Issue Brief
May 2020

Milbank Memorial Fund
Using evidence to improve population health.

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

By Stephanie B. Gold, MD, Larry A. Green, MD, and John M. Westfall, MD, MPH

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 urgent need for primary care payment reform demands wide-scale change now.

Update: This brief was revised on April 30, 2020 to incorporate additional information.

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.[1] 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.[2] 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 health care providers 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.

> **A system based in fee-for-service where codes for service delivery must be added piecemeal to allow primary care to do all that it needs to do will always put us behind.**

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 Center for Medicare and Medicaid Innovation (CMMI), began work in this direction for participating practices by decreasing FFS reimbursement while providing a prospective payment called a Comprehensive Primary Care Payment (CPCP) in addition to a care management PMPM that is risk-adjusted based on Hierarchical Condition Category (HCC) scores.[3] The HCC score is used to predict costs based on an individual patient's diagnoses and demographic factors. In 2017, the median care management fee was $11.25 PMPM averaged across payers. Medicare provided the largest care management fee at $28 PMPM. The majority of Track 2 practices elected to have the CPCP cover only 10% of total Medicare payments for selected evaluation and management services, though they will be required to select increasingly higher proportions in subsequent years.[4] Most other payers had not yet developed their own CPCP-equivalent in the first year of the program. These amounts have been insufficient to cover the myriad primary care activities not reimbursed through FFS codes-only 51% of Track 2 practices reported the Medicare payments were adequate to transform care and only 33% reported other payers' payments were adequate.[5]

Primary Care First, another CMMI demonstration project slated to start in 2021, builds on the CPC+ Track 2 model.[6] In this model, the majority of primary care payments take the form of a PMPM for all practices, with an additional reduced flat rate for visits and potential for upside and downside performance-based adjustments. Primary Care First has calculated an estimated Medicare PMPM amount ranging from $28 to $175 depending on the practice's average HCC score. These PMPM amounts are calibrated to represent about 60% of the total primary care payment.[7] Previous studies have estimated at least 63% of practice payment would need to be prospective to enable practice-wide transformation.[8] However, the total practice payment is designed to be budget neutral for CMS, so while it shifts from retrospective to prospective payment, this does not provide increased support

to most practices. Notably, CMS is soliciting proposals from other payers to offer alternative payments similar to Medicare in this model, but practices apply to Primary Care First before this is established, unlike the process for CPC+, where multipayer participation was assured in advance.

While there are many details in design and implementation of alternative payment models that complicate comparisons, breaking down these models into their underlying component parts supports understanding of broad conceptual similarities and differences (see Table 1).

Primary Care Payment Reform for All

CMS should set the course for the nation's primary care practices by universally instituting risk-adjusted, prospective PMPMs for the majority of primary care

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	• Can be used to encourage underutilized services	• Encourages greater volume • Redesigned services have to be added to billing codes piecemeal	• Insurers • Patients via cost-sharing mechanisms (deductibles, coinsurance)	• Current fee schedule favors procedural over cognitive care, leading to overall inadequate amounts of primary care reimbursement
	Capitation	Prospective payment for the full range of health care services of a specific population for a fixed period of time	• Enables greater flexibility and innovation in care delivery • Encourages cost control • Simplifies billing	• Potential for insufficient funds for higher needs patients	• Practices/ providers	• Without risk adjustment, amounts inadequate for patients with greater needs • Overall amounts inadequate if rates based on historic FFS reimbursement
	Blended FFS and Capitation	FFS plus prospective payment; prospective component may be specific to certain care elements (e.g. care coordination).	• Balances pros of FFS and capitation, favoring whichever model is the predominant portion of practice payment	• Balances cons of FFS and capitation, favoring whichever model is the predominant portion of practice payment	• Blend of insurers and practices/ providers	• Predominance of FFS over capitation may not reach a tipping point that enables restructuring practice
Payment model feature	Pay-for-performance (P4P)	Payment for achieving or improving upon defined metrics.	• Encourages improved quality and/or reduced costs	• Increases administrative burden	• Underlying model plus additional risk and/or reward to practices/ providers	• Measures used often focus on single diseases and processes rather than whole person outcomes or key components of high-quality primary care
	Shared Savings	Bonus payment for keeping costs below a benchmark if set quality targets are meet. If two-sided model, at risk of penalty if benchmark is exceeded.	• Encourages cost control • Links ability to receive savings to meeting quality targets	• May lead to inappropriate underutilization of services	• Underlying model plus additional risk and/or reward to practices/ providers	• Basing benchmarks on historic expenditures can perversely reward prior inefficiency • Conflicting messages if providers are paid FFS
	Risk adjustment	Adjustment based on patient and/or community characteristics to reflect anticipated costs	• Makes payments more commensurate with costs	• May encourage upcoding	• Underlying model with decreased risk to practices/ providers	• Most models of risk adjustment do not account for community-level risk, which improves predictive ability

payments in 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 CPC+ and Primary Care First as demonstration projects 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.[9]

Elements of CPC+ and Primary Care First highlight several key issues in scaling comprehensive primary care payment reform.

First, current primary care payment is inadequate both because it is retroactive and tied to specific services and because the overall amount is insufficient; both the "how" and "how much" are crucial. Simply shifting historic FFS amounts to equivalent prospective payments does not address the issue of systematic underinvestment in primary care.

Second, 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 also be necessary. This support should include assistance with practice finance management for alternative payments. In CPC+, payers noted that some practices were not ready to accept alternative payments or were encountering barriers in needing to switch their claims processing systems to accommodate these payments.[10]

Third, 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?

Fourth, if risk adjustment methodologies are inadequate, practices may have insufficient funds to care for sicker patients. Methods such as averaging an HCC score for the practice will likely not sufficiently account for within-practice variation of needs. Accounting for community-level risk based on social factors may improve risk prediction.[11,12]

Finally, 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.[13,14,15] Newer patient-oriented primary care measures[16] and measures designed to assess the pillars of primary care (comprehensiveness,[17] continuity,[18] coordination, access) are promising developments to consider. Additionally, the potential for downside performance adjustments of up to 10% in Primary Care First may introduce too much financial risk for practices.

These challenges, however, do not necessitate waiting before implementing comprehensive payment reform broadly; the potential benefits of enacting wide-scale prospective payment outweigh the potential risks. If we let perfect be the enemy of the good, primary care practices and their patients will suffer. Instead, CMS should plan for rapid-cycle improvements. Features of comprehensive payment reform—risk adjustment methodology, selection of performance measures—should be continuously reassessed and adjustments made accordingly. More important than the specific model chosen is that we move toward the majority of practice payment as a risk-adjusted, prospective amount; multipayer alignment; and limited adjustments for performance based on primary care appropriate, patient-centered measures.

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 risk-adjusted, prospective primary care payments 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

[1] Telehealth. Medicare.gov: The Official U.S. Government Site for Medicare. https://www.medicare.gov/coverage/telehealth. Accessed April 10, 2020.

[2] Rama A. Payment and delivery in 2016: the prevalence of medical homes, accountable care organizations, and payment methods reported by physicians. American Medical Association Policy Research Perspectives. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/prp-medical-home-aco-payment.pdf. Published 2017. Accessed April 10, 2020.

[3] Comprehensive Primary Care Plus. Centers for Medicare & Medicaid Services website. https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus. Updated April 8, 2020. Accessed April 10, 2020.

[4] Peikes D, Anglin G, Harrington M, et al. Independent evaluation of Comprehensive Primary Care Plus (CPC+): first annual report. Mathematica. https://www.mathematica.org/our-publications-and-findings/publications/independent-evaluation-of-comprehensive-primary-care-plus-cpc-first-annual-report. Published April 2019. Accessed April 10, 2020.

[5] 5Ibid.

[6] Primary Care First Model Options. Centers for Medicare & Medicaid Services website. https://innovation.cms.gov/innovation-models/primary-care-first-model-options. Updated April 8, 2020. Accessed April 10, 2020.

[7] Webinar: Primary Care First Model Options-Payment. Centers for Medicare & Medicaid Services website. https://innovation.cms.gov/webinars-and-forums/pcf-payment-webinar. Updated November 22, 2019. Accessed April 10, 2020.

[8] Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High levels of capitation payments needed to shift primary care toward proactive team and nonvisit care. *Health Affairs*. 2017;36(9):1599-1605.

[9] Quick COVID-19 primary care survey. The Larry A. Green Center and the Primary Care Collaborative. https://www.green-center.org/s/C19-Series-3-National-Sample-Executive-Summary-7zjf.pdf. Accessed April 10, 2020.

[10] Peikes D, Anglin G, Harrington M et al. Independent evaluation of Comprehensive Primary Care Plus (CPC+): first annual report. Mathematica. https://www.mathematica.org/our-publications-and-findings/publications/independent-evaluation-of-comprehensive-primary-care-plus-cpc-first-annual-report. Published April 2019. Accessed April 10, 2020.

[11] Hu J, Kind AJH, Nerenz D. Area deprivation index predicts readmission risk at an urban teaching hospital. *Am J Med Quality*. 2018;33(5):493-501.

[12] Ash AS, Mick EO, Ellis RP, Kiefe CI, Allison JJ, Clark MA. Social determinants of health in managed care payment formulas. *JAMA Intern Med.* 2017;177(10):1424-1430.

[13] Gillam SJ, Siriwardena AN, Steel N. Pay-for-performance in the United Kingdom: impact of the Quality and Outcomes Framework—a systematic review. *Ann Fam Med*. 2012;10:461-468.

[14] Roland M, Olesen F. Can pay for performance improve the quality of primary care? *BMJ*. 2016; 354:i4058.

[15] Roland M, Guthrie B. Quality and Outcomes Framework: what have we learnt? *BMJ*. 2016;354:i4060.

[16] Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A new comprehensive measure of high-value aspects of primary care. *Ann Fam Med*. 2019;17:221-230.

[17] Bazemore A, Petterson S, Peterson LE, Phillips RL. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. *Ann Fam Med*. 2015;13:206-213.

[18] Bazemore A, Petterson S, Peterson LE, Chung Y, Phillips RL. Higher primary care physician continuity is associated with lower costs and hospitalizations. *Ann Fam Med*. 2018;16:492-497.

AUTHORS

Stephanie B. Gold, MD, is a practicing family physician at a federally qualified health center in Denver, Colorado, a scholar at the Eugene S. Farley, Jr. Health Policy Center and an assistant professor in the Department of Family Medicine at the University of Colorado. Her research and policy work focuses on payment reform for primary care and integrating behavioral and social health with primary care. She serves on the executive committee of the board of the Colorado Academy of Family Physicians and is a member of the Colorado Primary Care Payment Reform Collaborative.

Dr. Gold completed medical school at the University of Virginia, family medicine residency at the University of Colorado - Denver Health Track, and a health policy fellowship with the Farley Center following residency.

Larry A. Green, MD, is distinguished professor of family medicine and the Epperson-Zorn Chair for Innovation in Family Medicine and Primary Care at the University of Colorado and senior advisor to the Eugene S. Farley Jr. Health Policy Center. He is an academic family physician who has served in various roles including medical practice in rural and urban settings, residency director, investigator, teacher, and department chair. He directed Prescription for Health, funded by the Robert Wood Johnson Foundation focused on addressing unhealthy behaviors in primary care practice and Advancing Care Together funded by the Colorado Health Foundation, aiming to change a broad spectrum of practices to provide integrated care. He served as the founding director of the Robert Graham Center for Policy Studies in Family Medicine and Primary Care in Washington, DC, and is a member of the National Academy of Medicine. His current work emphasizes redesigning how clinical practice, health professions education, and clinical research are done.

Dr. Green completed medical school at Baylor College of Medicine and family medicine residency at the University of Rochester.

John M. Westfall, MD, MPH, is a family doctor in Washington, DC, and director of the Robert Graham Center for Policy Studies in Family Medicine and Primary Care. Dr. Westfall was on the faculty of the University of Colorado for over 20 years, including serving as associate dean for rural health, director of community engagement for the Colorado Clinical Translational Science Institute, AHEC Director, and senior scholar at the Eugene S. Farley Jr. Health Policy Center. After joining the faculty at the University of Colorado Department of Family Medicine, Dr. Westfall started the High Plains Research Network, a geographic community and practice-based research network in rural and frontier Colorado. He practiced family medicine in several rural communities including Limon, Ft. Morgan, and his hometown of Yuma, Colorado.

In 2019, he completed two years as the medical director for Whole Person Care and Health Communities at the Santa Clara County Health and Hospital and Public Health Department. His research interests include rural health, linking primary care and community health, and policies aimed at assuring a robust primary care workforce for rural, urban, and vulnerable communities.

He completed his MD and MPH at the University of Kansas School of Medicine, an internship in hospital medicine in Wichita, Kansas, and his family medicine residency at the University of Colorado Rose Family Medicine Program.

Disclaimer: The opinions expressed in this article are the authors' own and do not represent the positions of their affiliated organizations.

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly,* a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022
www.milbank.org

Milbank Memorial Fund

Using evidence to improve population health.