Policy options for increasing Medicare payments to primary care clinicians

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Overview

- Findings about the primary care physician workforce
- Prior Commission recommendations and discussions
- Recent action taken by CMS
- Two options for increasing payments to primary care clinicians

The number of primary care physicians has declined, while the number of specialists has increased

Note: Figure shows the number of physicians who billed Medicare's physician fee schedule for at least 15 fee-for-service Medicare beneficiaries, rounded to the nearest thousand. "Primary care" includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." Data are preliminary and subject to change.

Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries.

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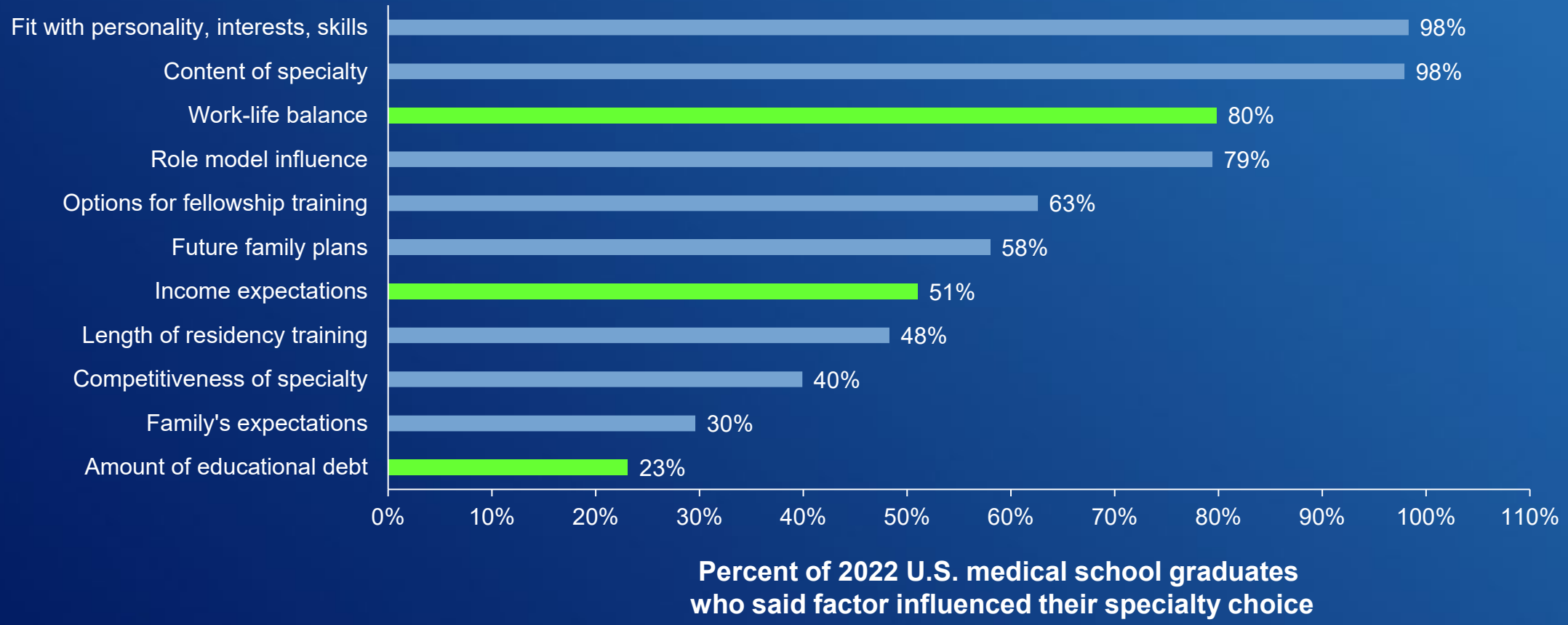
Among factors that influence medical school graduates' specialty choices, several can be affected by Medicare payments



Note: Figure shows percent of survey respondents who indicated that a given factor had a "strong" or "moderate" influence on their choice of specialty as they headed into residency programs. Survey was administered to all graduates of U.S. M.D.-granting accredited medical schools and had an 80% response rate. Data are preliminary and subject to change.

Source: Association of American Medical Colleges. 2022. *Medical School Graduation Questionnaire: 2022 All Schools Summary Report.* Washington, DC: AAMC, July. https://www.aamc.org/media/62006/download.

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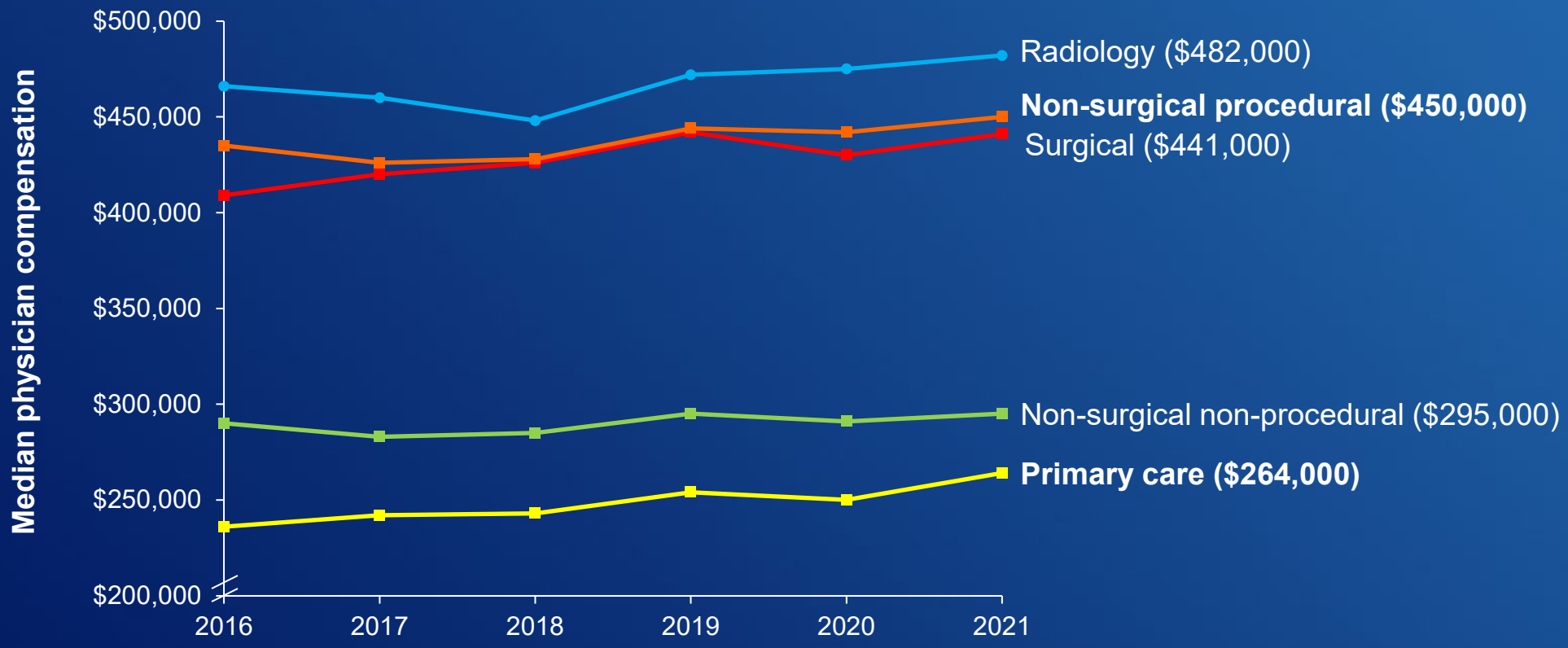
Primary care physicians' compensation is well below that of specialists



Note: "Non-surgical procedural" includes cardiology, dermatology, gastroenterology, pulmonology, and hematology/oncology. "Non-surgical non-procedural" includes psychiatry, emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. "Primary care" includes family medicine, internal medicine, and general pediatrics. Amounts have been pro-rated to reflect full-time work and rounded to the nearest thousand. Compensation does not include on-call pay. Data for each year are based on a separate sample of physicians. Data are preliminary and subject to change.

Source: SullivanCotter's Physician Compensation and Productivity Surveys, as reported in the "Physician and other health professional services" chapters of MedPAC's annual March reports.

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How E&M services become undervalued over time

- Billing codes for services are assigned work RVUs when a technology/technique is relatively new
- As clinicians become more adept at delivering non-E&M services (e.g., procedures), RVUs should decline
  - Would cause payment rates for all other services to increase, since changes to the fee schedule's codes must be budget neutral
- However, RVUs are often not reduced over time, resulting in some non-E&M services becoming overvalued
  - E&M services become undervalued (passive devaluation)

Note: Evaluation and management (E&M), relative value unit (RVU).

Commission recommendations and other work related to primary care

- Recommendations:
  - Bonus for primary care clinicians, paid for by reducing payments for specialists (2008)
  - Freeze payments for primary care, while reducing payments for all other services (2011)
  - A per-beneficiary payment for primary care clinicians, paid for by reducing payments for non-primary care services (2015)
- Other work:
  - Discussed an option to increase payments for ambulatory E&M services, paid for by reducing payments for all other services (2018)
  - Variety of options suggested by interviewees to attract clinicians to primary care (2019)
  - Three options for attracting more clinicians to geriatrics (2022)

Source: MedPAC. 2008. "Chapter 2: Promoting the use of primary care," in *Report to the Congress: Reforming the Delivery System*. Washington, DC: MedPAC, June; MedPAC. 2011. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14; MedPAC. 2015. "Chapter 4: Physician and other health professional services," in *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC, March; MedPAC. 2018. "Chapter 3: Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC, June; MedPAC. 2019. "Increasing the supply of primary care physicians: Findings from stakeholder interviews." Presentation. November 7; MedPAC. 2022. "Opportunities to strengthen the geriatric workforce." Presentation. March 3.

CMS increased payment rates for office/outpatient E&M visit codes in 2021

- Required 10% reduction to all services' payment rates to maintain budget neutrality
- In response, Congress passed a one-year increase to payment rates of 3.75% in 2021 and a one-year increase of 3% in 2022
- Increasing payment rates for office/outpatient E&M visits did not fully address the overvaluation of non-E&M services

Note: Evaluation and management (E&M).

Option #1: Create two separate fee schedules for E&M services and non-E&M services

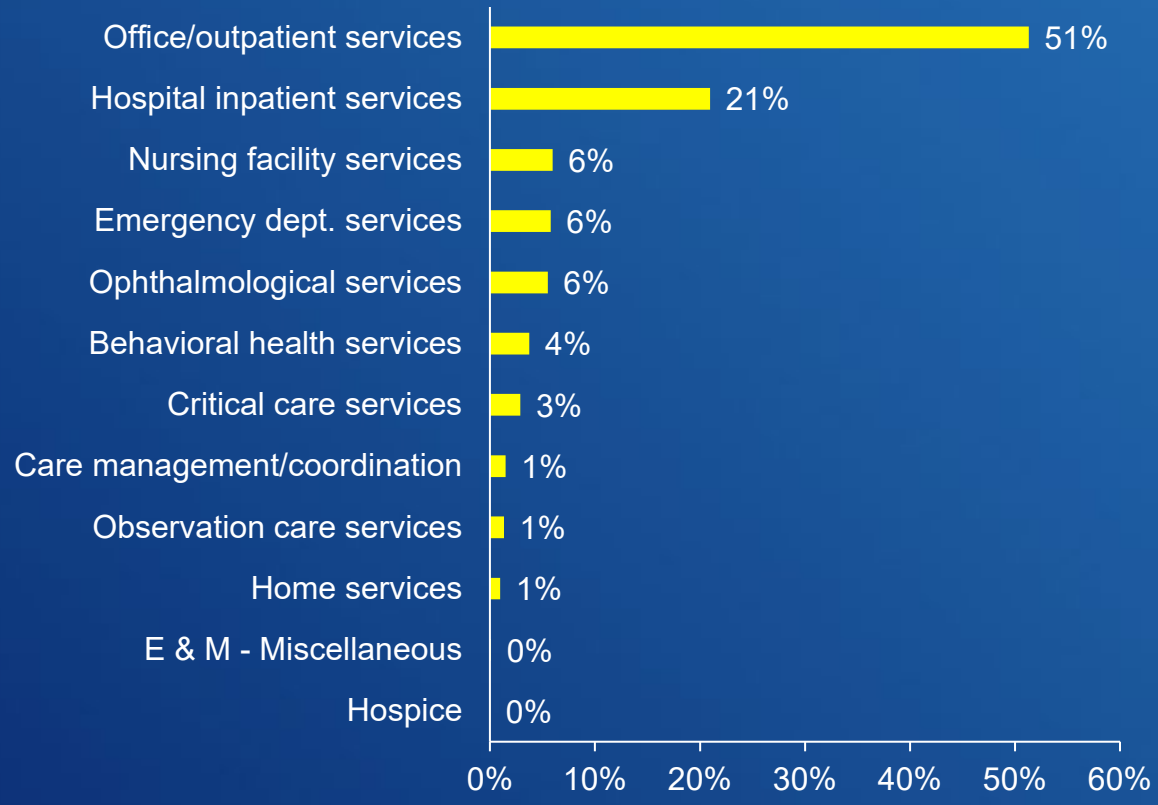
- Split the Physician Fee Schedule into:
  - E&M Fee Schedule
  - Non-E&M Fee Schedule
- Changes to codes in one fee schedule would have no effect on payment rates in the other fee schedule
- Each fee schedule would have its own conversion factor
  - Could be increased at different rates to achieve desired policy goals
- All clinicians could bill under both fee schedules, regardless of their specialty

Note: Evaluation and management (E&M).

Option #1: Key design decisions

- Which E&M services to include in the E&M Fee Schedule?
  - Including some E&M services in one fee schedule and other E&M services in another could cause payment rates for similar services to diverge
  - But could lower the cost of this policy

Share of Medicare E&M spending by category, 2019



Note: Evaluation and management (E&M). Codes are categorized using the Restructured BETOS Classification System. The denominator for the percentages shown in the graph is the total allowed charges for E&M services in 2019 ($48.6 billion). Data are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries.

Option #1: Key design decisions (continued)

- Non-E&M Fee Schedule: Changes to codes would be budget neutral
- E&M Fee Schedule: Waive budget neutrality?
  - Would allow CMS to increase payments for office/outpatient E&M visits (half of all E&M spending) without a large offsetting reduction to payment rates
  - But would increase Medicare spending and beneficiary cost sharing, and be inconsistent with other Medicare payment systems

Note: Evaluation and management (E&M).

Option #1: Implications

- Could increase payments for E&M services, thus reducing compensation disparities between primary care clinicians and specialists
- Could result in other payers increasing payments for E&M services, since many payers use Medicare's fee schedule as basis for their fee schedule
- Would mean that services with the same RVUs would have different payment rates depending on if they are E&M services or non-E&M services

Note: Evaluation and management (E&M).

Option #2: Establish a new per-beneficiary payment for primary care clinicians

- Pay primary care clinicians a monthly amount for each beneficiary attributed to them (no cost sharing)
- Primary care clinicians would continue to bill physician fee schedule for individual services
- Commission recommended a per-beneficiary payment for primary care clinicians that would start at $2.35 per beneficiary per month (2015)
- Payment would need to be larger to substantially reduce compensation disparities

Option #2: Key design decisions

- Should the per beneficiary payment be risk adjusted?
  - Would provide higher per capita payments to clinicians who treat more complex patients
- How to attribute beneficiaries to primary care clinicians?
  - In our 2015 recommendation, beneficiaries would be prospectively attributed to the clinician who provided plurality of primary care visits during prior year
  - But beneficiaries may switch primary care clinicians during the year
  - To address this issue, CMS could verify beneficiary attribution each quarter

Option #2: Key design decisions (continued)

- Size of per beneficiary payment?
  - Should be large enough to meaningfully reduce compensation disparities
  - Payments in CPC+ model ranged from $15-$28 per beneficiary per month
  - $20 monthly payment would result in total payments of $30,000 per clinician per year, on average
- How to define primary care clinicians?
  - In our 2015 recommendation, definition was based on Medicare specialty designation and billing patterns (at least 60% of allowed charges were for primary care services)
  - But clinicians in non-primary care specialties may also function as a beneficiary's primary care clinician
  - Could explore a definition based solely on billing patterns

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Note: CPC+ (Comprehensive Primary Care Plus). In our 2015 recommendation, primary care specialties included family practice, internal medicine, pediatrics, geriatrics, nurse practitioner, clinical nurse specialist, and physician assistant.

Option #2: Implications

- Would reduce compensation disparities between primary care physicians and specialists
- Would begin to shift clinician payments from fee-for-service to population-based payment approach
- If per beneficiary payment is budget neutral, no impact on Medicare spending, but it could lead to significant reductions in physician fee schedule payment rates
- If not budget neutral, would increase Medicare spending

Discussion

- Questions about the two options we presented?
- Interest in further exploring either (or both) option(s)?
- Other ideas?