Next steps in continuing to support primary care

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Presentation roadmap

- Background
- Investigating beneficiary-centered payment models for primary care
  - Full fee-for-service (FFS) plus a monthly per-beneficiary payment
  - "Partial capitation plus:" FFS payment divided between per-service payment and partial capitation payment
  - Design issues

Shortcomings of fee schedule for physicians and other health professionals

- Undervalues primary care relative to specialty care
- Disparities in average annual compensation (2012)
  - Family medicine: $216,000
  - Cardiology: $503,000
- Can motivate medical residents to choose specialty care over primary care
- Risks beneficiary access in long run
- Not well-designed for care coordination

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Fee schedule ill-suited to support care coordination

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

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Commission recommended a per beneficiary payment for primary care

- Recommendation in March 2015 would replace the expiring Primary Care Incentive Payment
  - Same definitions of visits and providers
  - Funded by reduced fees for all other services
- Additional payments for primary care should continue
- Goal of moving from service-based FFS payment to beneficiary-centered payment

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Two models to motivate discussion

Model 1: Full FFS plus a per-beneficiary payment for care management

Model 2: “Partial capitation plus”

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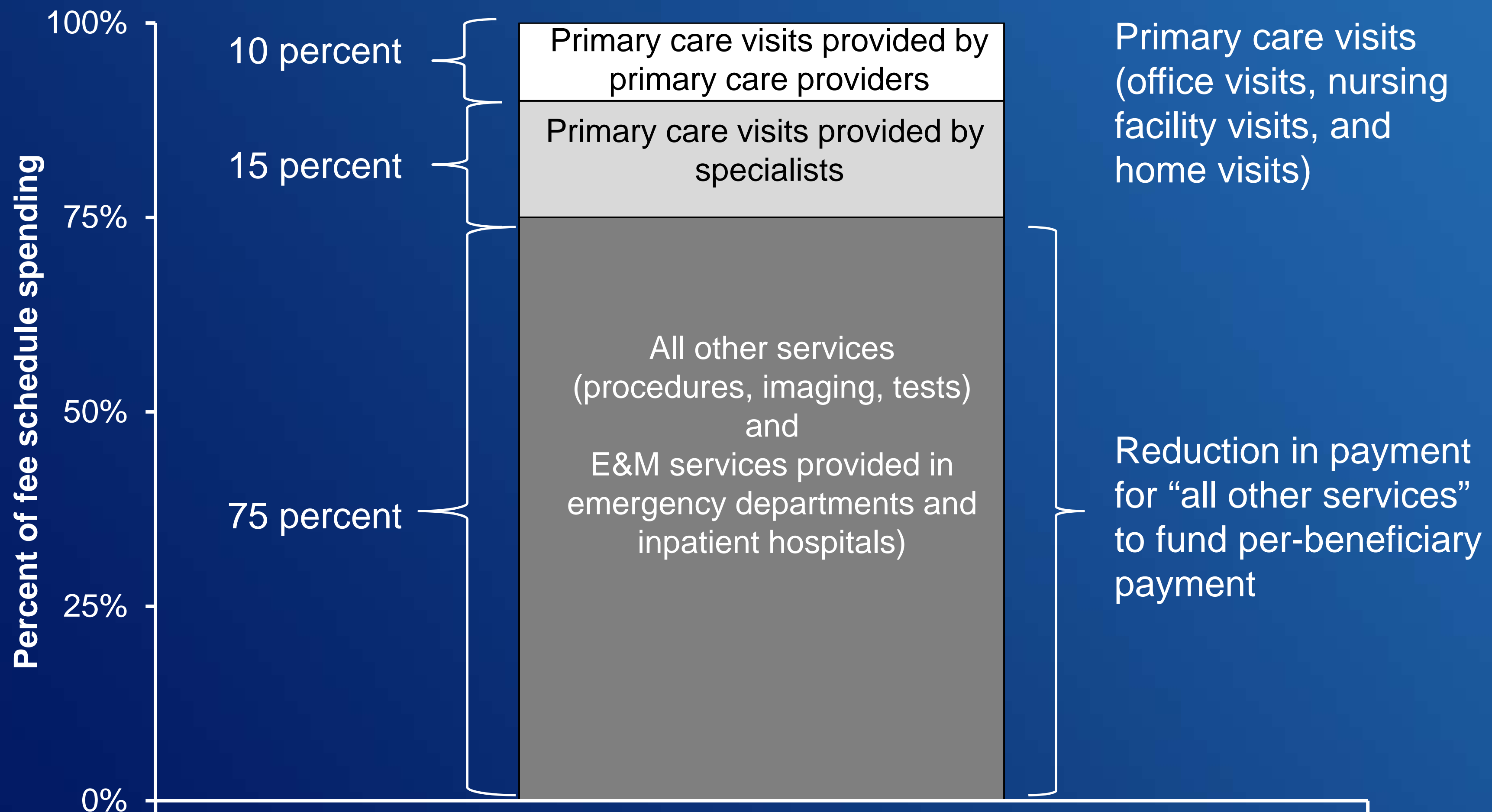
Recall per-beneficiary payment recommendation funded within fee schedule



Source: MedPAC analysis.

Model 1: Full FFS plus a per-beneficiary payment for care management

Increases in primary care spending funded with larger reductions in payment for all other services

Per-beneficiary payment rate ($)		Reduction in payment for all services other than primary care visits[1]	Percentage of fee schedule spending on		Increase in annual average program payment for primary care providers[4]	
Monthly	Annual		Primary care provided by primary care providers[2]	All services other than primary care visits[3]	Dollar increase	Percent increase
0.00	0.00	0%	***10%***	***75%***	0	0%
2.60	31.20	1.4%	11%	74%	3,854	7%
5.20	62.40	2.8%	12%	73%	7,708	14%
10.40	124.80	5.6%	14%	71%	15,416	29%
18.20	218.40	9.8%	17%	68%	26,978	50%

Notes: 1. Primary care visits are a subset of evaluation and management services (E&M) and include office visits, nursing facility visits, and home visits. All services other than primary care visits include procedures, imaging, tests, and E&M services provided in emergency departments and inpatient hospitals. 2. Primary care provided by primary care providers includes fee schedule spending on primary visits and the per-beneficiary payment for primary care providers. 3. The remaining 15 percent of fee schedule spending (not shown in the table) is spent on primary care visits provided by specialists. That share remains unchanged under Model 1 since payments for those services are not reduced to fund the per-beneficiary payment. 4. Program payment for primary care providers includes all program payments for all services under the fee schedule.

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Model 1: Full FFS plus a per-beneficiary payment for care management

- Pros
  - Increases payments to all primary care providers
  - Rebalances the fee schedule by increasing spending on primary care
  - Share of payment on a per-beneficiary basis/increases provider flexibility
- Cons
  - Still primarily service-centric FFS
  - Across-the-board payment reductions apply to over-valued, correctly-valued, and under-valued services

Model 2: Partial capitation plus

- Payment for primary care providers has 3 components

“Traditional” FFS payment divided between

1. Per-service payment for primary care visits

   plus

2. Partial capitation payment per beneficiary

   plus

3. “Add-on” per-beneficiary payment

- Objective
  - Move portion of FFS to beneficiary-based pay
  - Give providers more flexibility to optimally structure care (e.g., team-based care, telehealth)

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Model 2: Partial capitation plus

- Pros
  - Rebalances the fee schedule by increasing spending on primary care
  - Greater share of payment on a per-beneficiary basis/greater increase in provider flexibility
- Cons
  - Across-the-board payment reductions apply to over-valued, correctly-valued, and under-valued services
  - Redistributes FFS payment among primary care providers

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Model 2 increases share of Medicare program payments for primary care providers paid on a per-beneficiary basis

Model 2 assumptions:

- 60% of traditional FFS allocated to per-service payment
- 40% of traditional FFS allocated to partial capitation payment

Per-beneficiary payment rate ($)		Reduction in payment for all services other than primary care visits[1]	Average annual program payment for primary care providers[2]		Share paid on a per-beneficiary basis	
Monthly	Annual		Dollar increase	Percent increase	Model 1	Model 2
0.00	0.00	0%	0	0%	0%	0%
2.60	31.20	1.4%	3,854	7%	7%	32%
5.20	62.40	2.8%	7,708	14%	13%	36%
10.40	124.80	5.6%	15,416	29%	**22%**	**43%**
18.20	218.40	9.8%	26,978	50%	33%	52%

Notes: 1. Primary care visits are a subset of evaluation and management services (E&M) and include office visits, nursing facility visits, and home visits. All services other than primary care visits includes procedures, imaging, tests, and E&M services provided in emergency departments and inpatient hospitals. 2. Program payment for primary care providers includes all program payments for all services under the fee schedule.

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Special issue: Model 2 redistributes FFS payment among primary care providers

When Provider A with 200 beneficiaries moves from traditional FFS to Model 2 she "*trades*"

40% Provider A's average FFS payment X 200

for

40% System-wide average FFS payment X 200

Model 2 redistributes payment from providers with

- Higher payments per visit (e.g., level 4 and level 5 visits) to providers with lower payments per visit
- More visits per beneficiary to providers with fewer visits per beneficiary

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Model 2 special issue: Options to mitigate redistributive effects

- Set a higher per-service payment rate (e.g., 90% instead of 60%)
- Risk-adjust payments
  - Providers with more visits per beneficiary or higher payment rates per visit may have sicker patients
- Increase “add-on” per-beneficiary payment rate

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Design features: Beneficiary cost sharing

- Consistent with Commission's recommendation
  - No beneficiary cost sharing on "add-on" per-beneficiary payment
  - Beneficiary cost sharing remains the same on FFS payment

Design features: Practice requirements and performance measures

- For the per beneficiary payment, the Commission did not recommend practice requirements
  - Per-beneficiary payment of $2.60 per month too small
  - No strong evidence to support their effectiveness
- For the per beneficiary payment, the Commission did not recommend performance measures
  - Provider performance on controlling cost and improving quality difficult to measure for providers and practices with small Medicare patient panels
  - Random variations in health of patient panels could have strong impact on performance measures
  - May be able to focus on persistent statistical outliers

Design features: Beneficiary attribution poses a challenge

- Prospective attribution
  - Providers receive payment automatically without extra paperwork requirements
  - MedPAC has supported in the past (per-beneficiary payment, ACOs)
  - But, more problematic as “add-on” payment or partial capitation share increases
    - Providers could be paid for beneficiaries no longer under their care (Model 1 and Model 2)
    - In aggregate, Medicare could overpay for visits if beneficiary receives visits from additional providers (Model 2)

Design features: Beneficiary attribution poses a challenge *(continued)*

- Written consent
  - Encourage beneficiary-practitioner dialogue
  - Hold provider accountable to beneficiary
  - But, beneficiary may feel pressured to sign forms and
  - If beneficiaries are allowed to frequently switch primary care providers, could become administratively unwieldy

Discussion

- Goals
  - Rebalance fee schedule by increasing spending on primary care
  - Increase share of payment on a per-beneficiary basis/increase provider flexibility
- Models
  - Model 1: Full FFS plus a per-beneficiary payment
  - Model 2: Partial capitation plus
- Questions to guide choice of model
  - How much should be added to primary care?
  - What share of payment should be paid on a per-beneficiary basis?
- Issues
  - Redistribution (Model 2)
  - Attribution (Model 1 and Model 2)