HEALTH MANAGEMENT ASSOCIATES

# National Trends in Payment for Primary Care Services

## DE Primary Care Collaborative

## WHAT'S THE ATTRACTION OF PRIMARY CARE CAPITATION?

- Improve predictability of revenue stream and cash flow
- Movement away from strict reliance on face-to-face visits as payment
- Support practice transformation including use of a broader "non-billable" workforce
- Improve member-centric access to primary care
- Will enhance market competitiveness
- Facilitate care for a larger population via larger PCP panel sizes without increasing that PCP's visit volumes
- Reward for outcomes; revenue enhancement potential
- Align with any opportunity for shares savings and/or shared risk for the cost of health care services beyond primary care

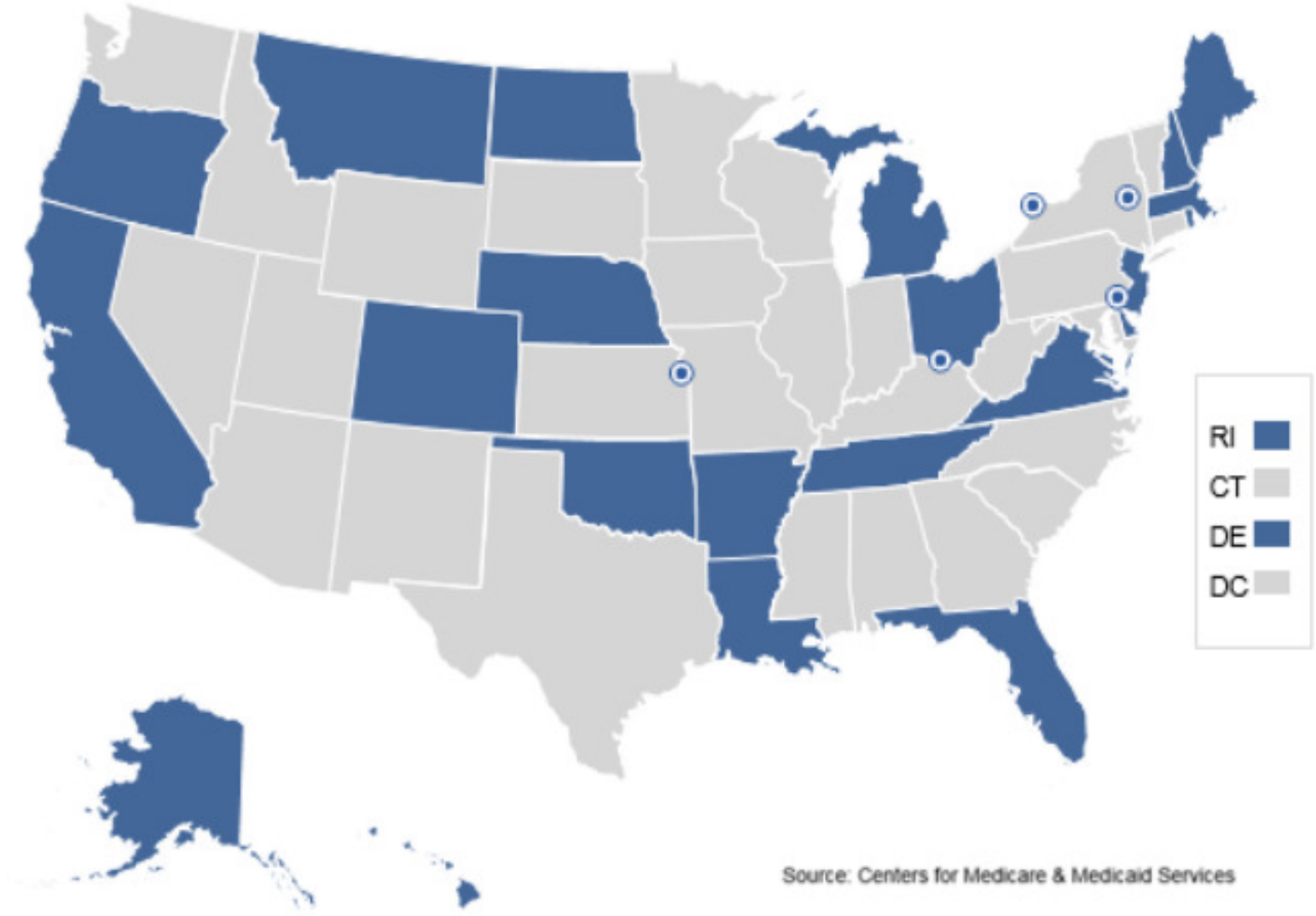
## CPC+

- 5 year program started in 2017 in 14 areas around the country
- CM fee risk based + prospective performance-based quality incentive + Medicare fee schedule
  - Strict FFS – track 1
  - Lower FFS + quarterly comprehensive primary care fee
- Initial findings:
  - Increase in alternative care options, behavioral health integration, hospital follow-up rates, and addressing social determinants of health

## PRIMARY CARE FIRST (PCF)

- 5-year voluntary program
- Aligns with Triple Aim
- Medicare FFS
- 70% patient revenue from primary care
- Two tracks:
  - PCF Model
  - PCF High Needs Population Model
- FQHCs are NOT eligible

# PRIMARY CARE FIRST GEOGRAPHIC REGIONS




Source: Centers for Medicare & Medicaid Services

# PCF TOTAL MEDICARE PAYMENT


Source: https://innovation.cms.gov/Files/slides/pcf-info-webinar-series-slides.pdf

# TOTAL PRIMARY CARE PAYMENT

## Professional Population-Based Payment

Payment for service in or outside of the office, adjusted for practices caring for higher risk populations. This payment is the same for all patients within a practice.

| Practice Risk Group | Payment *Per beneficiary per month* |
|---|---|
| **Group 1** (lowest average HCC) | $24 |
| **Group 2** | $28 |
| **Group 3** | $45 |
| **Group 4** | $100 |
| **Group 5** (highest average HCC) | $175 |

+

## Flat Primary Care Visit Fee

Flat payment for face-to-face treatment that reduces billing and revenue cycle burden

**$50.52**

**per face-to-face patient encounter**

*Adjusted for geography*

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on claims processing and more time with patients

Source: https://innovation.cms.gov/Files/slides/pcf-info-webinar-series-slides.pdf

## SERIOUSLY ILL POPULATION

- Providers meeting relevant care capability can opt to be assigned SIP without a PCP
- Payments
  - First time visit = $325
  - Monthly payments = $275
  - Flat fee primary care visit = $50
  - Quality payment = up to $50

## CMS DIRECT CONTRACTING MODEL

### Professional Population-based Payment

+ ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
+ 50% shared savings/shared losses with CMS
+ Primary Care Capitation equal to 7% of total cost of
+ care for enhanced primary care services

### Global Population-based Payment

+ ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
+ 100% risk
+ Choice between Total Care Capitation or Primary Care Capitation

## CAPITATED FQHC APM ELEMENTS

- **FQHCs receive no less than what they would have under PPS**
- FQHCs retain the right to opt in and out of the APM
- Current payment relationships can remain in place (wrap flow of payments from Medicaid agency directly or as pass through the health plans)
- No recoupment under the APM; reconciliation payment only if required to assure at least PPS equivalency
- Prospective adjustment can be based on performance on quality metrics

## STATUS OF THE CAPITATED FQHC APM APPROACH IN OTHER STATES

- Illinois implemented 2001 – 2013 without filing a State Plan amendment
- Oregon 2012
- Washington State 2017
- Other initiatives:
  - Negotiations on hold: California
  - New York, Connecticut, Colorado, Illinois, Iowa, New York, Michigan: in the planning phase


Summary:

Across 29 states, using outpatient and office based expenditures, narrow definition which is the same as DE had an average of 5.7% with range of 3.5-7.6%

the legislation or executive orders. See pcpcc.org/legislation.

| | |
|---|---|
| **CO** | HB 19-1233 (2019) establishes a multistakeholder primary care payment reform collaborative in the Division of Insurance of the Colorado Department of Regulatory Agencies. It also requires the insurance commissioner to establish affordability standards for premiums, with added targets for carrier investments in primary care. Additionally, it requires the Colorado Department of Health Care Policy and Financing and carriers that offer health benefit plans to state employees to set targets for investment in primary care. |
| **DE** | SB 277 (2018) promotes the use of primary care by:<br>• Creating a multistakeholder Primary Care Reform Collaborative under the Delaware Health Care Commission<br>• Requiring all health insurance providers to participate in the Delaware Health Care Claims Database<br>• Requiring individual, group, and state employee insurance plans to reimburse primary care clinicians at no less than the physician Medicare rate for three years |
| **ME** | Introduced in 2019, "An Act to Establish Transparency in Primary Health Care Spending" requires insurers to report primary care expenditures to the Maine Health Data Organization and requires the Maine Quality Forum to use this data to report annually to the Department of Health and Human Services and the legislature the percentage of total medical expenditures paid for primary care. |
| **OR** | SB 934 (2017) requires coordinated care organizations, the Public Employees' Benefit Board, and the Oregon Educators Benefit Board to spend at least 12% of total medical expenditures on primary care by January 1, 2023. It also requires the Department of Consumer and Business Services to establish requirements for carriers to submit plans for increasing spending on primary care as a percentage of total medical expenditures if the carrier is spending less than 12% of total medical expenditures. |
| **RI** | S 770 (2011) created the Care Transformation Collaborative. From 2009 to 2014, Rhode Island regulators required commercial insurers to raise their primary care spending rate by one percentage point per year (using strategies other than increasing fee-for-service rates) as a condition of having their rates approved. The state measured and increased its primary care spending from 5.7% in 2008 to 9.1% in 2012. Over this same period, total health care expenditures fell by 14%. Rhode Island achieved its target of 10.7% by 2014. |

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| **VT** | SB 53 (2019) requires the Green Mountain Care Board to determine the proportion of health care spending currently allocated to primary care, recommend the proportion that should be allocated to primary care going forward, and project the avoided costs that would likely result if that proportion was achieved. It also directs certain payers to provide a plan for achieving the level of primary care spend that is recommended by the board. |
| **WA** | In 2019, Washington appropriated $110,000 for fiscal year 2020 that is provided solely for the Office of Financial Management to determine annual primary care medical expenditures in the state, by insurance carrier, in total and as a percentage of total medical expenditure. Where feasible, this determination must also be broken down by relevant characteristics. The determination must be made in consultation with statewide primary care provider organizations using the state's all-payer claims database and other existing data. |
| **WV** | SB 641 (2019) creates the Primary Care Support Program to provide technical and organizational assistance to community-based primary care services and to report on West Virginia Medicaid primary care expenditures as a percentage of total West Virginia Medicaid expenditures. |

TABLE 3.1

## Comparison of Rhode Island and Oregon

Each state has a different definition for what constitutes primary care and different primary care investment goals.

| | Rhode Island | Oregon |
|---|---|---|
| **Primary Care Definition** | All payments to family physicians, internists, pediatricians, and affiliated advanced practice providers AND payments for approved "common good" services (health information technology, loan repayment, and practice transformation) | All payments for selected services to family physicians, general medicine physicians, pediatricians, OB/GYNs, psychiatrists, geriatricians, physician assistants, nurse practitioners, naturopaths, and homeopaths[1] |
| **Primary Care Spend Goal** | 10.7% by 2014 | 12% by 2023 |
| **Participating Payers** | Commercial: Blue Cross Blue Shield, UnitedHealthcare, Tufts | Prominent carriers[2]<br>CCOs<br>Medicare<br>PEBB/OEBB |

# CHOOSING A PRIMARY CARE REIMBURSEMENT MODEL THAT FACILITATES ADDITIONAL REVENUE

**Preserving PCP Revenue:**
**Fee-for-service PPS or Capitated APM?**

**Icing on the Cake**

- CM fee
- PCMH
- P4P
- Shared savings
- Partial capitation for non-PCP services

**A bigger piece of the cake (market share)**