Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

Alternatives to Fee-for-Service in Primary Care: Insights from Multi-Payer Efforts and Research

OCTOBER 30, 2017 Crystal Gateway Marriott Hotel Arlington, VA

Welcome

Charles Fazio, MD, MS
PAC Chair
SVP and Medical Director,
HealthPartners, Inc.

Today's Panel

Bruce Landon

Professor of Health Policy,
Harvard Medical School

Professor of Medicine,
Beth Israel Deaconess Medical Center (BIDMC)

Internal Medicine Practitioner, BIDMC

Christiane LaBonte

Payment Policy & Operations Lead, Division of Advanced Primary Care

CMMI

Alicia Berkemeyer

Vice President, Enterprise Primary Care and Pharmacy Programs

Arkansas Blue Cross and Blue Shield

Dr. Peter Hollmann

Chief Medical Officer

Assistant Clinical Professor of Family Medicine

University Medicine, Rhode Island

Eileen Wood

Senior Vice President, Clinical Integration

Chief Pharmacy Officer

Capital District Physicians' Health Plan, Albany NY

Payment for Primary Care: Implications from a Microsimulation Model

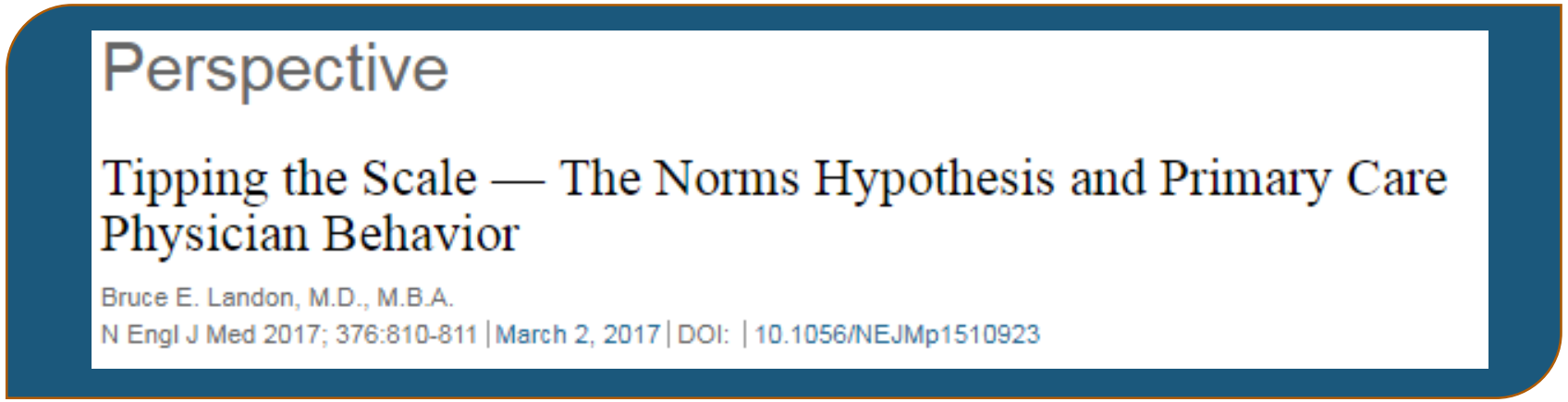
Bruce Landon, M.D., M.B.A.

- Department of Health Care Policy, Harvard Medical School
- Division of General Medicine and Primary Care, BIDMC

Background

PCMH demonstration programs to date have yielded relatively unimpressive results

- Successful in bringing additional resources to primary care
- But…little change in quality or utilization of services



- Our microsimulation model suggests that PCMH payment models used in most early evaluations were not sufficient to change practice

Source: Basu et al. **Effects of New Funding Models for Patient-Centered Medical Homes on Primary Care Practice Finances and Services: Results of a Microsimulation Model.** Ann Fam Med. **September/October 2016** vol. 14no. 5 **404-414**

Key Assumption

It is not rational to expect primary care practices to implement changes that adversely impact their costs or revenues

Changes in Care Delivery Strategies Under PCC

- Strategies to leverage physician effort enable time to care for larger panels
  - Expanded staff to handle lower level visits, telephone care, e-mail, e-visits, counseling, etc.
  - Enhanced triage to eliminate wasteful visits
  - Enhanced care coordination capabilities

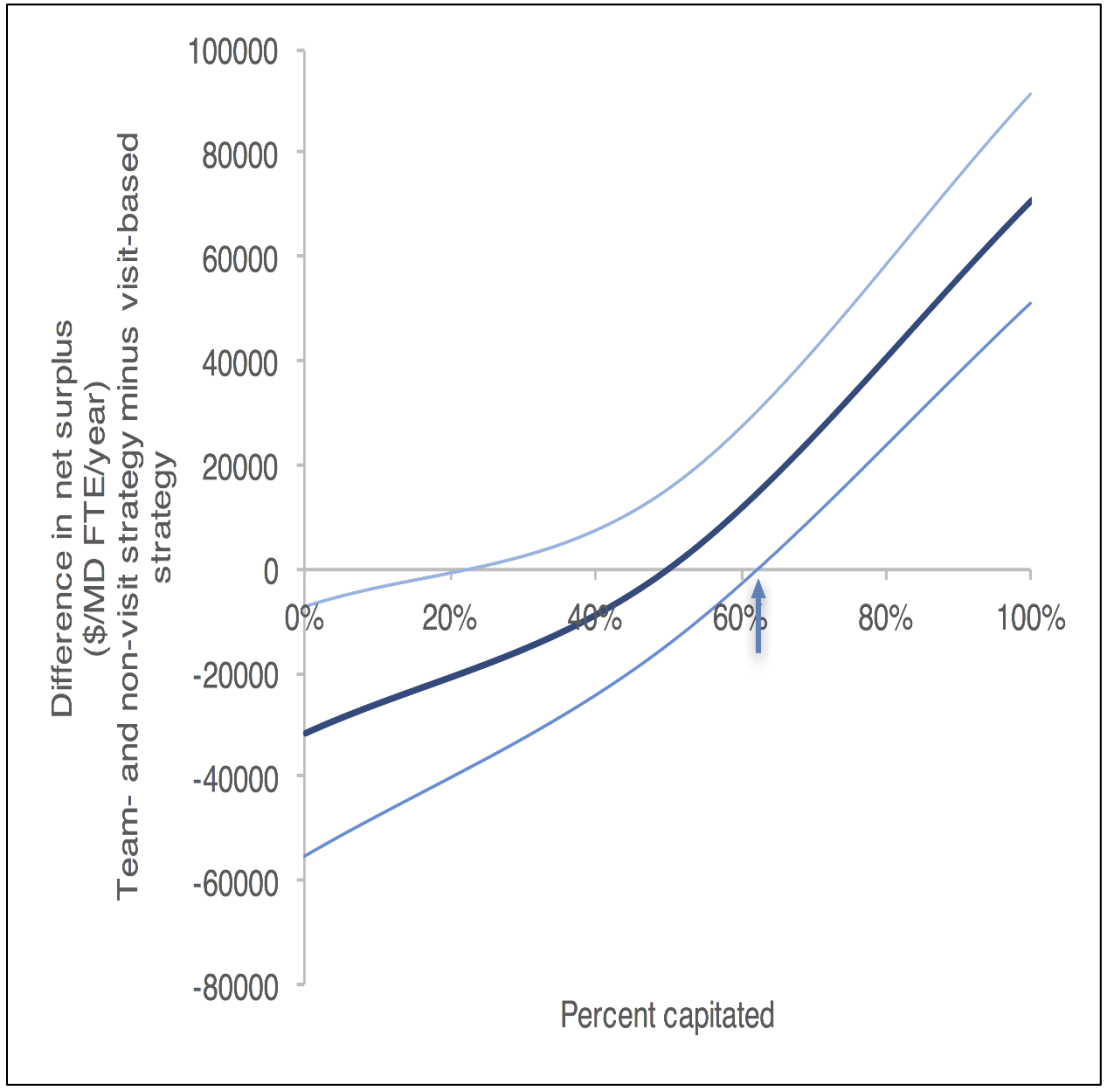
- Direct costs of above capabilities plus additional proportional overhead related to increased panel size

Results

Scenario	Metric	Payment Strategy		
		Traditional FFS	Capitation (at 110% prior year's FFS level)	
			50% capitation	100% capitation
Before transformation	Revenue	$530181	$556690	$583199
	Costs	$451893	$451893	$451893
	Net surplus	$78288	$104797	$131306
After transformation	Revenue	$528877	$613641	$698405
	Costs	$492987	$492987	$492987
	Net surplus	$35890	$120654	$205418
Change in net surplus ($/full-time MD/year)		$-42398	$15857	$74112

Capitation Threshold

- >63% capitation needed
- Varies little by changes in: # visits shifted, panel size, productivity, practice location
- But reduces with shared savings: to 56% under 0.6% shared savings



Take Home Points

- Success under different payment models requires that PCPs/practices do things differently
- Existing PCMH financing strategies will not be sufficient to motivate fundamental practice transformation
- Moving to PCC is promising, but thresholds are higher than most people thought

Thank you

landon@hcp.med.harvard.edu

Three Main Goals Underlie CPC+

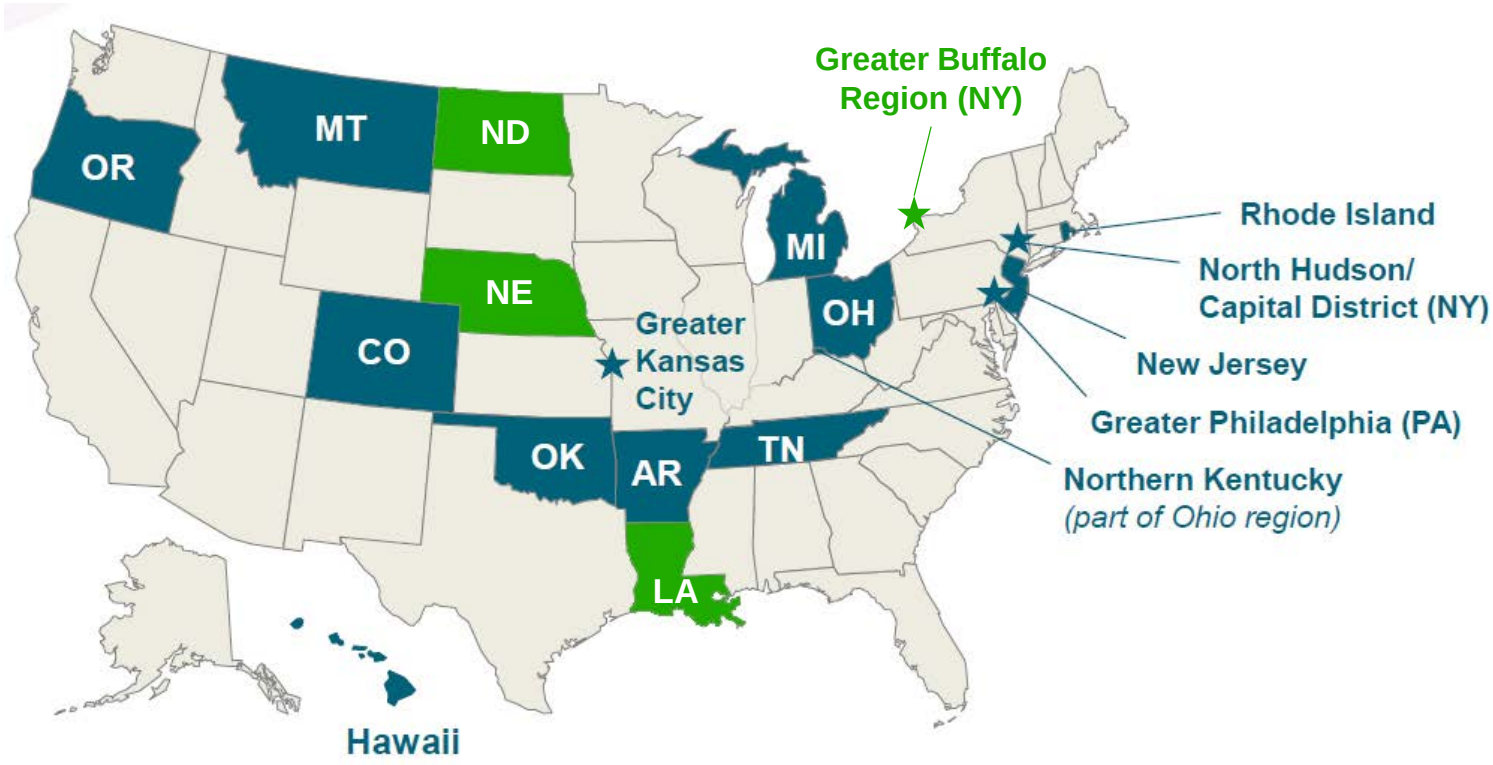
1. Advance care delivery and payment to allow practices to provide more comprehensive care that meets the needs of all patients, particularly those with complex needs

2. Accommodate practices at different levels of transformation readiness through two program tracks, both offered in every region

3. Achieve the core objectives of improving the quality and efficiency of primary care

CPC+ Program Overview

Structure, Participants, and Launch Dates



= Statewide Round 1 Region

= Statewide Round 2 Region

= Round 1 region comprising contiguous counties

= Round 2 region comprising contiguous counties

Practices

Over **2,800** practices participating in the model

Payers

Round 1 – 54 payers in 14 regions
Round 2 – 8 payers in 4 new regions + 5 additional payers in Round 1 regions

5 Years

1/1/2017 – Round 1 launch
1/1/2018 – Round 2 launch

Progress monitored quarterly

CPC+ Two Tracks

Track 1

Pathway for practices ready to build the capabilities to deliver comprehensive primary care.

Track 2

Pathway for practices poised to increase **comprehensiveness** of care through enhanced **health IT**, improve care of patients with **complex needs**, and inventory resources and supports to meet patients' **psychosocial needs**.

CPC+ Payment Innovations

To support the delivery of comprehensive primary care, CPC+ includes three payment elements:

	Care Management Fee (PBPM)	Performance-Based Incentive Payment	Underlying Payment Structure
Track 1	$15 average	$2.50 opportunity	Standard FFS
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

LAN Action Collaboratives

A LAN Action Collaborative (AC) provides a **results-oriented forum** for sharing, integrating, and applying new knowledge and tailoring solutions to **APM implementation challenges**.

This will support **committed** participants with a **shared aim** to take more effective **action** in their organizations to **increase effective implementation of APMs** that make a **collective impact** on the U.S. health care system.

The Role Of The PAC

The Intersection of the PAC and CPC+

REGIONAL

NATIONAL

CPC+

Multi-payer primary care APM designed to support practice-level transformation in 18 regions by encouraging regional payers to align alternative payment model, data sharing, and quality measure approaches

SHARED MILESTONES

Seeking solutions that enable better care to multi-payer primary care APM implementation challenges, such as:

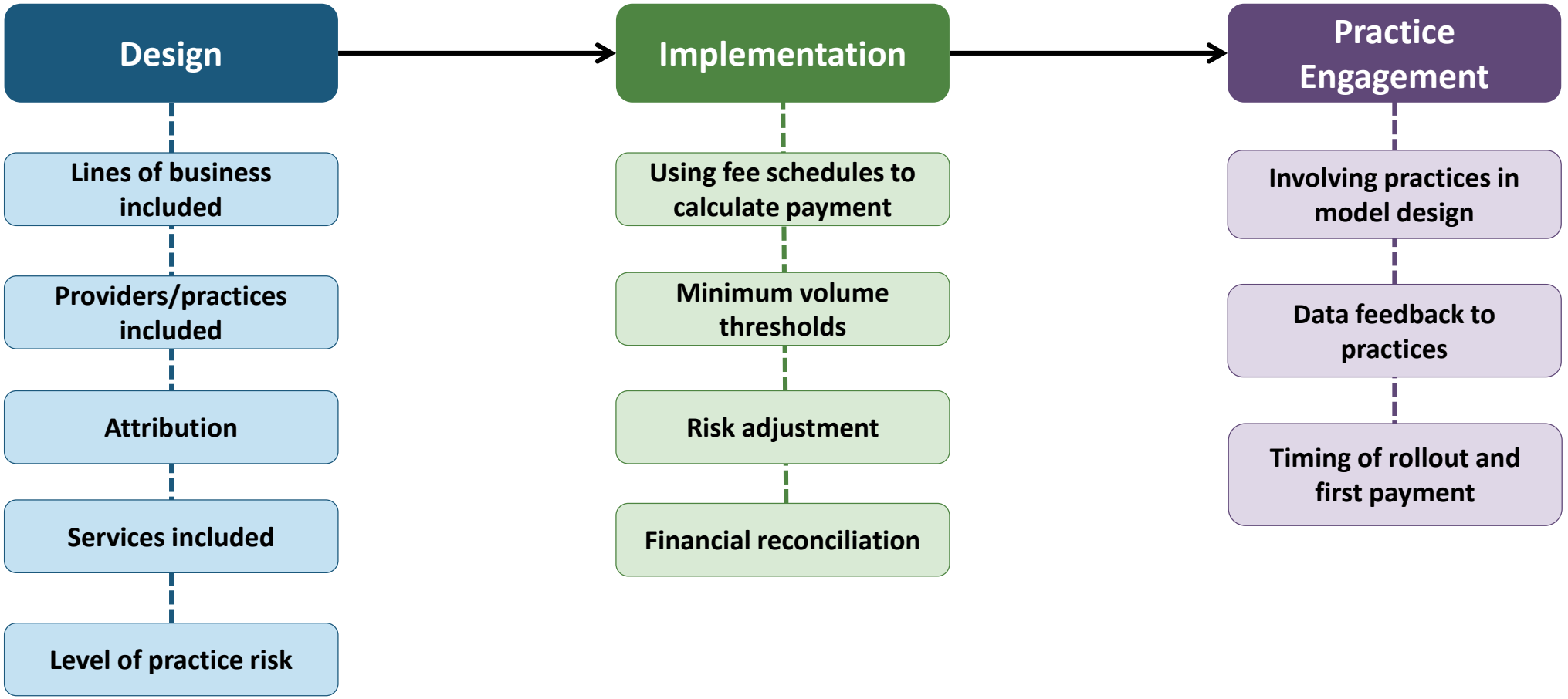
- Aggregating multi-payer data
- Aligning quality measures
- APM payment issues
- TCOC considerations

PAC

Establishes a national table for regional CPC+ payers to collaboratively identify and implement solutions, share promising practices, and accelerate progress towards successful implementation of APMs in primary care

Strengthening collaboration and empowering participants to take action to advance APM adoption as part of improving primary care delivery and outcomes

Track 2 Alternative to FFS Payment: PAC Work Flow



LAN Resources

https://hcp-lan.org/resources/

Exit Survey

We want to know what you think!

Please take a moment to complete the exit survey so we can continue to improve and enrich the LAN.
https://www.surveymonkey.com/r/lansummitsession

Contact Us

We want to hear from you!

www.hcp-lan.org

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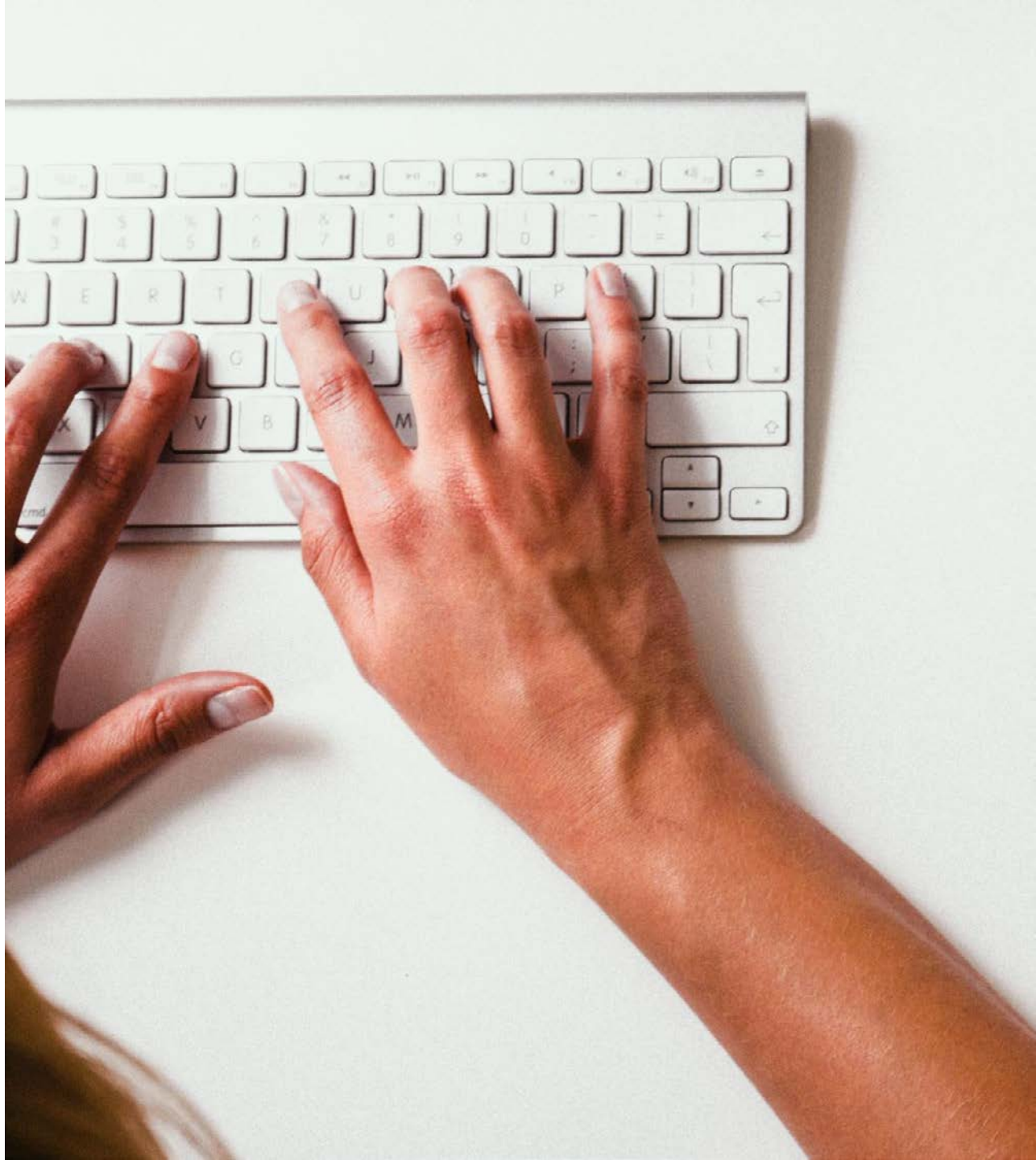

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Thank You!

Back Up Slides

Team Members

- Sanjay Basu, MD, PhD
  - Stanford University, Prevention Research Center; Institute for Economic Policy Research; Centers for Health Policy, Primary Care & Outcomes Research
- Asaf Bitton, MD, MPH
  - Harvard Medical School, Center for Primary Care; Ariadne Labs; Center for Medicare & Medicaid Innovation
- Bruce Landon, MD, MBA, MSc
  - Harvard Medical School, Department of Health Care Policy
- Russ Phillips, MD
  - Harvard Medical School, Center for Primary Care
- Zirui Song, MD, PhD
  - Harvard Medical School; Massachusetts General Hospital, Department of Medicine

HARVARD MEDICAL SCHOOL | Department of Health Care Policy

Stanford | CHP/PCOR Center for Health Policy/Center for Primary Care and Outcomes Research

CENTER FOR PRIMARY CARE
HARVARD MEDICAL SCHOOL

Avoidable or Triage-able Visits

Principal diagnosis	ICD-9 Code	Proportion of all visits (%)	Avoidable visits[1], among visits for the principal diagnosis (%)	Triage-able visits[2], among visits for the principal diagnosis (%)
Hypertension	401.9	8.4	23.7	53.0
Diabetes	250	6.3	19.5	54.3
Routine exam	V700	4.2	17.0	36.0
Hyperlipidemia	272.4	1.9	14.1	42.7
URI	465.9	1.6	7.6	61.8

Avoidable visits: visits for a routine chronic problem for which the treating physician did not order any laboratory studies, imaging studies, medications, or provide any health education/counseling.

Triage-able visits: visits for which no new diagnostic codes were assigned to a patient, and no laboratory studies, imaging studies, or medications were ordered by the physician.

Potential Impact on Panel Size