Primary Care Payment and Provider Compensation Reform: Emerging Trends

January 15, 2015
Presentation Agenda

1. The rationale for primary care payment reform

2. Update on models in use across the U.S.
   – Contracted payment: new programs in 2014
   – Employee compensation: innovation examples
   – Direct practice payment models

3. Key considerations for success
Why reform payment?

Why change payment? Two commonly cited rationales:

1. **infrastructure support**: Belief that for a practice to operate as a medical home, it requires additional resources in the practice setting, including physician and other care team member time on traditionally non-billable activities, care management, HIT, and space and equipment.

2. **incentive alignment**: Many believe that only changes to the payment system that motivate and support efficient and effective care and counter the fee-for-service “gerbil wheel” incentive will generate practice transformation.
Why “compensation”, and not just “payment”?

- 42% of physicians in the U.S. are employed (AMA 2012 Physician Practice Benchmark Survey)
  - Percentage was growing
  - Specific trend towards hospital employment

- The AMA estimates that 60% of family physicians and pediatricians are employed (NY Times, 2-13-14)
American physicians, worried about changes in the health care market, are streaming into salaried jobs with hospitals. Though the shift from private practice has been most pronounced in primary care, specialists are following.

Last year, 64 percent of job offers filled through Merritt Hawkins, one of the nation’s leading physician placement firms, involved hospital employment, compared with only 11 percent in 2004. The firm anticipates a rise to 75 percent in the next two years.

Today, about 60 percent of family doctors and pediatricians, 50 percent of surgeons and 25 percent of surgical subspecialists — such as ophthalmologists and ear, nose and throat surgeons — are employees rather than independent, according to the American Medical Association. “We’re seeing it changing fast,” said Mark E. Smith, president of Merritt Hawkins.

Health economists are nearly unanimous that the shift away from fee-for-service payments to doctors, the system where private physicians are paid for each procedure...
Approaches to Reforming Payment: Third-party Contracted Payment

1. **Modified Fee-for-Service (FFS)**
   a. discrete new codes
   b. higher payment levels

2. **Supplemental Payments**
   a. lump sum payments
   b. PMPM (or PMPY) fee for all patients
   c. PMPM fee for some patients
   d. PMPM fee with a P4P opportunity

3. **Shared Savings**
   a. Shared savings
   b. PMPM (or PMPY) and shared savings

4. **Comprehensive Payment**
   a. Comprehensive payment with PCMH investment

5. **Direct Access**
   a. Retainer fee

6. **Integrated Strategies**

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Approach #3b: PMPM payment and shared savings

Case examples:

- **PA Chronic Care Initiative Phase 2** (MAPCP demo.): Each payer groups practices and determines savings by comparing trend of participating practices to book-of-business trend. PMPM netted out. Distribution of savings linked to performance on quality measures.

- **Maryland Multi-payer PCMH Program**: Primary care practices can earn a % of the savings they generate through improved care and better patient outcomes. Practices that meet performance and measurement criteria and achieve savings relative to their own trended baseline receive a percentage of cost savings.
New PMPM payment and shared savings model: Arkansas Medicaid

- $4 PMPM payment is a “prospective investment to a clinical site for which there must be verifiable evidence of progress in medical home functionality”

- The Arkansas PCMH model benefits providers that
  - hit a targeted, risk-adjusted per-member per-year spending level regardless of spending reduction
  - gives smaller, graduated rewards to less efficient practices that achieve spending reduction in pursuit of the threshold for risk-adjusted per-member per-year expenditures

- Must have at least 5000 attributed lives for shared savings eligibility – and can pool lives with others to get there. Statewide default pool for those <5000

- Coupled w/episode-based payment for specific conditions
New PMPM payment and shared savings model: Arkansas Medicaid

- **Method A**: providers are assessed on absolute performance and eligible for 50% of shared savings if they achieve risk-adjusted average per beneficiary spending below a preset statewide threshold.

- **Method B**: providers are placed in one of three strata based on their own performance in the previous year (high, medium-to-high or below medium spending) and then assessed based on improvement.
  - If the practice meets at least a two percent minimum savings rate during the performance year compared to a preset practice benchmark (set using historical practice costs projected forward), it can share 10%, 30% or 50% of the savings, depending upon in which stratum it started.
Approaches to Reforming Payment

Approach #4a: Comprehensive payment with P4P and/or shared savings

Case examples:

- **Capital District Physicians Health Plan** (NY): Risk-adjusted PMPM comprehensive payment covering all primary care services. Payments support an investment in medical home systems to improve care. Additional 15-20% of annual payments are performance-based and paid as a bonus.
Approaches to Reforming Payment

- Why comprehensive payment for primary care anyway?

- **Pros:**
  - Removes the financial imperative to see as many short-visit patients per day as possible.
  - Removes the financial barrier to delivering traditionally non-compensated care.
  - Allows for “operating at the top of one’s license” and improved work experience.

- **Cons:**
  - Creates a financial incentive to limit patient visits and to ration a service that is correlated with better health, lower cost and better patient experience.
New comprehensive payment with P4P and shared savings model: Mass. Medicaid

- **Massachusetts Primary Care Payment Reform:**
  A three-part payment model:
  - Risk-adjusted PMPM comprehensive payment covering primary care services and possibly some behavioral health
  - Quality incentive opportunity
  - Shared savings (and shared risk) opportunity

- Implemented March 1, 2014 with 30 practices, including a significant number of FQHCs.
Massachusetts PCPR: Comprehensive Payment

- Intended to reduce dependence on appointment volume and RVUs and thereby support expanding the care team, offering telephone and email consultations and group appointments, and expanding appointment lengths for complex patients.

- Includes some outpatient behavioral health services for those providers integrating behavioral health services (three tier design). Behavioral health MCO pays its portion of the comprehensive payment.

- Payments are risk-adjusted.

- Behavioral health providers can serve as medical homes.
Massachusetts PCPR: Quality Incentive

- Similar to many other pay-for-performance programs, participants can earn a bonus payment based on quality performance
- “Gate and ladder” model, applied to both gains and losses
- Selected 23 measures are common to other programs in use in the state and cover seven domains:
  - Access, patient-centeredness, behavioral health integration, care coordination, preventive and chronic care, women’s health, pediatric health
Massachusetts PCPR: Shared Savings

- **Track 1**: Up and downside risk. 60% share capped at 10%, so -6% real exposure

- **Track 2**: Up and downside risk. 60% share capped at 10% up and 5% down, so -3% real exposure [introduced for Year 2]

- **Track 3**: Upside risk only. 25-50% share capped at 10%, so 5% real opportunity

- Use practice-specific, risk-adjusted projected *non-capitated* spend target rather than comparison to market trend.
New comprehensive payment with P4P and shared savings model: Oregon PCA

- **Oregon Primary Care Association**: Eight CHCs are paid on a comprehensive basis for medical-home oriented primary care services as part of a pilot approved by the CMS. PMPM payments are negotiated with each clinic based on previous claims experience and features of the populations served. Went live in two waves in 2013 (3) and 2014 (5).

- The methodology converts each CHC’s federally defined Prospective Payment System (PPS) rate to a comprehensive equivalent for their scope of primary care services. For the Medicaid wrap payment (50-70% of Medicaid rev.)

Two CCOs use comprehensive payment.
New comprehensive payment with P4P and shared savings model: Oregon PCA

- FQHCs asked OPCA for a payment methodology to better align with the PCMH model. Why?
  - Current reimbursement a barrier to medical home transformation by not supporting alternative patient encounters and promoting “visit churn”
  - Provider team retention issue

- Not value-based pay, but consider to be a bridge to it
- Also eligible for PCMH PMPM and PFP and with one CCO “enabling services” FFS payments.
- The state will study patient encounter data and make a supplementary payment to help the health center recoup its costs if the comprehensive payment is less than what a CHC would have received under FFS.
New comprehensive payment with P4P and shared savings model: Oregon PCA

Payment reform tied to practice transformation work, including a learning collaborative.

Pilot Evaluation Criteria:

- FQHCs will report applicable CCO measures plus five UDS measures.
- The State will track total global costs and success will be considered achieved if costs grow by no more than 3.4% trended from the prior year.
- For established patients who are enrolled at the beginning and end of the study period, 70% of people will have had a meaningful touch in the last 12 months.
How does comprehensive payment differ from what was tried in the 1990s?

Current primary care comprehensive payment models are not the same as those used in the 1990s.

- Payments are now sometimes supplemented to build in investment in PCMH infrastructure – especially for practice-based care management.
- Payments are supplemented with P4P quality opportunities and/or shared savings opportunities.
- Rates can be risk-adjusted.
- Payers are able to provide practices with much more useful reports, and for large systems, raw claims data for provider analysis – and systems have the means to analyze the data.
- Practices have EHR-based data available.
Direct Primary Care

- Refers to a payment model whereby patients pay a monthly or yearly payment to primary care physicians for expanded primary care services, often including:
  - Annual exams
  - Email and telephone access
  - Specialist and hospitalist coordination
  - Basic labs and x-rays (sometimes for an additional cost)

- This approach can appeal to patients who are uninsured, or insured under a high-deductible or catastrophic insurance plan, as it is a less expensive alternative. It is also appealing to patients who want enhanced access.
  - One study identified costs of between $10-100 / per month
Direct Primary Care

- It appeals to providers because:
  - they are not incentivized to see more patients per day;
  - can have a reduced panel size;
  - can spend more time with patients, and
  - do not have the administrative or financial burdens of reporting to or collecting payment from insurers.

- It differs from “concierge care” in that the “retainer fee” is less expensive, because the primary care services are more basic.

- The model is slowly becoming more popular, with self-insured employers and individuals, but resistance from insurers, specialists and hospitals, and lack of awareness could stymie rapid growth.
Direct Primary Care: Paladina Health

- **Paladina Health**, owned by DaVita, provides employer-sponsored primary care to over 20 employers through patient-centered medical homes.
- Individuals can also enroll directly.
- It charges between $69-109/month per member and offers primary, preventive, urgent and chronic disease management care.
- It puts fees at risk based on achieving certain targets related to cost savings, patient satisfaction and clinical outcomes.

**Direct Primary Care: Qliance**

- **Qliance** is a Washington-based provider group that offers employer-based primary care coverage.
  - Patients can also choose Qliance through the Washington Exchange in combination with a Medicaid plan, or enroll directly.

- Qliance member fees average about $65 per month and offer typical primary care services, plus basic x-rays, EKGs, lab tests, blood draws and urgent care at no additional costs.

- Qliance has a diverse patient panel including employees of Expedia and Comcast, the Seattle firefighter’s union and 15,000 Medicaid recipients.

- It claims to save 20% of the total cost of care over traditional FFS primary care providers.
New Trends Reforming Payment: In Summation

- Big question is what happens to primary care payment when practices enter ACO contracts.
  - Some examples of continuing PMPM payments.
  - Other cases where there are no such payments.

- As ACO growth continues in *some* markets, ACO shared savings arrangements are likely to replace PCMH shared savings.

- ACOs are for everyone and everywhere, however, and many payers recognize “one size won’t fit all.”

- Comprehensive payment is likely to grow, as FFS is counter to new models of care delivery – and many providers hate it.
Physician Compensation

- In today’s FFS-dominated health care financing system, provider organizations (POs) typically utilize production-based compensation models to distribute funds internally to employed physicians.

- In this manner, internal provider compensation has been aligned with FFS payment incentives by reinforcing provider productivity, rather than quality or other aspects of value.

- Recent Stanford study of highly performing primary care practices found balanced compensation was one of several common characteristics.¹

¹ See http://petersonhealthcare.org/most-valuable-care
Examples of PCP Compensation Models

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<th>Variables</th>
<th>Organization #1</th>
<th>Organization #2</th>
<th>Organization #3</th>
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<tr>
<td><strong>Organizational Details</strong></td>
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<td>APM as % of revenue</td>
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<td><strong>Compensation Details</strong></td>
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<td>RVU/Productivity</td>
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<tr>
<td>Total</td>
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<tr>
<td><strong>Bonus Opportunity</strong></td>
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<td>Yes, based on system performance on APM</td>
<td>Yes, based on medical group performance on APM</td>
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“Bonus” is defined here as a payment that is not embedded in the individual base compensation model, and therefore serves as a supplemental payment.
## Value-oriented Performance Details

### Compensation Details

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<tr>
<td>Value-oriented Performance</td>
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### Value-oriented Performance Detail

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**Primary Care Payment and Provider Compensation Reform: Emerging Trends**

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“Readers…may be surprised by the extent to which Geisinger physicians are compensated for fee-for-service productivity, while more modest financial incentives are focused on quality and efficiency. This approach not only reflects the business realities of the fee-for-service system, but also the teachings from behavioral economics such as prospect theory, which describes how modest financial incentives can produce a disproportionately large impact.”

Motivation for Changing Compensation

- Many did not want to incentivize providers in a way that was at odds with payment incentives at the organization level.

  “We have a new contract with BCBS that has financial incentives tied to outcomes, safety and service. Our [physician] compensation program aligns with the measures in our BCBS contract.”

- Others, especially those in markets with lower utilization of APMs, were motivated by anticipation of future APM changes – either to respond to new APM activity or to spur payers and purchasers to develop APMs.
Motivation for Changing Compensation

“We did it because ‘life sucked’ for PCPs who were on the hamster wheel of performing to high HEDIS expectations….

We wanted to free up PCP time to do team huddles and care for more patients, without more visits, through email and video visits.”
In addition, de-linking physician compensation from pure volume incentives was important to some organizations’ overall strategy, vision, and viability for example to:

- align compensation with the mission and vision
- improve PCPs’ work life and compensation
- respond to budgetary pressures
- offer more market-competitive compensation
Increasing Value-Oriented Compensation

- Innovators view their compensation models as dynamic.
- Many interviewees planned to increase the portion of PCP compensation based on performance.

“We’re piloting plans that completely change the game. RVUs will be about 25 percent of total physician compensation in the new system.”

“We want to get to a “65/35” percent split between volume and value-oriented measures, but we don’t want to get too far out of sync between what creates revenue for the physicians and revenue for the system.”

- A few intended to minimize additional physician compensation changes for the near future to let the existing compensation approach play out.
Can Financial Incentives Backfire?

- Motivation theory and research suggests that in certain circumstances, financial incentives can actually backfire and create a decline in performance.

“Quality has improved, but I am not sure it’s related to the physician compensation arrangement. There are people who feel that when you offer a financial reimbursement you can actually do harm.”

- A few POs indicated that non-financial incentives might be more or as important to behavior change.

“Is compensation a driver, or is it used to keep people away from doing what they want to do? Transparency is a bigger motivator than what we do with money.”
Daniel Pink’s Theory of Motivation

motivation

extrinsic

vs.

intrinsic

schedules deadlines

salary bonuses

autonomy mastery purpose
This method also reflects Geisinger’s complementary emphasis on nonfinancial incentives, which create a context in which peer pressure for efficiency and quality can be effective. This pressure does not come from Geisinger’s senior management, but rather from colleagues with shared goals and professional pride in exerting their collective autonomy to improve patient care.

Key Considerations for Success

1. Payment and compensation design work is tricky. Assume the work will require ongoing assessment and revision over many years.

2. “Culture eats strategy for breakfast” (Drucker). Customize your payment/comp strategy to your culture and tie in non-financial strategies.

3. Involve those most affected – there is no greater truism.

4. Don’t be physician-centric. As responsibilities are distributed and care becomes team-based, incentives need to apply to the team and to each of the team’s members.