Paying for Primary Care: Is There A Better Way?

Robert A. Berenson, M.D.

Senior Fellow, The Urban Institute

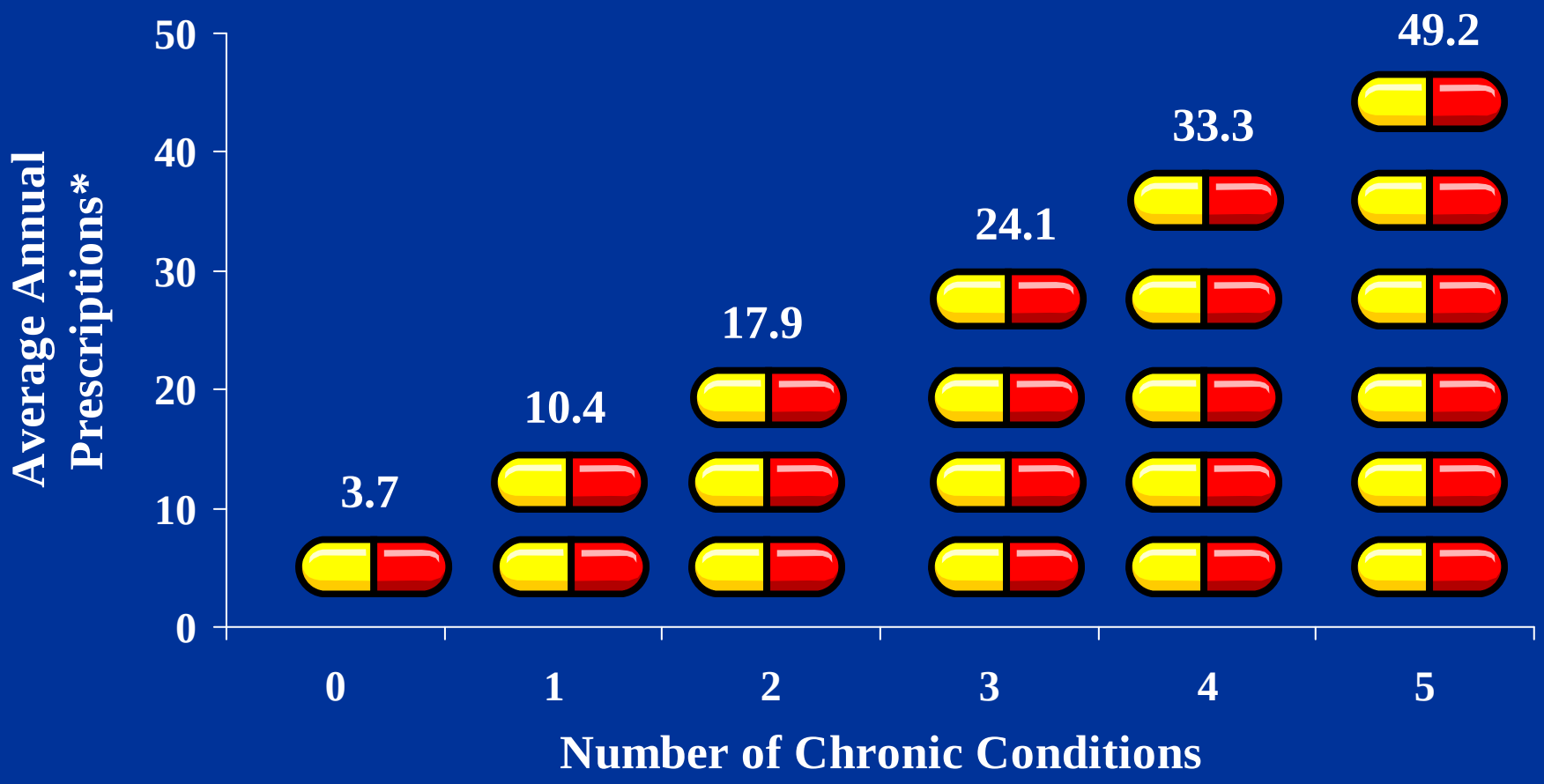
CHCS Regional Quality Improvement Initiative, Providence, R.I., July 25, 2007

Medicare Challenges Makes the Case for a New Model – a Medical Home

- > 43 million. By 2030, 78 million
- 29% in fair/poor health
- 23% have cognitive impairments
- Age Distribution:

Under 65 (disabled)	14%
➢85	11%

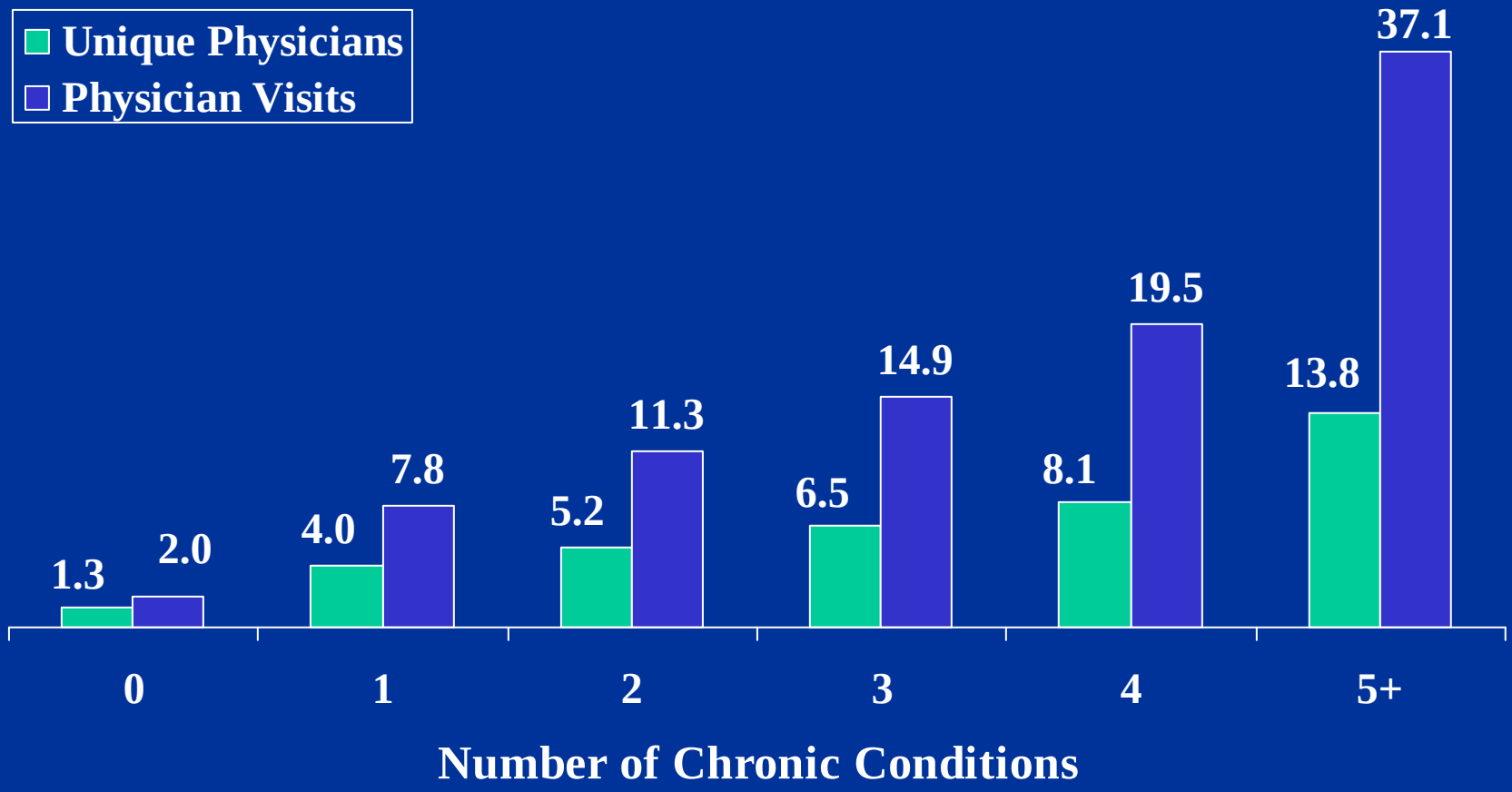
Annual Prescriptions by Number of Chronic Conditions



*Includes Refills

Sources: Partnership for Solutions, "Multiple Chronic Conditions: Complications in Care and Treatment," May 2002; MEPS, 1996.

Utilization of Physician Services by Number of Chronic Conditions



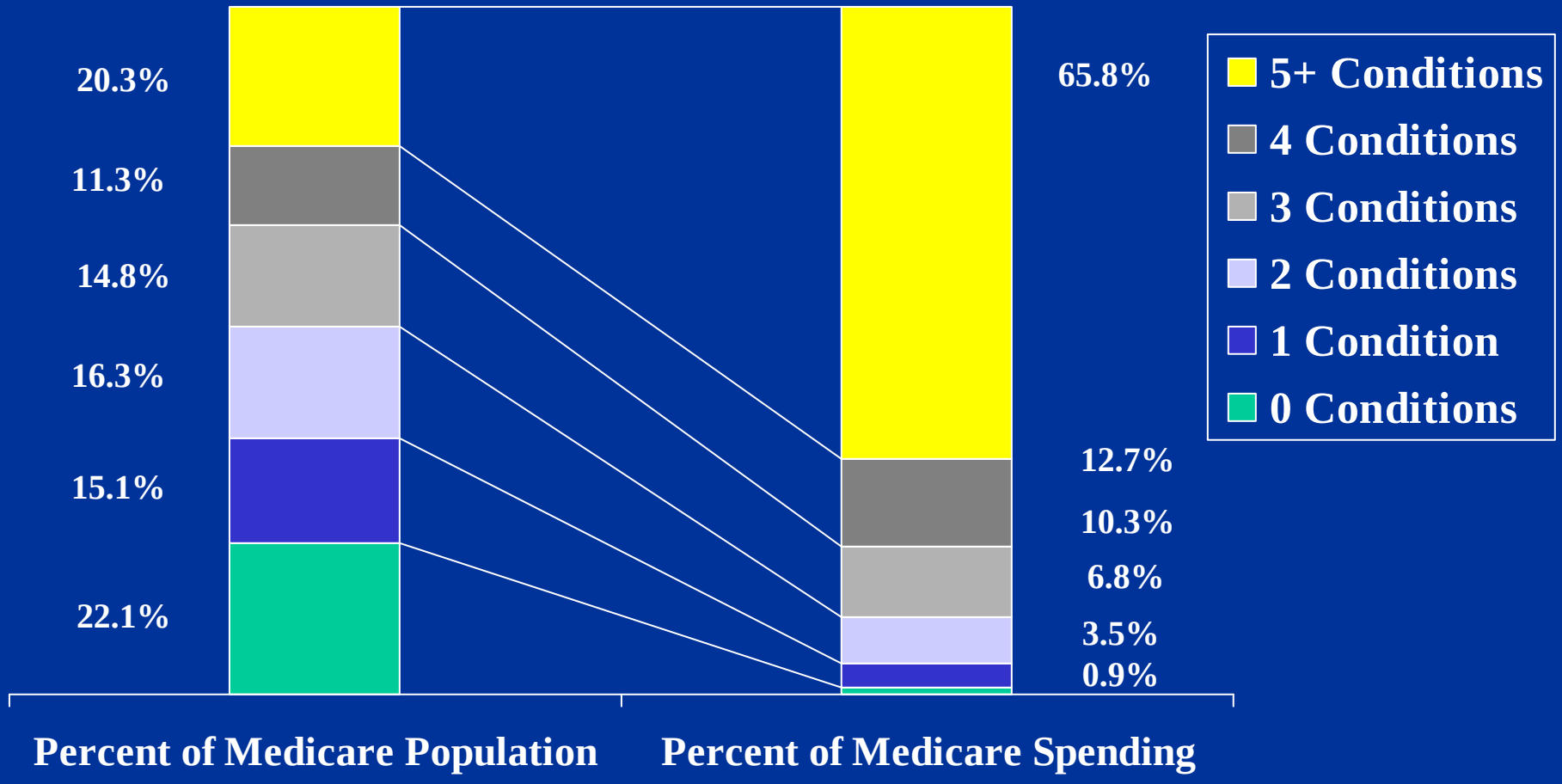
Sources: R. Berenson and J. Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform," prepared for the Partnership for Solutions, March, 2002; Medicare SAF 1999.

Incidents in the Past 12 Months

Among persons with serious chronic conditions, how often has the following happened in the past 12 months?

	Sometimes or often
1. Been told about a possibly harmful drug interaction	54%
2. Sent for duplicate tests or procedures	54%
3. Received different diagnoses from different clinicians	52%
4. Received contradictory medical information	45%

Medicare Spending Related to Chronic Conditions



Source: Partnership for Solutions, "Medicare: Cost and Prevalence of Chronic Conditions," July 2002; Medicare Standard Analytic File, 1999.

The Basic Problem with How Medicare (and others) Pay M.D.s

- The Resource Based Relative Value Scale (RBRVS)-based fee schedule has inherent limitations, even if improved (which is overdue)
- By design, the relative values of 6000+ codes are, at best, an approximation of underlying resource costs, not an attempt to determine what services beneficiaries need, that is, real value
- And, what purports to be an objective process is, despite good intentions, inherently subjective and somewhat political. It does not favor primary care

Fee-For-Service Is Necessarily Rooted in Face-to-Face Encounters

- There are plenty of reasons, e.g.,
  - high transaction costs, associated with non-face-to-face, frequent, low dollar transactions;
  - major program integrity concerns
  - “moral hazard” driving expenditures
- Yet, increasingly, face-to-face visits do not encompass the work of primary/principal care for patients with chronic conditions (most beneficiaries). Thus, we need to think about payment mechanisms other than FFS

Gaps in FFS Payments

- Current payment policies do not support the activities (not services) that comprise the Wagner Chronic Care Model, incl. non-physician care, team conferences, coordinating care with other physicians, harnessing community resources, using patient registries to facilitate preventive services, etc.
- N.B. This model is more than an electronic health record, which some of view as necessary but not sufficient for what a medical home needs to do

Chronic Care Strategies That Bypass Physicians Make No Sense

- From 30 years of Medicare demos -- approaches that are supplemental to the patient/physician relationship have had little impact – the MMA disease management demo seems to be failing; in commercial and Medicaid settings D.M. may have some, but limited, usefulness.
- In contrast, CMS just announced positive results from the Medicare physician group practice demo, which incentivizes, rather than bypasses, practices – mostly, but not only, large groups

We Should Not Expect Pay-for-Performance to Solve the Problem

- It focuses on marginal dollars and ignores the incentives in the basic payment system -- which drive behavior
- A lot of what we want physicians to do is not easily measurable. Are we looking under the light for the keys lost in the bushes?
- P4P can't easily address "overuse" and "misuse" quality dimensions, much less cost.
- We are still learning about P4P. Don't overload it.

The Bottom Line

- In Medicare, fixing the SGR problem – the accumulated $300 billion “deficit” in the budget baseline -- is the easy part
- The availability of PCPs, geriatricians, and even surgical generalists affects patient care and is in jeopardy -- for all payers and patients. Virtually no one is going into generalist specialties and primary care docs are burning out
- Current payment incentives affect the nature of care and costs and do not produce what changing demographics and chronic care burden require

The Bottom Line (cont.)

- A one-size fits all, RBRVS fee schedule no longer makes sense as physicians increasingly do very different things
  - Perhaps, PCPs need mixed FFS and prospective monthly payments (with a dash of P4P)
  - Surgeons could be paid for episodes (but addressing the bias to inappropriate surgical episodes)
  - Other specialists who perform one-time, discrete services might still be paid FFS for their services
- The payment system should promote integrated care, including multi-specialty groups, but not single specialty consolidation

Continuum of Approaches for Paying for "Medical Home" Services

- Aggressive, politically difficult RBRVS/fee schedule revaluations
- New CPT codes for targeted medical home activities
- A new payment, i.e. pmpm or pppm, for chronic care management activities to the practice on top of FFS payments
- Bundled payment for medical services and medical home activities – either a more improved pmpm or a hybrid FFS/bundled payment approach

FFS Revaluations

- Hope that better payment for E&M services cross-subsidizes medical home activities (as some are already included in pre and post service work, according to the RBRVS methodology
- Avoid difficult design issues of a formal medical home --
  - Who qualifies for payment, e.g. primary care or principal care?
  - The physician or the practice?
  - Is there a formal patient lock-in – hard or soft?
  - No obligation to hold any one accountable and all that that entails

FFS Revaluations -- Cons

- No obligation to hold any one accountable and all that that entails – in a FFS system, it might be putting good money after bad
- Politically difficult to redistribute within a fee schedule context
- A CPT code based payment system that pays for specific services cannot really accommodate the set of "soft" activities we want to promote

New CPT Codes for Particular Medical Home Activities

- Or particular services in the Chronic Care Model
- As examples, palliative care family conferences, “email consultations,” geriatric health assessment
- These should be included in CPT and paid for, but can’t really include most medical home or care coordination activities on a FFS payment basis, as discussed before
- Even here, face political obstacles to adoption from vested interests who are involved in CPT

Pmpm Payment for Medical Home and/or Chronic Care Management

- Assumes there is a definable and designated subpopulation that "qualifies" for additional activities supported with additional payment
  - Would small practices reengineer their processes for a small subset of patients which may make up a highly disproportionate share of health spending but not a relatively small share of their time and attention?
  - Compounded if not an all-payer approach

An Add-on PMPM Payment (cont.)

- Which raises the fundamental question, do all patients benefit from a medical home or should the approach be targeted to only some, for efficiency?
- How would eligible patients be selected – physician referral (then self-referral issues), history of high costs, data mining re conditions and co-morbidities – the issues that are relevant to eligibility for case management?

Bundled ("Capitated") Payments for All Services and All Patients or a FFS Hybrid

- The advantage is that all patients are included, so no practice dissonance for different patients and risk adjustment handles the fact that different patients have different needs for chronic care management
- But should medical home services be provided to everyone? Do they all want a home? Is this efficient? (But some of us think FFS sends wrong signals for all patients)
- Can we correct the execution errors of 1990s capitation approaches related to: insurance risk, absence of risk adjustment, mechanical actuarial conversion of pmpms under FFS to a situation when more is expected of the practice?

A FFS/Bundled Payment Hybrid

- Some very smart people, e.g., Joe Newhouse, have recommended a mixed approach to soften the effects of capitation and FFS payment incentives
- Some European primary care payment models, e.g. Denmark, is a hybrid
- But surely more complex operationally for the payer and maybe the practice and may negate some of the appeal of bundled/“capitated” payments

The Rhode Island Chronic Care Sustainability Initiative:

Building an Advanced Medical Home Pilot in Rhode Island

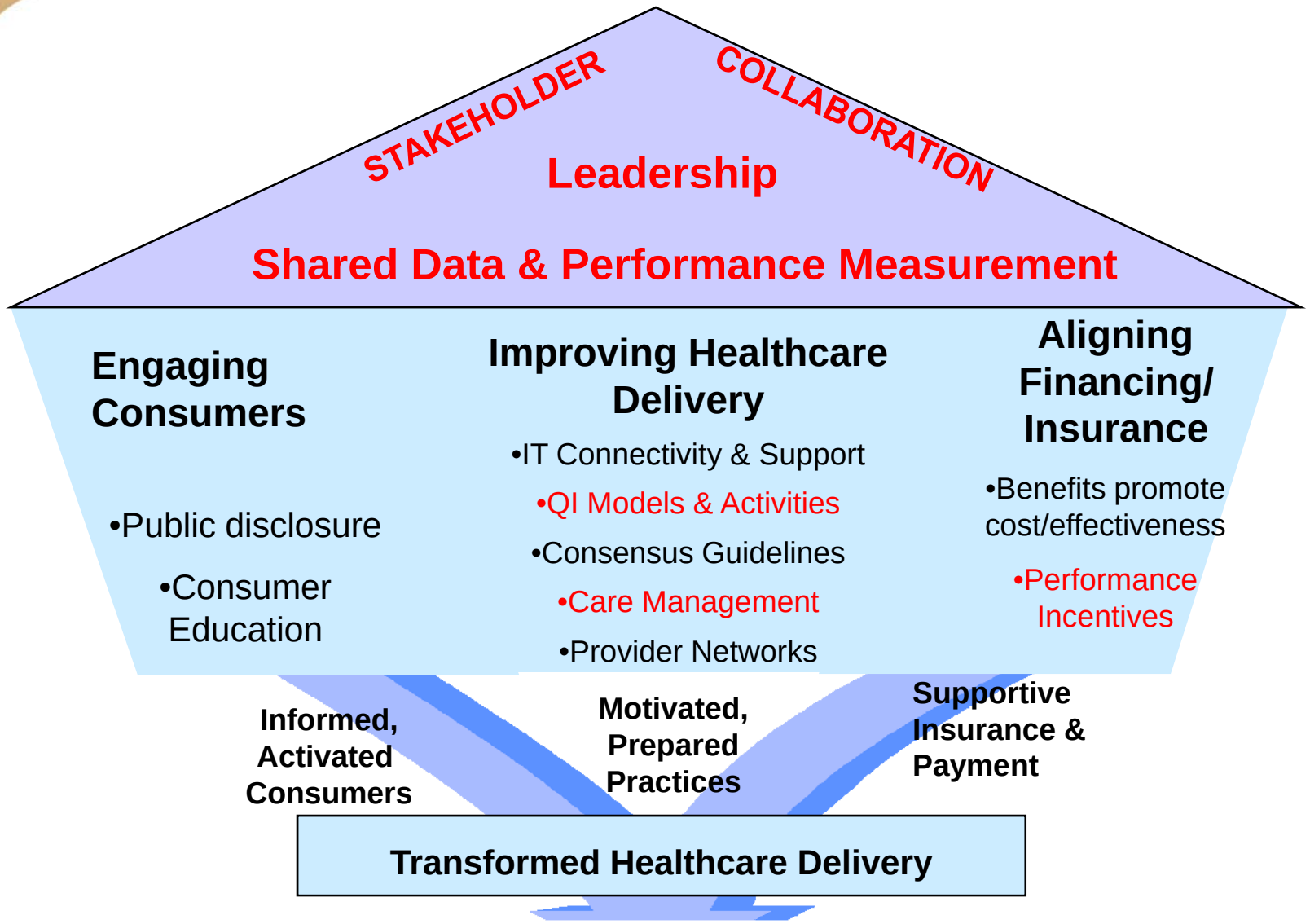
QUALITY PARTNERS OF RHODE ISLAND

Advancing Excellence in Healthcare

Participants in CSI Rhode Island

- **Payers** (representing 67% of insured residents)
  - Medicaid; all Commercial payers in Rhode Island (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, United HealthCare – New England)
- **Purchasers** (including 70,000 self-insured residents)
  - The two largest private sector employers (Care New England, Lifespan) Rhode Island Medicaid, State Employees - health benefits program, Rhode Island Business Group on Health
- **Providers**
  - Largest primary care provider organizations (including Community Health Centers and hospital based clinics), Rhode Island Medical Society
- **State**
  - Office of the Health Insurance Commissioner, Department of Human Services, Department of Health, Economic Development Corporation

QUALITY PARTNERS OF RHODE ISLAND



McColl Institute at Group Health

QUALITY PARTNERS OF RHODE ISLAND

Why An All-Payer Initiative?

Improved Quality, Reduced Costs, Stronger Primary Care

Fundamental Changes in Care Delivery

Investment in New Delivery Systems at the Practice Level

How do you build an All-Payer Initiative?

Elements of the CSI RI Pilot

- Common Practice Sites
  - All payers will select the same core group of practice sites in which to administer their pilot (although they may also have additional sites)
- Common Measures
  - All payers will agree to assess practices using the same measures, drawn from national measurement sets
- Common Services
  - All payers will agree to ask the pilot sites to implement the same set of new clinical services
- Common Conditions
  - Pilot sites will be asked by all payers to focus improvement efforts on the same chronic conditions
- Consistent Payment
  - Method and intent of incentive payments will be consistent across all payers

QUALITY PARTNERS OF RHODE ISLAND

Common Services: Selection

- Based on Patient-Centered Medical Home and Chronic Care Models
- Literature review: Which services linked to improved outcomes/costs
- Local Experience: History of Chronic Care Collaborative in State
- Feasibility

QUALITY PARTNERS OF RHODE ISLAND

Common Services:
The CSI RI "Key Services"

1. Link patients to providers
   - Mutual agreement between providers and payers

2. Care Coordination/Case Management
   - Planned visits, co-location or coordination with specialists, links to community resources, enhanced care team

3. Self-Management Support
   - Group Visits

QUALITY PARTNERS OF RHODE ISLAND

Common Services:
The CSI RI "Key Services"

4. EHR or Electronic Disease Registry
   - Specified functionality to support care management
5. Evidence-based guidelines embedded in clinical practice
6. Enhanced Access to Care
   - Choice of several methods

QUALITY PARTNERS OF RHODE ISLAND

Consistent Payment:
The Elephant in the Room

- Tentative agreement on: current FFS model, with enhanced PMPM for all members to pay for implementing “Key Services”
- Options for Linking PMPM to “Performance:”
  - Baseline practice qualification, then consistent PMPM throughout Pilot with Audit and Feedback of measures (favored by ACP, AAFP)
  - Consistent PMPM throughout Pilot, with available INCREASE in PMPM in second year if benchmarks are met
  - Consistent PMPM in Year 1, with performance benchmarks in Year 2 in order to receive level payment

QUALITY PARTNERS OF RHODE ISLAND

What's the "Right" PMPM?

- It Depends
- Variables:
  - Cover all costs, plus some increased income for providers?
  - Pay all practices the same, despite differences in prior investments?
  - What about FFS Medicare?
  - What about differences in case mix by provider?
  - Account for practice assistance provided by payers?

QUALITY PARTNERS OF RHODE ISLAND

CSI RI Approach to Payment

- Be transparent about costs
- Share as much information as possible across stakeholders
- Put objective assessment of costs on the table

QUALITY PARTNERS OF RHODE ISLAND

CSI Next Steps:

- Each plan developing contract amendments based on CSI Key Services and Measures, and own initiatives
- Contract amendments to be shared with group??????
- Procurement of cost estimate for implementing Key Services
- “Reconciliation” of each payer’s proposal to form a consistent CSI pilot
- Start date: Late 2007

QUALITY PARTNERS OF RHODE ISLAND

Deidre S. Gifford, MD, MPH
Chief, Health Policy and Programs
Quality Partners of Rhode Island
401-528-3255
dgifford1@riqio.sdps.org

QUALITY PARTNERS OF RHODE ISLAND