



*Advising the Congress on Medicare issues*

# Promoting the use of primary care

Cristina Boccuti, John Richardson, Kevin Hayes  
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# Overview

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- Importance of primary care and its risk of underprovision
- Initiatives to promote the use of primary care
  - Medical home programs
    - Implementation design questions and considerations
  - Maintenance of certification efforts
  - Fee schedule changes

# Importance of primary care

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- Increasing the use of primary care services and reducing reliance on specialty care can improve the efficiency and coordination of health care delivery without compromising quality.
  - Fisher et al., 2003
  - Starfield and Shi, 2002
- Yet, under current Medicare FFS incentives, primary care services are at risk of being:
  - Undervalued
  - Underprovided

# Medical home programs

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- Medical home programs
  - General concepts, goals
  - Previous MedPAC work – care coordination programs
- Implementation design questions involve tradeoffs

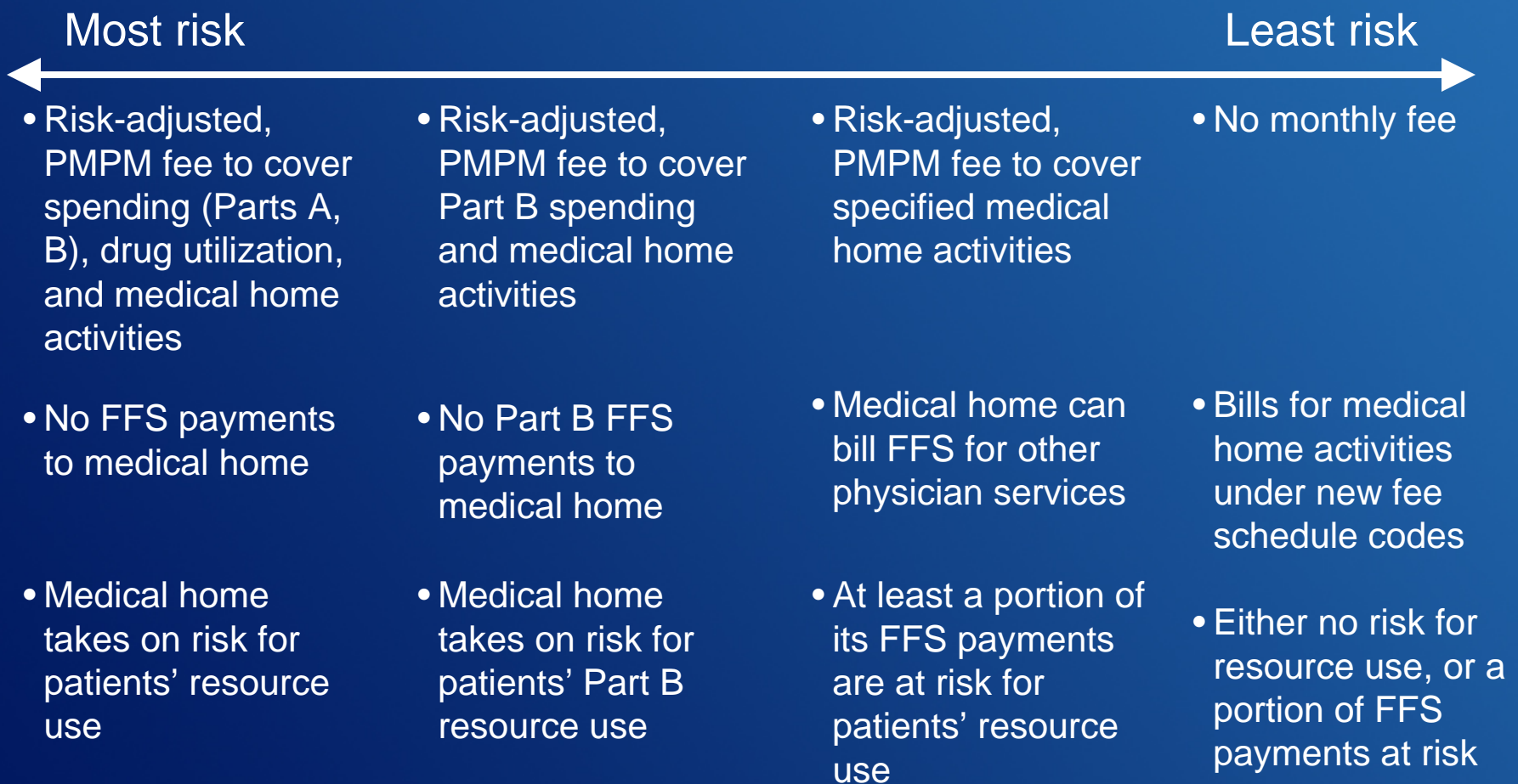
# What defines a medical home?

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## *Considerations:*

- Services it provides, beyond diagnosis and treatment
  - (e.g., care coordination, patient education, health IT, electronic medical record, patient registry, evidence-based medicine, etc.)
- Practice size
  - (e.g., number of physicians, number of Medicare patients)
- Practice specialty and staffing
  - (e.g., multispecialty, primary care, selected specialties, dedicated care coordinator)
- Responsibility for overall resource use and health outcomes
- Accreditation by an external body

# How should Medicare pay for services provided by medical homes? Should medical homes bear risk for resource use and quality?





# Can beneficiaries seek care from specialists without a referral from their medical home?

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## *Considerations:*

- *Most restrictive:* Referral required from medical home for all specialists
- *Somewhat restrictive:* Referral generally required with an exception for specified specialties
- *Least restrictive:* No referrals required to seek specialty care

# Which beneficiaries could be eligible to participate in a Medicare medical home program?

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## *Considerations:*

- Targeted approach - Beneficiaries with:
  - Multiple chronic conditions
  - Specified chronic conditions (e.g., CHF, diabetes)
  - High-cost beneficiaries
- All beneficiaries
- Special circumstances: nursing home residents, snowbirds



# Should beneficiary incentives to join medical homes be considered? What role should beneficiaries play in seeking primary care services?

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## *Considerations:*

- Reduced monthly Part B premiums for joining medical home
- Tiered cost-sharing for fee schedule services
- Public education efforts to inform beneficiary about the benefits of primary care and medical homes

# Components of Maintenance of Certification (MOC) programs

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- MOC programs build on existing board certification process
  - Licensure, formal exam every 6-10 years, interim self-tests of medical knowledge
- Specialty boards creating MOC programs under criteria set by ABMS and ACGME
- New component of MOC: Self-evaluation of practice performance
  - Example: ABIM Practice Improvement Modules

# How could Medicare use MOC to promote primary care?

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- Could increase payments to physicians completing MOC from primary care specialty boards
  - P4P or across-the-board increases?
  - Budget-neutral by decreasing payments to other physicians?
- Adapt private payers' uses of MOC
- Concern: Weakened MOC criteria over time?
  - Medicare, 3rd party reviews of MOC criteria

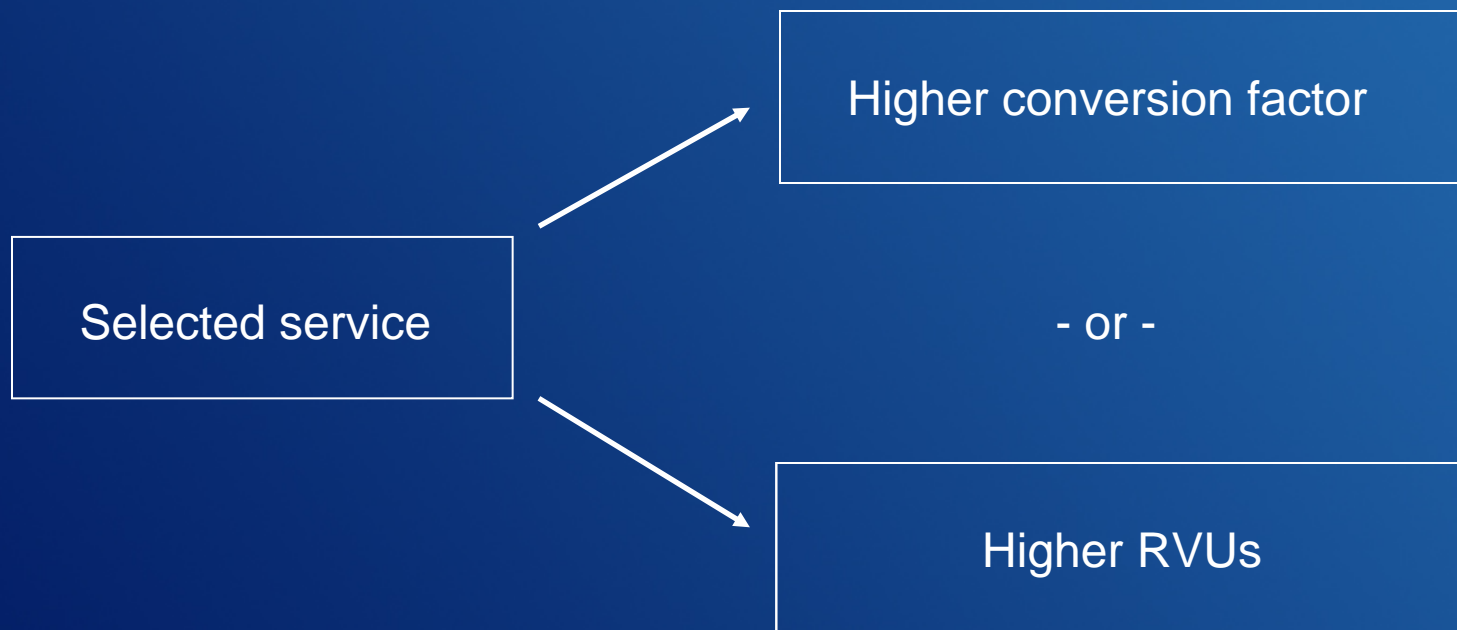
# Increasing fee schedule payments for primary care

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- Fee schedule adjustments
- Policy changes that would indirectly increase payments for primary care
  - improve the five-year review of relative values for physician work
  - improve the accuracy of payments for practice expense
  - automatically adjust relative values for services with rapid growth in spending
- Allow comparative effectiveness information to inform the level of payment

# Service-specific fee schedule adjustments

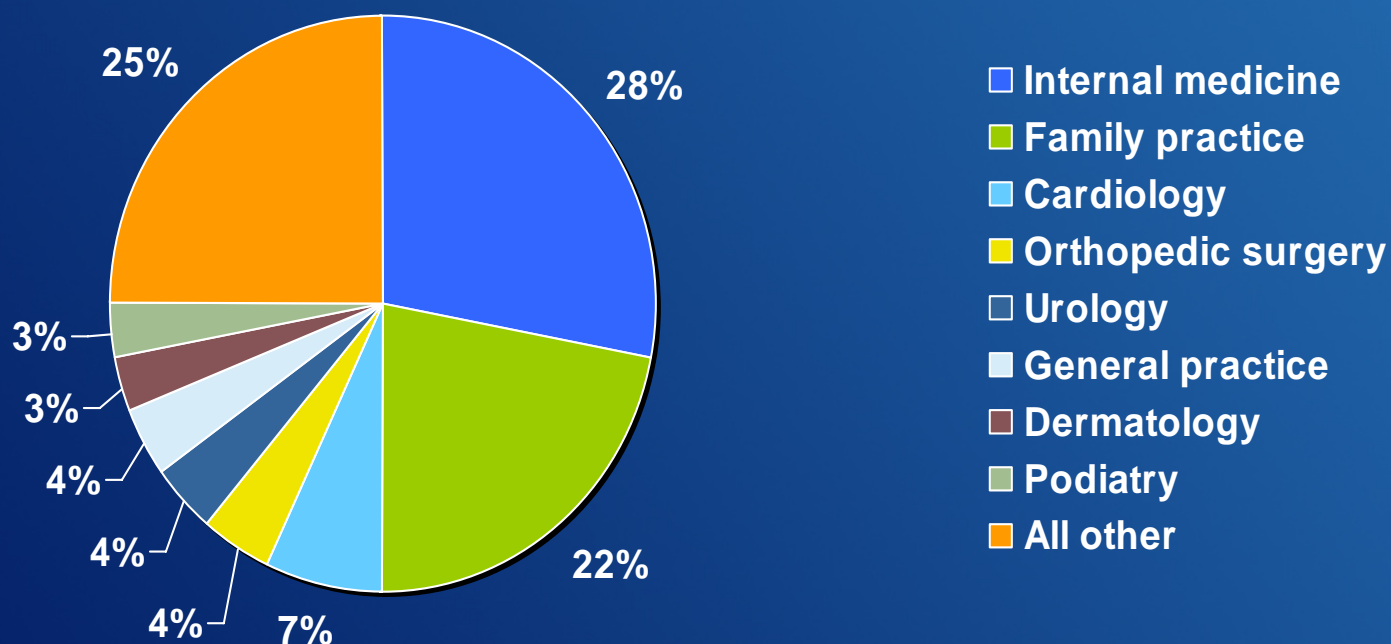
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Note: RVU (relative value unit).

# If service-specific only, adjustments not targeted

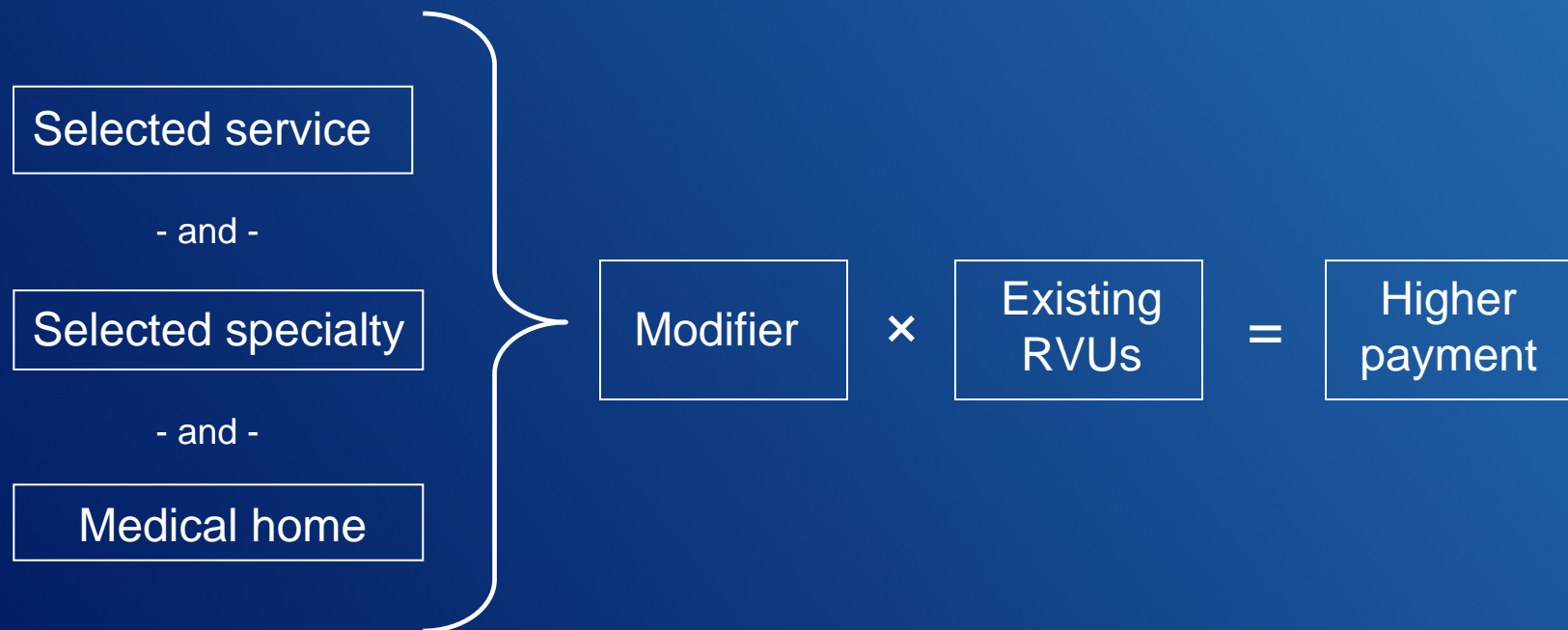
Allowed charges, mid-level office visit



Source: MedPAC analysis of 2005 claims data for 100 percent of Medicare beneficiaries.

# Adjustments that consider service, specialty, and medical home

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Note: RVU (relative value unit).