Assuring Payment for Enhanced Primary Care: Lessons from PCMH Pilots

Medical Home Summit

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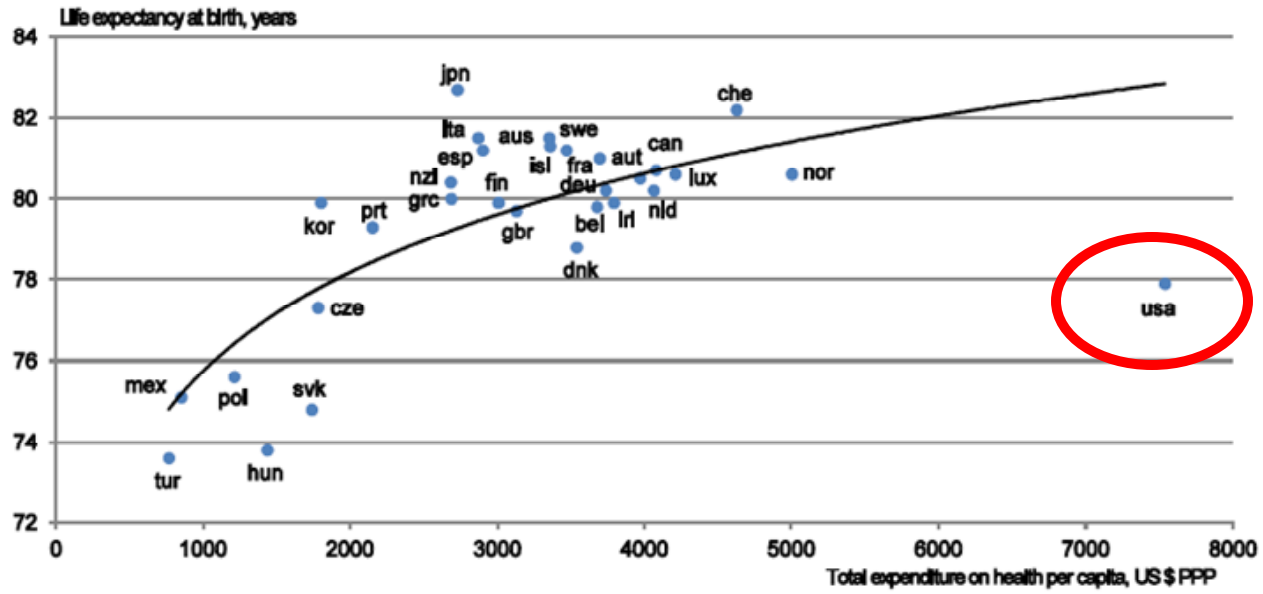
Maine Quality Counts
Better Health Care. Better Health.

The Context!

Figure 1. **There are large differences in life expectancy and health care spending across OECD countries 2008**[1]



1. Or latest year available.

Source: OECD Health Data 2010.

Investing in Primary Care?

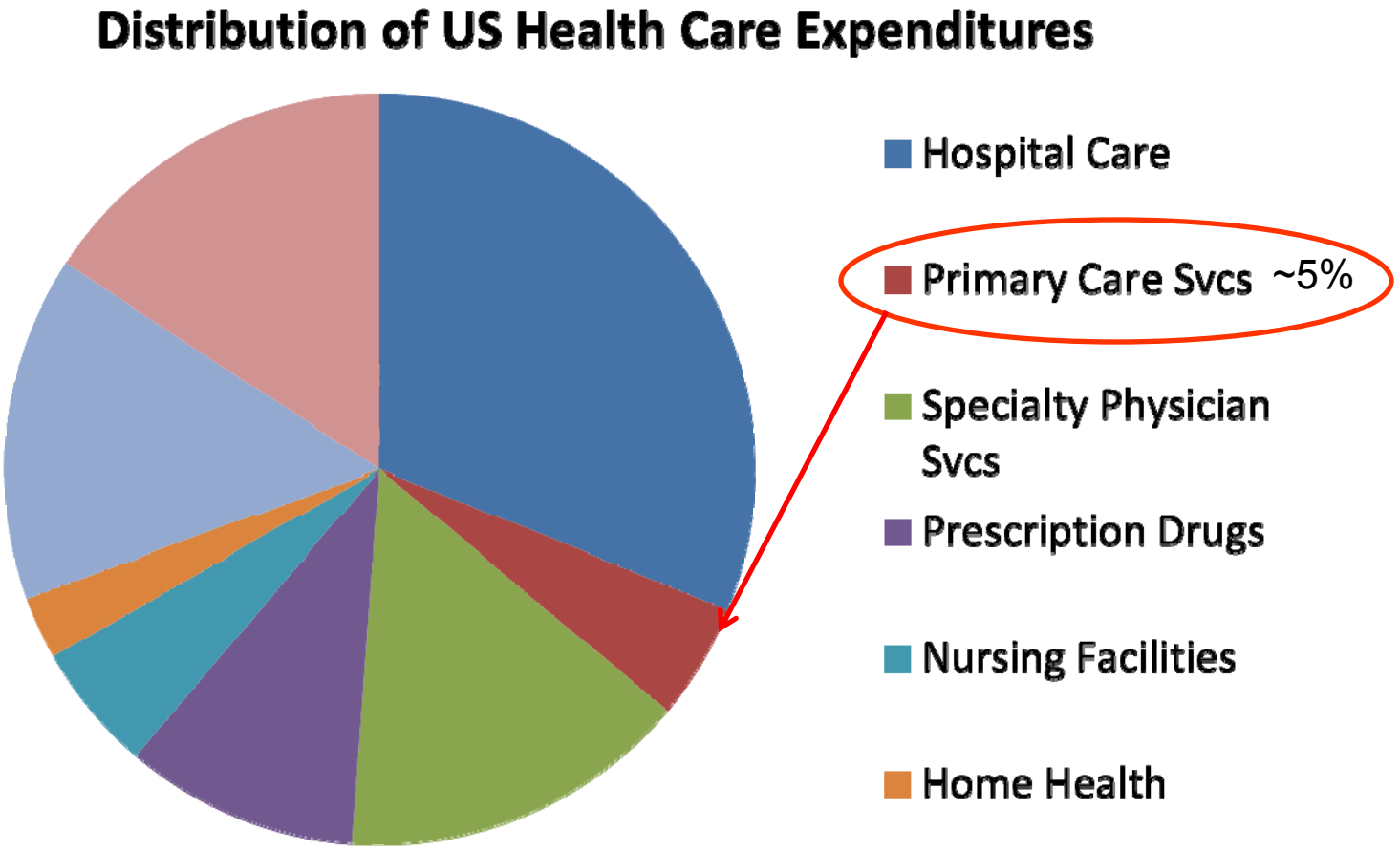
Key Concepts

1. **HOW MUCH** we pay for primary care – i.e. % total health care $$ spent on primary care

2. **HOW we pay** primary care – i.e. fee-for-service vs. alternative payment models

   (Corollary: how provider groups pay individual providers - i.e. provider compensation)

Current U.S. Investment in Primary Care



Can We Learn from Other Countries?

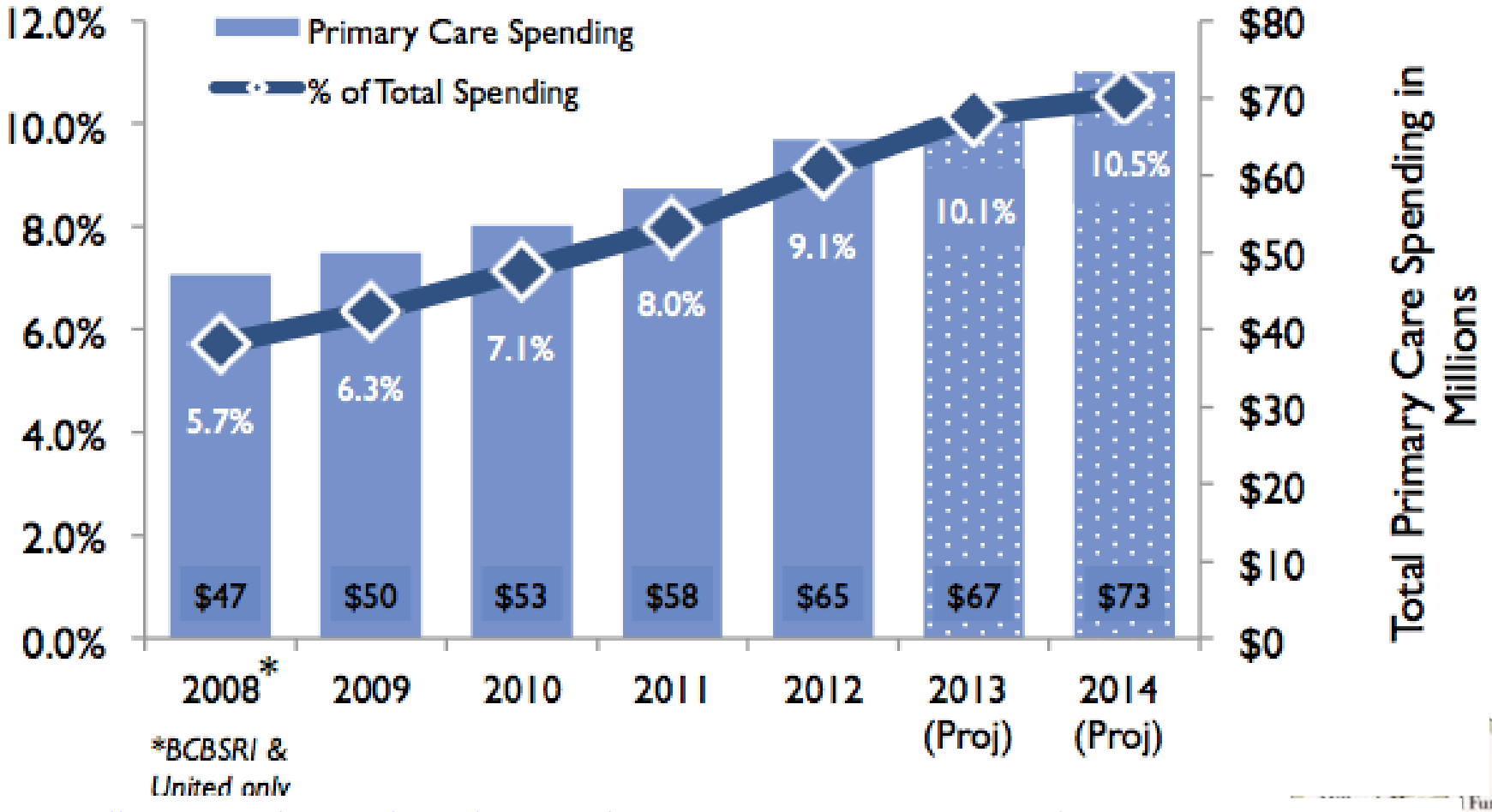
- Countries with overall lower costs and well-established primary care systems spend significantly more on primary care*
  - Canada: 20%
  - Chile: 30%
  - Netherlands: 15%
  - UK: 10%
  - US: ~5%

*Loewenson & Simpson, Strengthening primary care to improve health: Learning for the USA from high and middle income countries, Training & Research Support Centre, Oxford UK, August 2014

Learning from RI Experience?

- RI Office of Health Insurance Commissioner est'd "Affordability Standards" for health plans
- Required plans to track & report percent total health care costs spent on primary care
- Required plans to increase percent spent for primary care by 1% per year

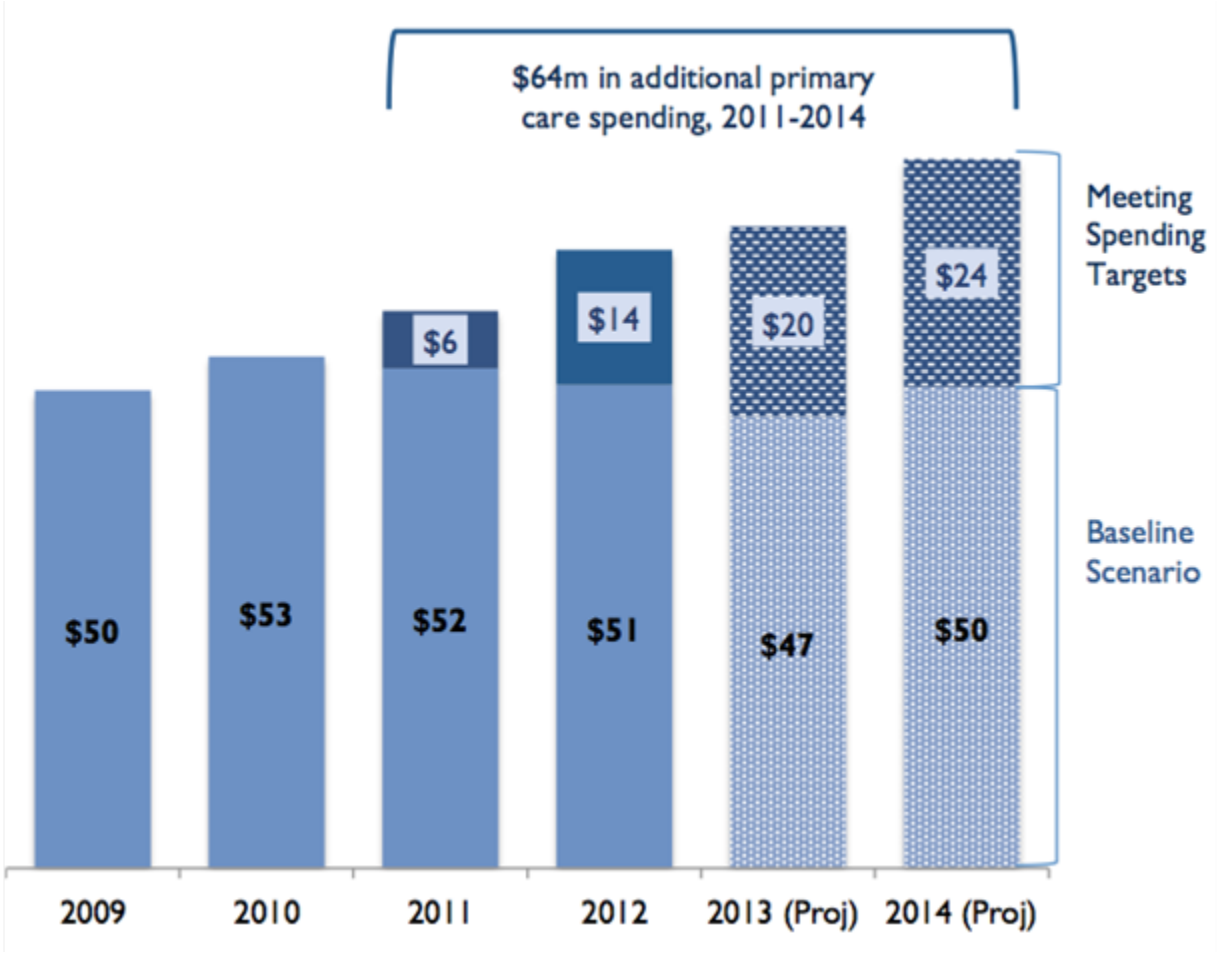
Increasing RI's Primary Care Spend



Source: http://www.ohic.ri.gov/documents/Insurers/Reports%202/2013%20Primary%20Care%20Spend%20Report/1_Primary%20Care%20Spend_Final.pdf

From Chris Koller, Milbank Fund, former RI OHIC Commissioner

The Result: Addnl ~$64M Invested in RI Primary Care Infrastructure



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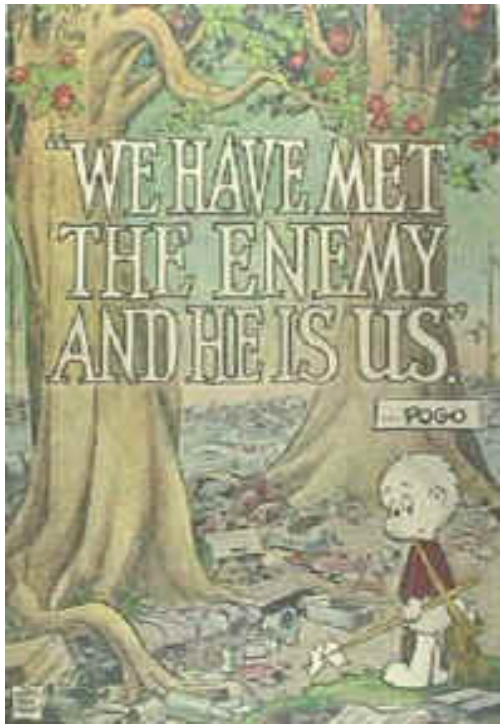
Current US Primary Care Payment Models

- Fee-for-service (FFS) = predominant model
  - Most markets, ≥95% primary care payments
  - Exceptions in some markets (e.g. MA, Kaiser)
- Enhanced FFS
- Pay-for-performance (P4P)
- PMPM “care management”/PCMH payments
- Shared savings
- ACOs (???)

Primary Care Payment within ACOs: Does Anything Change?

- FFS remains most predominant payment model for primary care providers within most ACOs*
- Relying on FFS payments continues to emphasize volume & threatens meaningful practice change
- Little meaningful change yet to focus on/concept of “productivity”



*Payment Reform for Primary Care within ACOs, A. Goroll & S. Schoenbaum, *JAMA*, Aug 2012

PCMH Pilot Payment Models

- Multi-payer pilots: have typically included most (not all) major private payers, +/- Medicaid
- Medicare participating in only 2 PCMH demos: MAPCP, CPCI
- Most PCMH pilots have used blended payment model
  - Modest prospective (PMPM) care management payment (e.g $3 pmpm)
  - Ongoing FFS payments
  - +/- performance-based payments - e.g. P4P incentives, potential for shared savings

Aligning Payers and Practices to Transform Primary Care:

A Report from the Multi-State Collaborative

by Lisa Dulsky Watkins, MD

Click to download from Milbank.org

Milbank "Aligning Payers" Guiding Principle #1

Multiple insurers (ideally all insurers) must pay for enhanced primary care services in same (or at least) similar way

- Only way to make practice transformation expectations manageable for primary care practices
- Multi-payer investments required to transform care sufficiently to stabilize and ultimately bring down health care costs

Do the Math…

Costs of Practice Transformation

4 Provider Practice (*Example)*

- Provider time for transformation, care management activities (non-reimbursed via FFS): $50K
- RN care manager: $100K
- 1 additional MA: $50K
- EMR/data management: $50K

TOTAL: $250,000

Current Payment Possibilities

MAPCP Practice (*Example)*

- Medicare: $7pmpm X 1000 pts X 12 = $84,000
- Medicaid: $12 pmpm X 500 pts X 12 = $72,000
- Commercial payers: $3 pmpm X 1000 pts X 12 = $36,000

TOTAL (all payers): $192,000

Total (Medicaid only): $72,000

Single payer changes not adequate to support required changes!

Moving Beyond Pilots: Need for…

- More substantial, widespread, and sustained payment change for primary care
- Commitment to multi-payer approaches to alternative primary care payment models
- More linking of practice transformation with payment reform
- More efficient accountability methods
- Higher investment in primary care – i.e. higher total % spend on primary care (not just rearranging current dollars!)

Current "Institutionalized" PCMH / Alternative Primary Care Payment Models

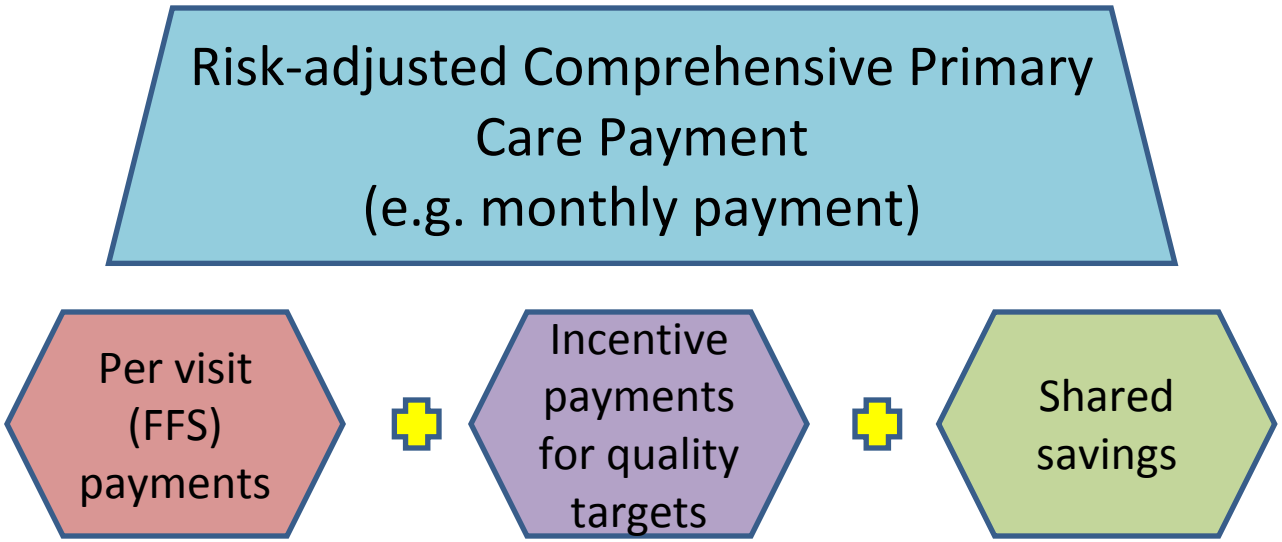
- Anthem Wellpoint: Enhanced Personal Health Care initiative
- State/regional plans – e.g.
  - Maine Community Health Options (CO-OP)
  - NY Capital District Physicians
- Other national commercial payers?
- Medicaid – ACA Sect 2703 Health Homes programs (states' commitments to continuing HH payments - beyond ACA-mandated 8 quarters?)
- Medicare - ???

Evolving Alternative Primary Care Payment Models

- Additional codes within current fee-for-service (FFS) system – e.g. Medicare Transitional Care Management, Chronic Care Management fees
- Supplemental payments on top of FFS – e.g.
  - Anthem Enhanced Personal Health Care pmpm
- Shared savings on top of FFS – e.g.
  - Medicare Shared Savings, commercial ACO contracts
- Comprehensive primary care payments (aka partial capitation)
- Episode of care payments (e.g. Arkansas)
- Direct Primary Care (subscription/retainer fee)

Ideal Model: Blended Approach?

- Any payment model holds potential for unintended consequences
- Address through blended models



Examples of Blended Payment Models with Comprehensive Primary Care Payment

- Capital District Physicians Health Plan (NY)
- Mass Medicaid Primary Care Payment Reform initiative
- Oregon Primary Care Assn
- CMS Comprehensive Primary Care Initiative (CPCI)
- UK, Netherlands, Canada

Or for Something Dramatically Different… Direct Primary Care

- Monthly “subscription service” payments paid directly to primary care practice outside of traditional insurance system
- Typically ~$40-50/month (*not* concierge levels!)
- Can be coupled with catastrophic coverage
- Direct payment by some employers
- Emerging businesses – e.g. MedLion, Qliance, Paladina Health, Iora

CMS: Setting the Pace

- HHS Secretary Burwell sets "bold goals" for payment reform Jan 26, 2015
  - Aim to link 85% of all Medicare FFS payments to quality or value by 2016, 90% by 2018
  - Aim to make 30% of Medicare payments thru alternative payment models by 2016; 50% by 2018
  - "We believe that, by working in partnership across the public and private sectors, we can accelerate these improvements and integrate them into the fabric of the U.S. health system"

www.nejm.org/doi/pdf/10.1056/NEJMp1500445

CMS: Setting the Pace or Adding Complexity?

- CMS Medical Home demonstrations
  - MAPCP demo - 8 states
  - Comprehensive Primary Care Initiative (CPCI) 7 markets
- Medicare Chronic Care Management Fee
- CMS Value-Based Payment Modifier
- CMMI Transforming Clinical Practice Initiative
- CMS Advanced Primary Care Models - RFI

Medicare Comprehensive Primary Care Initiative

- CPCI = 4-year pilot from CMMI, funded by ACA
- Currently in 7 regional “markets”
- 482 practices covering 335,000 Medicare beneficiaries
- Uses blended payment model with risk-adjusted care management fee (avg. $20pmpm) + FFS + shared savings opportunity (Yrs 3 & 4)
- Requires alignment with commercial payers on general payment model principles
- Requires practices to meet 9 key milestones
- Positive results (savings) from Yr1 evaluation

CPC Comprehensive Primary Care ...by the numbers

In the first two years of the Comprehensive Primary Care (CPC) initiative, practices have transformed how they deliver primary care, guided by the nine CPC milestones. These figures are a snapshot of practices' progress in their work to achieve better care, smarter spending, and healthier people.

482 practices in **7** regions

38 public & private payers

1 in **5** practices is located in a rural area

1 in **3** practices has two or fewer practitioners

2600+ practitioners

5 staff members involved in care management at the average practice

205 patient and family advisory councils

100% of practices offer 24/7 access to a practitioner who can access their EHR in real-time

93% of practices asynchronously communicate with patients through an online portal

86% median rate of follow-up to patients who are discharged from the hospital or emergency department

2.7 million active patients including:

335,000+ Medicare FFS beneficiaries

66,000+ Medicaid FFS beneficiaries

88% of patients are risk-stratified

1 in **7** patients receives care management

95% of practices use their EHR to monitor clinical quality measures at the practice- and panel-level

Source: Practice-reported progress at the end of 2014 (Q9).

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

New Medicare Payment: Chronic Care Management (CCM) Code

- Began Jan 1, 2015 for providers paid on Medicare Physician Fee Schedule (gen'ly not FQHCs, RHCs)
- New benefit for Medicare beneficiaries with two or more significant chronic conditions expected to persist ≥12 mos that puts individual at risk for decline, exacerbation, or death
- New CPT code = 99490
- Provider payment ~$40/mo for ≥ 20 mins non-visit based care management services

CCM: The Good, Bad & Not-So-Attractive

Good!

- Provides new revenue source for non-visit based care management services
- Can support services that many primary care/PCMH practices are already delivering
- Provides resources to support team-based care

Caution!

- FFS payment – not fully consistent with VBP principles
- Practices must be aware of & follow ~complex CMS reg's
- Requires practices to est. new admin structures, processes
- Only accountability is CMS audit; payment not linked to outcomes
- Beneficiaries will be subject to Medicare co-pay (~$8/mo)

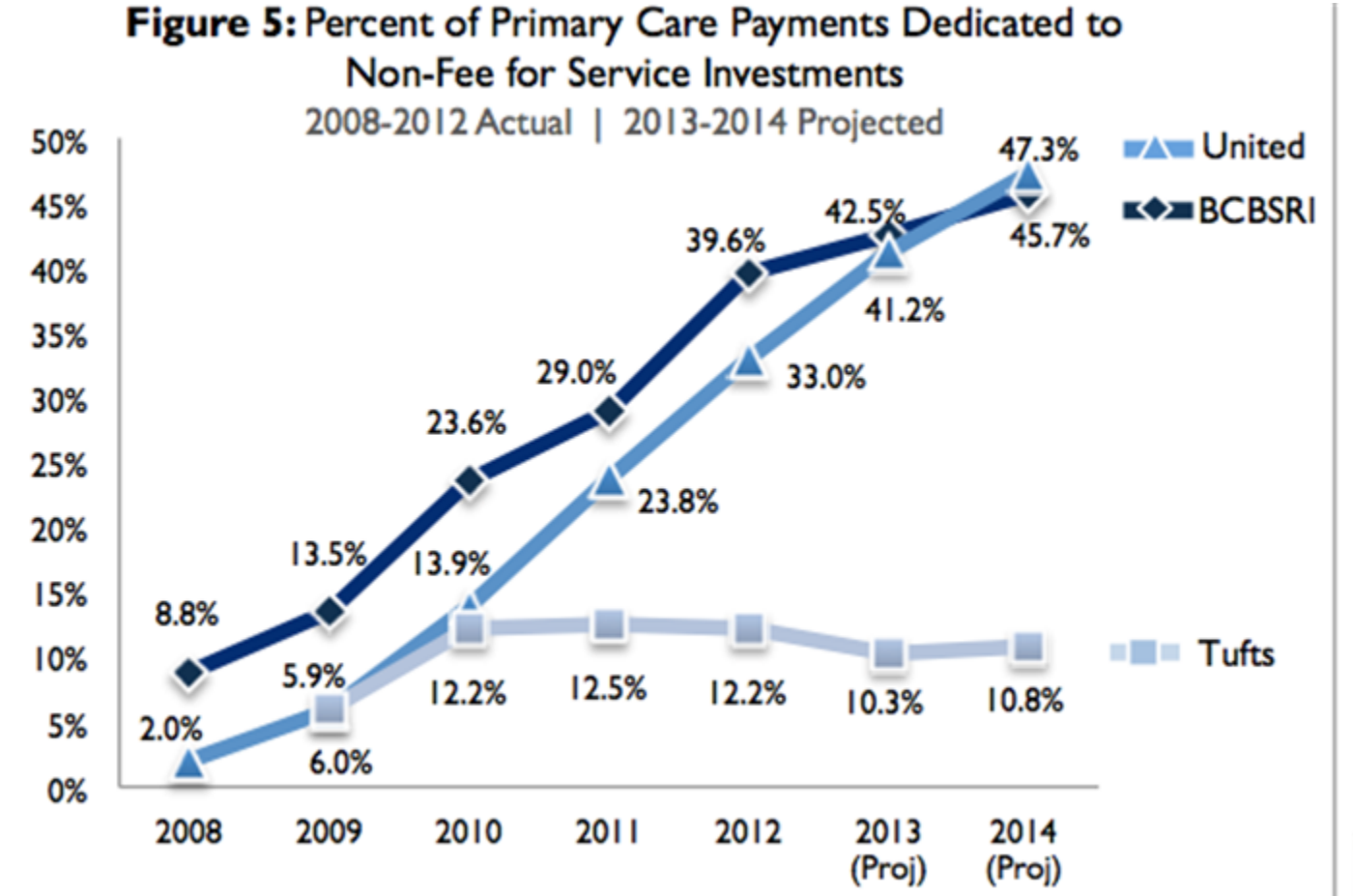
Building Support for Primary Care Payment Reform

- Advance the collective evidence of value of PCMH & other advanced primary care models, nationally & internationally (business case for status quo??)
- Build public support for value of primary care!
- Leverage employers to keep commercial payers at table
- Align with state Medicaid programs, SIM initiatives
- Align with Medicare (?)

Learning from RI Experience?

- RI Office of Health Insurance Commissioner "Affordability Standards" for health plans
- Required health plans to track & report percent payments for primary care paid through non-FFS payment models
- Required plans to increase percent paid in non-FFS models by 1% per year

Moving Payment Away From FFS



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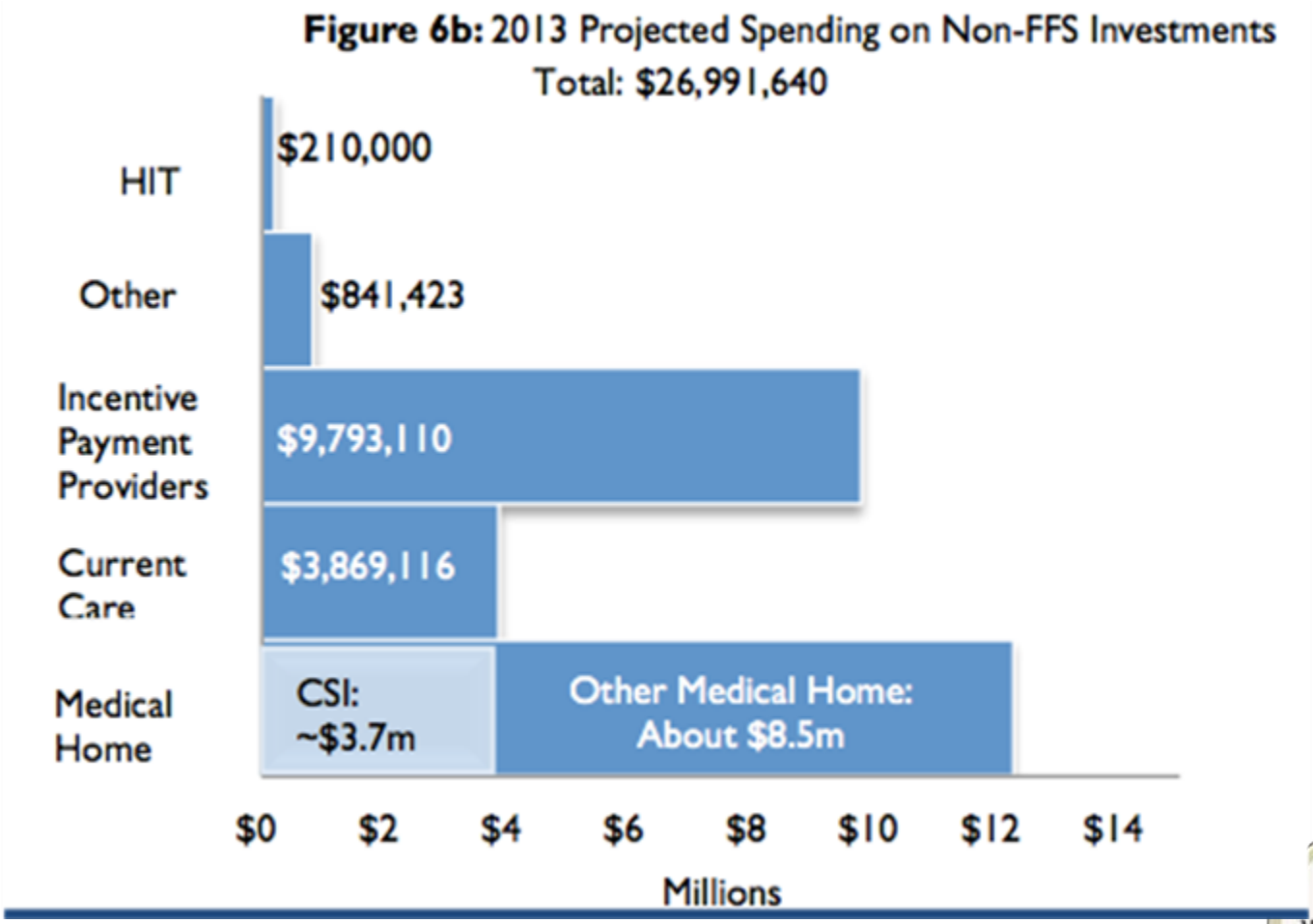
Non FFS Spending



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Maine Patient Centered Medical Homes/Health Homes
What is a Patient Centered Medical Home (PCMH)?

Contact Info / Questions

- Maine Quality Counts
  - www.mainequalitycounts.org
  - PCMH Pilot
  - http://www.mainequalitycounts.org/page/2-659/patient-centered-medical-home
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