Primary Care Payment and Provider Compensation Reform: The Way Forward

January 29, 2014
Presentation Agenda

1. The rationale for primary care payment reform

2. Models in use across the U.S.
   - Contracted payment
   - Patient payment
   - Employee compensation

3. Key considerations for success
Why change payment? Two commonly cited rationales:

1. **infrastructure support**: Belief that for a practice to operate as a medical home 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 is growing
  - Specific trend towards hospital employment
  - Still, the majority of physicians are still self-employed

- Organizations that employ physicians are increasingly interested in compensation models that align with the value-based payment models introduced by insurers and public payers
What are these models trying to accomplish?

1. Remove the exclusive economic incentive to focus on throughput.
2. Free the primary care team to spend time on activities that will most benefit the patient.
3. Encourage attention to measurable improvement in patient intermediate outcomes.
4. Foster attention to the patient is not in the primary care setting (i.e., out-of-sight, but not out-of-mind).
5. Create sensitivity and attention to avoidable resource consumption.
Sobering Facts

1. Financial incentives do influence behavior.

2. Financial incentives are not all that influences behavior.

3. Despite good intent and earnest efforts, incentive designs suffer from unintended consequences and do not achieve their full objectives.
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. Primary care capitation with P4P and/or shared savings

5. Direct Access
   a. Retainer fee
Approaches to Reforming Payment

Approach #1a: Modified FFS with new codes

Case examples:

- **BCBSMI**: T-Codes for practice-based care management (and also delegated DM fees)
- **Horizon BCBS of NJ**: paid for traditionally non-reimbursed care management services
- **Texas Medicaid**: paid for traditionally non-reimbursed care management services for children
Approaches to Reforming Payment

Approach #1b: Modified FFS with higher payment levels

Case examples:

- **BCBSMI**: 10% higher E&M code rates to 1200 qualifying practices
- **BCBSTN**: higher fee-schedule for NCQA PCMH-recognized primary care practices
- **Medicaid “primary care bump”**: increased rates under the ACA to Medicare Part B levels
Approaches to Reforming Payment

Approach #2a: Supplemental payment - lump sum

Case example:
- **PA Chronic Care Initiative** (SE, SC and SW Regions): ten participating insurers paid periodic lump sum payments to qualifying practices using a fixed amount per clinician FTE, tiered by practice size)
Approaches to Reforming Payment

Approach #2b: Supplemental payment - PMPM for all

Case examples:

- **Vermont**: three insurers and state Medicaid pay FFS with sliding scale PMPM based on level of achievement against NCQA PPC-PCMH standards
- **Rhode Island**: three insurers and state Medicaid make PMPM payment with requirement of NCQA recognition
- **Community Care of NC**: FFS with PMPM payment to PCPs and another PMPM payment to regional PCP networks for care management and Rx consultation
Approaches to Reforming Payment

Approach #2c: Supplemental payment - PMPM for some

Case examples:

- **Minnesota Health Care Programs**: FFS with PMPM payments to state-certified Health Care Homes for “care coordination services.” Payment levels tiered (4) and only for enrollees with one or more major conditions (proposed to CMS). Adjustments for SPMI and primary language other than English.

- **PPACA Section 2703 Health Homes** (e.g., Missouri): PMPM payments for adults with SPMI and for adults with two or more chronic conditions

- **Ambulatory ICU**: Initially developed for Boeing with three large providers in St. Louis
Approaches to Reforming Payment

Approach #2d: Supplemental payment with P4P

- The model endorsed by the PCPCC.
- PMPM fee referred to as a “monthly care coordination payment.”

Case examples:

- **EmblemHealth and Colorado Multi-Payer Initiative**: PMPM care management payment, and P4P
- **THINC RHIO**: PMPM payment for PCMH structural measures (NCQA Level 2) and for performance on 10 HEDIS measures
Approaches to Reforming Payment

Approach #3a: PMPY “shared savings” payment

Case example:

- **Bridges to Excellence**: Practices must be Level 2 certified for BTE’s Physician Office Link and any two condition-specific programs (e.g., Diabetes, Cardiac Care and Spine Care). Fixed $250/pt split between physician and purchaser/payer, informed by BTE ROI analysis.
Approaches to Reforming Payment

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.

- **Massachusetts PCMH Initiative**: Practices are assessed across payers by line of business using state’s APCD. Trend must be lower than total state trend to generate savings. PMPM netted out. Distribution of savings linked to performance on quality measures.

- **Arkansas Medicaid**: Coupled w/episode-based payment
Approaches to Reforming Payment

Approach #4a:
Primary care capitation 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

Approach #4a (continued):
Primary care capitation with P4P and/or shared savings

Case example:

- **MA Primary Care Payment Reform**: Three-part payment model:
  - Risk-adjusted PMPM comprehensive payment covering primary care services and possibly some behavioral health.
  - Pay-for-performance opportunity for quality.
  - Shared savings (and shared risk) opportunity.
Approaches to Reforming Payment

- **Approach #5: Direct access payment**
  Direct payment by patient. More affordable variant of concierge model. Used with and without health insurance payment.

**Case example:**
- **GreenField Health** (Portland, OR): charges sliding annual fee based on patient age ($120 to $756) “for services not covered by most insurance products”; in addition to regular FFS insurance payments
Current Approaches to Reforming Payment: In Summation

- Many different approaches – we don’t know which work better or worse yet – but we are learning quickly.

- Payment models vary based on:
  - focus and objectives of individual PCMH initiatives
  - payer and provider preferences
  - administrative capabilities
  - statutory stipulations

- Clear insurer and public payer trend away from simple infrastructure investment and towards linking some or all payment to performance on cost and quality.
A Few Unresolved Issues

- How to reconcile primary care payment models with other emerging forms of health care delivery and financing, e.g.,
  - Condition-specific payment (aka chronic condition bundled or episode-based payment)
  - ACO contracting under shared savings or shared risk terms
- Shared savings/risk with small populations
- Use of supplemental payments:
  - Small practices vs. larger practice organizations
  - Risk-adjusting payments
Arkansas Model

- PCMH began in 2012 as part of CMS CPCI multi-payer demo. Broader initiative now being implemented with support from CMMI Testing Grant
- Marries PMPM supplemental payment ($1PMPM for transformation and on average $4PMPM (risk-adjusted) for care coordination with…
- Episode-based payment to a “Principle Accountable Provider.” Includes some medical episodes for which primary care the “PAP”: URI, asthma, COPD and ADHD. Other episodes in development.
Physician Compensation

- Traditionally payment has been exclusively or near-exclusively tied to productivity (service volume).
- Hospitals and medical groups increasingly looking to align compensation with insurer payment incentives.
- Transition has been slow – considered a “third rail” issue by many.
Case examples:

- **ThedaCare** (WI): 66% productivity, 33% “quality” (clinical quality, patient satisfaction, group financial performance)
- **Geisinger Health System** (PA): 75% productivity, 17% quality, 8% efficiency, with a goal of 55% productivity, 33% quality and a 10% efficiency bonus
- **Cambridge Health Alliance** (MA): moved from 95% productivity, 5% quality to 80% salary, 15% quality, 5% productivity
“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.”

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.

Vermont Multi-Party ACO Pilot Standard:
“The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:

- aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organizations) with ACO performance incentives for cost and quality, and
- distributing any earned shared savings.”
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