The Right Way to Pay for Primary Care
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Hawaii Family Health Goals

- Exceptional Medical Care
- Maximize the number of patients served
- Ensure fair pay for our employees
How many patients should we have?

- Estimated average panel size: 2500
  - Origin – speculation by authors of an article in Family Practice Management, 2000

- Survey of panel size: 2300
  - Origin – survey of physicians published in Journal of General Internal Medicine, 2005

- Number of physicians who can accurately estimate their panel size: 1/3
  - Origin – Journal of the American Board of Family Medicine, 2014
How much time does patient care require?

- To provide all recommended acute, chronic and preventive care for 2500 patients: 21.7 hours/day

- To provide chronic care management to the top 10 chronic conditions for 2500 patients, if controlled: 3.5 hours/day
  - Origin: Annals of Family Medicine, 2005

- To provide chronic care management to the top 10 chronic conditions for 2500 patients, if not controlled: 10.6 hours/day
  - Origin: Annals of Family Medicine, 2005
Estimated number of patients that a solo physician can successfully manage with quality care: 983

- Origin: Annals of Family Medicine, 2012
Delegated portions of preventative and chronic care only

All acute care was left to physician
Train RNs to work to their maximum level in primary care
  ◦ Prevention
  ◦ Chronic Care Management
  ◦ Acute Care
  ◦ Refills
  ◦ Phone triage

All under the direct collaboration/supervision of physician
HFH Payment Models

- Fee For Service
  - 2008 – current

- CPC+ (Track 2)
  - 2017 – current

- Per Member Per Month (global)
  - 2017
HFH Costs / Revenue 2017

- Total practice revenue $671,819
  - Usual practice revenue ~$950,000
  - $149,353

- Total practice costs $821,172
  - Usual practice costs ~ 850,000
CPC+ Revenue

- Performance Based Incentive Payment (PBIP)
  - Annual
  - Quality Measures

- Care Management Fee (CMF)
  - Quarterly
  - Risk Stratification

- Comprehensive Primary Care Payment (CPCP)
  - Quarterly
  - Hybrid PMPM / FFS
CPC+ Revenue

Performance Based Incentive Payment (PBIP)
- Repaid to CMS if measures not met at end of year reporting
- 9 measures at 70% + CAHPS

Care Management Fee (CMF)
- Tiered payment for each patient
- Based on individual medical complexity

Comprehensive Primary Care Payment (CPCP)
- Partial PMPM (40%)
- Reduced FFS (60%)
CPC+ Additional Costs

- CPC+ Consultant Services
  - Caravan $1125 / month

- CPC+ In-Office Management
  - RN at 20 hours/week ~$2,500 / month

- Total additional Costs
  - ~$39,000
Per Member Per Month

- Full FFS → Full global (PMPM)
  - No transition period
- Based on 3 previous years of billables
  - Average PMPM ~$24
- ~1000 patients (50%)

- No Care Management Fee (CMF)
- Pay for Quality (PBIP) – quarterly
  - Removed if practice reverted back to FFS
  - By entering data on a separate website (not CMS website)
Two weeks of vacation
Working 200 hrs /month
Hourly wage ~ $118

$15 Biller
$12 Reception
$12 MA

$79 / hr
For overhead + staff benefits + MD salary
Reasonable Hourly Wage with PMPM

Goal Hourly Wage $164
- MD $125
- MA $12
- Reception $12
- Billing $15

Patient Panel Required

Compromise
- Patient Care
- Physician Work Hours

PMPM $24
Two weeks of vacation
Working 200 hrs /month
Hourly wage ~ $118
## Fee For Service

<table>
<thead>
<tr>
<th>CPT</th>
<th>2008</th>
<th>2013</th>
<th>2018</th>
<th>10 yr change</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMSA 99213</td>
<td>$ 61.69</td>
<td>$ 65.28</td>
<td>$ 67.41</td>
<td>9%</td>
</tr>
<tr>
<td>CMS 99213</td>
<td>$ 52.25</td>
<td>$ 61.04</td>
<td>$ 59.76</td>
<td>14%</td>
</tr>
<tr>
<td>HMSA 99214</td>
<td>$ 86.44</td>
<td>$ 98.70</td>
<td>$ 99.63</td>
<td>15%</td>
</tr>
<tr>
<td>CMS 99214</td>
<td>$ 78.45</td>
<td>$ 89.28</td>
<td>$ 87.96</td>
<td>12%</td>
</tr>
<tr>
<td>Minimum Wage</td>
<td>$ 7.25</td>
<td>$ 7.25</td>
<td>$ 10.10</td>
<td>39%</td>
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[Graph showing fee changes for different CPT codes from 2008 to 2018.]
## Disadvantages of Payment Models

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<thead>
<tr>
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<th>CPC+</th>
<th>PMPM</th>
<th>FFS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Only provides money for direct Medicare patients (~10% of practice)</td>
<td>Huge upfront costs to practice</td>
<td>Reimbursements fail to keep up with inflation</td>
</tr>
<tr>
<td>Admin</td>
<td>Admin requirements</td>
<td>Only way to increase revenue is to increase number of patients ($24 PMPM)</td>
<td>Fails to manage the patient as a whole</td>
</tr>
<tr>
<td>requirements</td>
<td></td>
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<tr>
<td>Complex rules</td>
<td>Complex rules and changing requirements</td>
<td>Rewards for doing less for patients (over-referring, less point of care tests, use urgent care)</td>
<td></td>
</tr>
<tr>
<td>and changing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>requirements</td>
<td></td>
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<td>P4Q incentivizes MD to discharge noncompliant or complex patients</td>
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Fair and Reasonable Pay

- Doctors need to afford to repay their debt

- Multiple factors affect their income consideration:
  - Average medical school debt
    - $192,000
  - Average undergraduate debt
    - $40,000
  - Average age of completion of training
    - 30 years old
Working Backward to Fair and Reasonable Pay

- Determine a reasonable panel size for the provider and the support staff needed based on evidence and local need
  - Each region has its own costs and challenges
    - Big Island is isolated with solo practices
  - Team Based practices can care for more patients but need increased PMPM to support necessary clinical team
- Use this panel size and regional information to determine the hourly wage for a PMPM
Fair and Reasonable Pay Hybrid

- Determine a fair wage PMPM for support staff and provider
- Add an overhead correction factor to the PMPM
- Offer additional FFS for new patients
- Offer additional FFS for procedures
- Remove financial incentives for quality
- Simplify reporting