pcc primary care collaborative

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January webinar

Thursday, January 27
2:00 to 3:00 p.m. ET

PRIMARY CARE PAYMENT REFORM

Foundational Concepts and Approaches

MODERATOR

ANN GREINER, MCP

President & CEO, Primary Care Collaborative

agenda

01 PCC announcements and introductions

02 Presentation

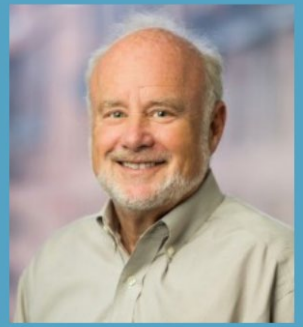
Robert A. Berenson, MD | Urban Institute

03 Discussion

- **Robert A. Berenson, MD** | Urban Institute
- **Peggy O'Kane** | The National Committee for Quality Assurance
- **Vivek Garg, MD, MBA** | Humana

04 Audience Q&A

Presenter



BOB BERENSON, MD

Fellow, Urban Institute

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Strengthening Primary Care Delivery Through Payment Reform: Issues in Implementing the NASEM Hybrid Model

Robert A. Berenson, MD
Institute Fellow, Urban Institute

Primary Care Collaborative Webinar

January 27, 2022

There are many ways for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary.

-- Jamie Robinson, Milbank Quarterly 2001

Salary

- In Robinson's caricature – "salary undermines productivity, condones on-the job-leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem"
- In the absence of a single payer, salary is not a practical approach for a third-party payer like Medicare
- Some multispecialty groups effectively use salary, if they have the culture to support it
- But the experience of hospitals purchasing primary care practices in the late 1990s and placing fee schedule-driven, entrepreneurial physicians on a guaranteed salary was not a positive one – leading to many divestments a few years later

Fee-for-service (FFS)

FFS rewards the provision of inappropriate services, fraudulent upcoding of visits and procedures, and the churning of “ping-pong” referrals among specialists.

Advantages

- Rewards industriousness/activity
- More readily compatible with benefit designs relying on patient cost-sharing
- Implicitly does risk adjustment – the sicker the patient, the more the services
- Long established – “Better the Devil We Know…”

Disadvantages

- Rewards excessive volume
- Pays only for what is codified and covered for payment – especially a problem in primary care where >25% of activities are not coded and paid
- Perpetuates silos of care
- High transaction/billing costs
- The MPFS is overly complex with 8000+ codes, modifiers, etc., making it susceptible to gaming and overt fraud on the one hand and underpayment on the other

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Note that FFS and a fee schedule are not synonymous. It is feasible to pay using bundled service codes, including a PMPM, as the MPFS already does commonly

Capitation

Robinson – “Capitation rewards the denial of appropriate service, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient.”

Advantages

- Lets clinicians determine how best to allocate time and resources to care for patients
- Lower transaction and billing costs (until the payer requires encounter information, reporting for risk adjustment and performance measurement, etc.)
- With many forces driving “more is better” – malpractice, consumerism, moral hazard of insurance, etc., payment that rewards more prudent spending is a counter-balance
- Predictable revenue stream, see Covid
- Promotes alignment of individuals to a practice for continuity, coordination, etc.

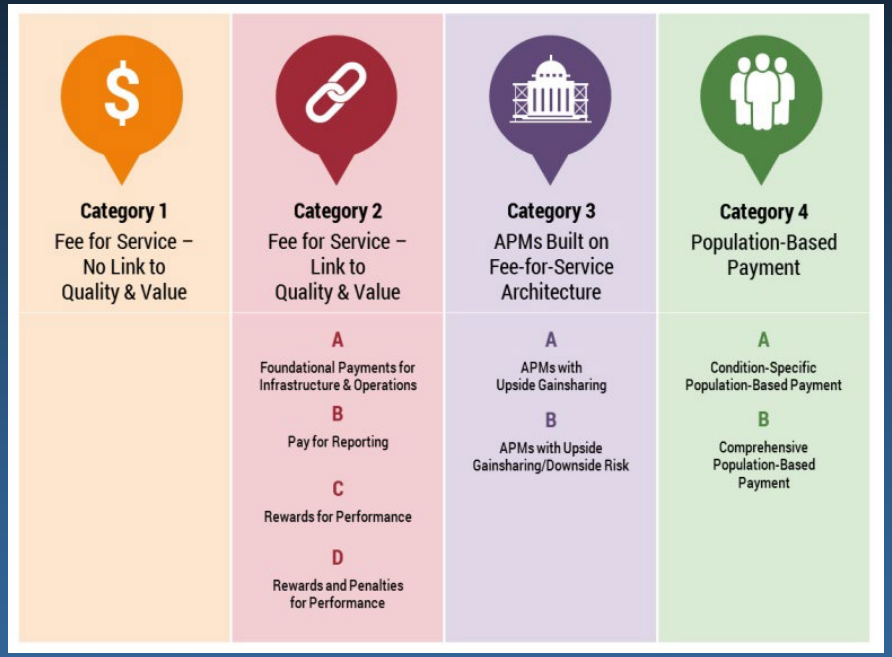
Disadvantages

- Potential for stinting, often in ways not readily detectable
- Requires risk adjustment, but less sophisticated and complex than with global capitation, reflecting the difference between performance risk and insurance risk
- Incentive to refer out liberally, so some form of downstream spending or utilization accountability is needed -- but not easy
- High-cost patients can overwhelm spending performance on most patients, if accountable for total cost of care. Risk adjustment models mis-estimate costs for high- and low-cost outliers

The special case of telehealth

- There is a fundamental mismatch between payment for most telehealth and FFS
  - High frequency, low price services should not be paid FFS because the billing costs are too high relative to appropriate payment
  - Coding for telehealth is arbitrary, ever changing as the technology changes, and is easily gameable by providers
  - Reduced time costs and inconvenience of office visits would increase volume greatly (unless benefit design included too high deductibles)
- Permanent "pay parity," as now under the Public Health Emergency, would likely set back prospects for alternative payment models, especially for primary care for a long time
- Thus, the desire to support telehealth implies the need for a hybrid, FFS/capitation method soon – "to make a virtue of necessity"

CMS/LAN APM Framework



How payment reform got off track

- All payment models have advantages and disadvantages. The HHS/CMS/LAN value continuum ignores that reality
  - In recent years, as much value has been produced with fee schedule reforms as with APMs
  - How clinicians spend their time and what they order or refer to others can affect value and spending as much as whether they assume financial risk
- There has been too much focus on elegant incentives, ignoring operational issues that can make APMs problematic, e.g., condition-based episodes suffer from misdiagnosis and need for severity adjustment, telehealth where billing costs exceed the payment
- Policy judgments often have been ideological/political rather than evidence-based, e.g., the outsized role of P4P (MIPS)
- Too much deference to providers' interests
  - "On-ramps" and "training wheels" in place far too long
  - Voluntary demos not very instructive for various reasons

"Ironically, metrics-based programs can undermine quality improvement by shifting resources and attention to measurement and reporting and away from actually improving care." – Goitein, Health Affairs, 2020, 39:264.

Generic payment approaches

to improving payment for primary care

All require <u>additional</u> funding – not budget neutral to current funding

1. Raise fee levels for primary care-oriented services and add new codes for care coordination, management, telehealth
2. Standard fee schedule with added PBPM payments for medical home-type activities, e.g., teams, care planning, telehealth
3. Hybrid -- reduced payments for the standard fee schedule and PBPM payments to cover cost of teams, telehealth, and activities not typically paid in a fee schedule – like CPC+
4. Reduced and simplified fee schedule payments -- (fewer codes, more accurate payments, etc.) and PBPM in roughly equal proportions – a new model
5. "Comprehensive" (capitation, PBPM) payments for most services, with a remnant of FFS for specific services, such as vaccinations (to get changing input prices right and improving likelihood particular services will be provided. (FFS has no value?)

Key design features of a #3-#4 blended payment model

- The desired mix of FFS and capitation
- Empanelment/alignment of beneficiaries to practices
- How best to risk adjust the capitation portion
- Which services to continue to pay FFS and how much
- What accountability should be adopted specific to the model, including whether primary care practices be accountable for total cost of care
- How best to build in accountability and/or incentives for practices to address health care disparities and imperative for greater equity
- The role for quality improvement projects
- Whether there is a way to “pass through” the new payment model to hospital-employed clinicians and promote independent practices

In health policy, magic bullet answers tend to have more appeal than incremental adjustments. Politicians faced with daunting issues in healthcare are eager to embrace new ideas promoted by academics and think tanks. However, in implementation, intrinsic flaws in design… tend to be ignored. Once launched, inconvenient data about cost savings and quality tend to be downplayed or ignored until intrinsic flaws become manifest, which would be a signal to embrace a new idea.

-- Naoki Ikegami, Int. J Health Policy Manag 2015, 4(9):635

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THANK YOU

Discussion

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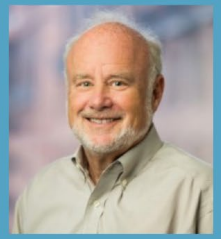		
BOB BERENSON, MD Fellow, Urban Institute	**PEGGY O'KANE** Founder and president, National Committee for Quality Assurance	**VIVEK GARG** Chief Medical Officer and SVP, Primary Care, Humana

Q&A