estimates, but did not reduce work RVUs by same proportion
  - Time estimates reduced by about 18 percent
  - Work RVUs reduced by about 7 percent

Funding source: target savings from overpriced services

- Absent change in current policy, savings redistributed equally across fee schedule
  - Under-priced, accurately-priced, and overpriced services all receive same percentage increase
- Under improved approach, savings redistributed to per-beneficiary payment
  - Would do more to rebalance fee schedule

Summary

- Primary care bonus expires at the end of 2015
- Options discussed today
  - Extend existing bonus
  - Replace it with per-beneficiary payment
- If per-beneficiary payment, what are the Commission's next steps?
  - Design issues
  - Funding