

# How Payment Reform Could Enable Primary Care to Respond to COVID-19

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## Policy Points

- > Prospectively paid, risk-adjusted per member per month payments allow clinicians on the front lines of care to adapt to challenges fluidly and meet the needs of their patients and communities as they arise.
- > The Centers for Medicare and Medicaid Services should set the course for the nation's primary care practices by universally implementing the Primary Care First model for Medicare now and providing similar guidance for state Medicaid agencies.

## ABSTRACT

Primary care practices across the country are transforming the way they provide care—in some cases literally overnight—in response to the COVID-19 pandemic. Practices are devising new protocols to isolate patients with possible COVID-19, navigating shortages of personal protective equipment, providing behavioral health support to patients with emotional distress from social isolation, and managing as much care as possible through telehealth. To better equip practices for such changes, primary care payment reform is needed, both to provide sufficient funds for transformation and to uncouple payment from the delivery of specific services.

## THE NEED FOR PRIMARY CARE PAYMENT REFORM

On March 6, the Centers for Medicare and Medicaid Services (CMS) expanded Medicare's coverage of telehealth, allowing for continued delivery of care while protecting patients from potential exposures.<sup>1</sup> That such a ruling was needed at all highlights the deficiencies in the way that primary care is currently paid for. Despite efforts over the last several years to advance payment reform, the majority of primary care is still paid for on a fee-for-service (FFS) basis.<sup>2</sup> FFS is frequently criticized for incentivizing volume over value, but not enough attention is paid to another severe flaw: payment that is retroactive and tied to delivery of specific covered services does not allow for clinicians to flexibly design and deliver care.

In advanced primary care models, an interprofessional team provides more accessible, comprehensive, and coordinated physical and behavioral health services longitudinally. Increased access includes non-face-to-face care such as video and telephone visits. While crucial during a pandemic, virtual visits are also appropriate and beneficial for many needs year-round. Yet primary care practices have been struggling to implement

such advanced care models for years because business models and payment policies have not kept pace.

Non-face-to-face visits are just one example of countless primary care approaches and tasks that are not covered under current FFS codes. Other unreimbursed care may include quality improvement meetings, asynchronous communication with patients, and employing non-billable care team members such as community health workers.

## First Steps

Prospectively paid, risk-adjusted per member per month (PMPM) amounts, independent of the specific services delivered, allow clinicians on the front lines of care to adapt to challenges fluidly and meet the needs of their patients and communities as they arise. Customization and application of the best solutions for each patient—personalized, relationship-based care—can be implemented without regard to what fees are paid for what service by what provider.

The Comprehensive Primary Care Plus (CPC+) Track 2 model, a demonstration project of the Centers for Medicare and Medicaid Innovation (CMMI), began work in this direction for participating practices by decreasing FFS reimbursement while providing a care management PMPM.<sup>3</sup> In 2017, the median care management fee was \$11.25 PMPM,<sup>4</sup> insufficient to cover the myriad primary care activities not reimbursed through FFS codes.

Primary Care First, another CMMI demonstration project slated to start in 2021, builds on the CPC+ Track 2 model.<sup>5</sup> In this model, the majority of primary care payments take the form of a PMPM, with an additional reduced flat rate for visits and performance-based adjustments. Primary Care First has calculated an estimated PMPM amount ranging from \$28 to \$175, depending on the practice's average Hierarchical Condition Category (HCC) score. The HCC score is used to predict costs based on an individual patient's diagnoses and demographic factors. These PMPM amounts are calibrated to represent about 60% of the total primary care payment.<sup>6</sup> Previous studies have estimated at least 63% of practice payment would need to be prospective to enable practice-wide transformation.<sup>7</sup>

The Primary Care First model improves upon early iterations of capitation by risk-adjusting payments for the patient population. Risk adjustment ensures practices caring for patients with greater health care needs have adequate funds to address those needs. Additionally, the model incorporates a linkage to quality through performance-based adjustments and limits the financial risk to primary care practices to costs under their control.

## Primary Care First for All

CMS should set the course for the nation's primary care practices by universally implementing the Primary Care First model for Medicare now and providing similar guidance for state Medicaid agencies. Commercial payers and self-insured employer-based health plans should follow suit. Congress should enact legislation to enable this change and drive progress. While piloting Primary Care First as a demonstration project moves the needle in the right direction, all practices need more flexible payment, and waiting for results before scaling such payment reform means five more years of most practices continuing to be unable to optimally meet their patients' needs. The urgent need for primary care payment reform demands wide-scale change now. The COVID-19 pandemic has made this all the more urgent. The loss of revenues from face-to-face visits is placing some practices in danger of closing their doors.<sup>8</sup>

While Primary Care First is one of the most promising alternative payment models for primary care, it will not be perfect. This dramatic change in primary care payment has the potential for several unintended consequences. (See Table 1.)

First, implementation may be more difficult for practices with limited prior experience in practice transformation. This may be an issue particularly in smaller independent practices that lack the resources of a larger system. For such practices, beginning with an initial step of providing an intermediate PMPM alongside decreased FFS reimbursements similar to CPC+ Track 2 may allow for a successful transition. To ensure that practices are prepared to use proactive funds to advance models of care, practice transformation support from CMS will be necessary.

Second, without multipayer participation and alignment, the overall prospective funds at the practice level will be insufficient to enable significant practice change, and practices will experience increased administrative burden. If, for example, a practice receives a PMPM tied to particular requirements from a payer that covers 20% of their patient population, can they afford to implement and systematize a practice-wide change? If not, are they to provide tiered care based on each patient's payer source?

Third, if risk adjustment methodologies are inadequate, practices may have insufficient funds to care for sicker patients. CMS may find that averaging an HCC score for the practice does not sufficiently account for within-practice variation of needs. Accounting for community-level risk based on social factors may improve risk prediction.<sup>9,10</sup>

**Table 1. Pros and Cons of Different Payment Models and Payment Model Features for Primary Care**

	Payment model or feature	Description	Pros	Cons	Who Bears Financial Risk	Operational Issues
Base payment model	Fee-for-service (FFS)	Retrospective reimbursement based on certain billing codes for specific services to patients	<ul style="list-style-type: none"> <li>• Can be used to encourage underutilized services</li> </ul>	<ul style="list-style-type: none"> <li>• Encourages greater volume</li> <li>• Redesigned services have to be added to billing codes piecemeal</li> </ul>	<ul style="list-style-type: none"> <li>• Insurers</li> <li>• Patients via cost-sharing mechanisms (deductibles, coinsurance)</li> </ul>	<ul style="list-style-type: none"> <li>• Current fee schedule favors procedural over cognitive care, leading to overall inadequate amounts of primary care reimbursement</li> </ul>
	Capitation	Prospective payment for the full range of health care services of a specific population for a fixed period of time	<ul style="list-style-type: none"> <li>• Enables greater flexibility and innovation in care delivery</li> <li>• Encourages cost control</li> <li>• Simplifies billing</li> </ul>	<ul style="list-style-type: none"> <li>• Potential for insufficient funds for higher needs patients</li> </ul>	<ul style="list-style-type: none"> <li>• Practices/providers</li> </ul>	<ul style="list-style-type: none"> <li>• Without risk adjustment, amounts inadequate for patients with greater needs</li> <li>• Overall amounts inadequate if rates based on historic FFS reimbursement</li> </ul>
	Blended FFS and Capitation	FFS plus prospective payment; prospective component may be specific to certain care elements (e.g. care coordination).	<ul style="list-style-type: none"> <li>• Balances pros of FFS and capitation, favoring whichever model is the predominant portion of practice payment</li> </ul>	<ul style="list-style-type: none"> <li>• Balances cons of FFS and capitation, favoring whichever model is the predominant portion of practice payment</li> </ul>	<ul style="list-style-type: none"> <li>• Blend of insurers and practices/providers</li> </ul>	<ul style="list-style-type: none"> <li>• Predominance of FFS over capitation may not reach a tipping point that enables restructuring practice</li> </ul>
Payment model feature	Pay-for-performance (P4P)	Payment for achieving or improving upon defined metrics.	<ul style="list-style-type: none"> <li>• Encourages improved quality and/or reduced costs</li> </ul>	<ul style="list-style-type: none"> <li>• Increases administrative burden</li> </ul>	<ul style="list-style-type: none"> <li>• Underlying model plus additional risk and/or reward to practices/providers</li> </ul>	<ul style="list-style-type: none"> <li>• Measures used often focus on single diseases and processes rather than whole person outcomes or key components of high-quality primary care</li> </ul>
	Shared Savings	Bonus payment for keeping costs below a benchmark if set quality targets are met. If two-sided model, at risk of penalty if benchmark is exceeded.	<ul style="list-style-type: none"> <li>• Encourages cost control</li> <li>• Links ability to receive savings to meeting quality targets</li> </ul>	<ul style="list-style-type: none"> <li>• May lead to inappropriate underutilization of services</li> </ul>	<ul style="list-style-type: none"> <li>• Underlying model plus additional risk and/or reward to practices/providers</li> </ul>	<ul style="list-style-type: none"> <li>• Basing benchmarks on historic expenditures can perversely reward prior inefficiency</li> <li>• Conflicting messages if providers are paid FFS</li> </ul>
	Risk adjustment	Adjustment based on patient and/or community characteristics to reflect anticipated costs	<ul style="list-style-type: none"> <li>• Makes payments more commensurate with costs</li> </ul>	<ul style="list-style-type: none"> <li>• May encourage upcoding</li> </ul>	<ul style="list-style-type: none"> <li>• Underlying model with decreased risk to practices/providers</li> </ul>	<ul style="list-style-type: none"> <li>• Most models of risk adjustment do not account for community-level risk, which improves predictive ability</li> </ul>



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Fourth, performance measures have the potential to detract from patient-centered care. The evidence from pay-for-performance programs to date suggests they have increased administrative burden and negatively impacted continuity of care while only leading to small improvements in quality.<sup>11,12,13</sup> Newer patient-oriented primary care measures<sup>14</sup> and measures designed to assess the pillars of primary care (comprehensiveness,<sup>15</sup> continuity,<sup>16</sup> coordination, access) are promising developments to consider in future iterations of the Primary Care First model.

These challenges, however, do not necessitate waiting before scaling broadly; the potential benefits of enacting wide-scale prospective payment outweigh the potential risks. Instead, CMS should plan for rapid-cycle improvements. Features of the model—risk adjustment methodology, selection of performance measures—should be continuously reassessed and adjustments made accordingly.

### **Creating a Flexible System of Payment for the Future**

While the COVID-19 pandemic is unprecedented, there are always new challenges to face or changes to adapt to in primary care. The need for flexibility in care delivery is not new, and it will not disappear after COVID-19 cases begin to decrease. A system based in FFS where codes for service delivery must be added piecemeal to allow for primary care to do all that it needs to do now and in the future will always put us behind. Managing the immediate needs of patients during this crisis should not mean pressing pause on crucial improvements to our systems of care that are needed concurrently. Let us implement Primary Care First now for all practices and enable the largest platform of health care delivery to adapt to meet people's needs—for the current COVID-19 crisis, for routine care, and for future crises yet unknown.

## NOTES

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