The Future of Primary Care: Taking the Pulse of Primary Care Transformation, Nationally and Globally

Asaf Bitton MD, MPH

Director, Primary Health Care, Ariadne Labs
Brigham & Women’s Hospital
Harvard Medical School & T.H. Chan School of Public Health

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Disclosures

- I am a senior advisor at the Center for Medicare and Medicaid Innovation working on a federal multipayer primary care redesign and transformation effort called Comprehensive Primary Care Plus (CPC+).
  - The views expressed here do not represent any official CMS viewpoints.

- My wife works at the Advisory Board Company, a health care research and consulting firm.
  - They have no association with the materials presented here.
There is no such thing as a “primary care service”. There are only primary care functions and specialty care functions. We know what the primary care functions are; they are evidence-based.

-Barbara Starfield
Key Primary Care Functions: The 5 C’s

- First-Contact Access
- Longitudinal Continuity
- Comprehensiveness (Whole-Person Focus)
- Coordination
- Person-Centeredness
The Primary Care Value Proposition

IT'S A FACT

U.S. adults who have a primary care physician have 33 percent lower health care costs and 19 percent lower odds of dying than those who see only a specialist. As a nation, we would save $67 billion each year if everybody used a primary care provider as their usual source of care.


WHAT MEDICAL HOMES PROVIDE

BETTER QUALITY CARE

- Percent of adults with chronic diseases having problems with care coordination
  - Without a medical home: 54%
  - With a medical home: 33%

FEWER HOSPITAL ADMISSIONS AND LOWERS COSTS

- People with medical homes, who have access to 24/7 care, experienced:
  - Fewer hospital admissions: 18%
  - Fewer hospital readmissions: 36%
  - Total medical cost savings: $$$

MORE SATISFIED WORKERS AND BETTER CARE FOR MINORITY PATIENTS

- Percent of staff reporting high emotional exhaustion at 12 months
  - Medical home staff: 10%
  - Non-medical home staff: 30%

- Medical homes reduce racial disparities in accessing medical care:
  - 3 out of 4 whites, African Americans, and Hispanics with medical homes reported getting the care they need when they need it

Comparative Performance

Better primary care functions are associated with better outcomes

*Rank based on patient satisfaction, expenditures per person, 14 health indicators, and medications per person in Australia, Belgium, Canada, Denmark, Finland, Germany, Netherlands, Spain, Sweden, United Kingdom, United States

Source: Commonwealth Fund and Lisa Letourneau, MD
Changing Direction

“If you don’t change direction, you may end up where you are heading.”

-Lao Tzu
“Current care systems cannot do the job.
Trying harder will not work.
Changing systems of care will.”

Institute of Medicine. Crossing the Quality Chasm. 2001
1. **Evolution**
   - Patient-Centered Medical Home
   - Incremental payment reform (care mgmt fees, enhanced P4P, shared savings)

2. **Devolution**
   - Minute clinics
   - Concierge care
   - Limited IT solutions

3. **Revolution**
   - Addressing Population Health and Social Determinants of Health
   - Primary Care Capitation / Global Payment / Integrated IT
Future Trajectories for Primary Care

1. Evolution
   • Patient-Centered Medical Home
   • Incremental payment reform (care mgmt fees, enhanced P4P, shared savings)

2. Devolution
   • Minute clinics
   • Concierge care
   • Limited IT solutions

3. Revolution
   • Addressing Population Health and Social Determinants of Health
   • Primary Care Capitation / Global Payment / Integrated IT
PCMH = “Great Primary Care, Delivered by a Team”

- Whole Person
- Personal Physician
- Enhanced Access
- Quality/Safety
- Physician Led Practice
- Care Coordination
- Payment Reform

Connected through HIT

PCMH Joint Principles
Sounds Like a Nursing Home…

• “Patient Centered Medical Home” (PCMH)
• Not a great name...
• Patients and many providers not aware
Medical Homes and Accountable Care Organizations

Sub-specialty PCMH
Sub-specialty “Medical Home Neighbor”
Sub-Specialty Procedural Practice

Hospital Sub-Acute Care

Patient-Centered Medical Home

Source: David Bates MD, MSc and Asaf Bitton MD, MPH
What is the scope of PCMH transformation nationwide?
PCMH Nationwide with Payment Reform

Source: Sam Edwards, Asaf Bitton, Johan Hong, Bruce Landon. *Health Aff* 33, 10 (2014):1823-1831
Payment

Enhanced FFS only

PMPM only

FFS + PMPM

FFS + PMPM + P4P

Shared savings

N=114

Source: Sam Edwards, Asaf Bitton, Johan Hong, Bruce Landon. *Health Aff* 33, 10 (2014):1823-1831
Transformation

### EXHIBIT 2

Practice Recognition And Transformation Support Used By 114 Patient-Centered Medical Home Initiatives That Include Payment Reform Incentives, 2013

<table>
<thead>
<tr>
<th>Type of recognition or support</th>
<th>Single commercial payer</th>
<th>Medicaid only</th>
<th>Multiple payers</th>
<th>All</th>
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<tr>
<td></td>
<td>Small</td>
<td>Large</td>
<td></td>
<td></td>
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<tr>
<td>Formal recognition required</td>
<td>73%</td>
<td>83%</td>
<td>48%</td>
<td>62%</td>
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<tr>
<td>On practice entry(^a)</td>
<td>45</td>
<td>60</td>
<td>73</td>
<td>54</td>
</tr>
<tr>
<td>After practice entry(^a)</td>
<td>55</td>
<td>40</td>
<td>28</td>
<td>47</td>
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<tr>
<td><strong>RECOGNITION TYPE(^b)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCQA or other external(^a)</td>
<td>100</td>
<td>80</td>
<td>64</td>
<td>85</td>
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<td>Internal(^a)</td>
<td>0</td>
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<td>0</td>
<td>31</td>
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<td>24</td>
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<tr>
<td>Pay for recognition level(^a,b)</td>
<td>38</td>
<td>45</td>
<td>30</td>
<td>24</td>
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<tr>
<td>Target level NCQA 3(^c)</td>
<td>94</td>
<td>100</td>
<td>67</td>
<td>83</td>
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<tr>
<td>Practices that achieved NCQA level 3 (mean)(^c)</td>
<td>81</td>
<td>76</td>
<td>57</td>
<td>54</td>
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<tr>
<td><strong>TRANSFORMATION SUPPORT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use practice consultants</td>
<td>8</td>
<td>55</td>
<td>61</td>
<td>91</td>
</tr>
<tr>
<td>Use learning collaboratives</td>
<td>15</td>
<td>52</td>
<td>61</td>
<td>95</td>
</tr>
<tr>
<td>Data sharing between payers and practices</td>
<td>98</td>
<td>97</td>
<td>83</td>
<td>100</td>
</tr>
<tr>
<td>Data sharing among practices</td>
<td>68</td>
<td>86</td>
<td>57</td>
<td>81</td>
</tr>
</tbody>
</table>

Survey Take-Away Points

- Substantial enthusiasm for the PCMH reflected in the large number of initiatives
  - Trend away from small, limited, single-payer pilots (i.e., multipayer or across the board)
  - Trend toward larger, open-ended delivery reform efforts
- Some integration of risk sharing; much less so for accountable care
- Heterogeneity will inform what we learn from evaluations

Source: Sam Edwards, Asaf Bitton, Johan Hong, Bruce Landon. National PCMH Initiatives Survey 2013
PCMH Estimates Nationwide

• At least 21 million pts in payment-linked PCMH
• VA with another 1065 clinics (9 million pts)
• Dept of Defense – TriCare (2 million pts)
• 12,000 practices by NCQA (~ 14 million pts);  
• 3500 by Joint Commission (4.5 million pts)  
• CMMI CPC+ (3 million pts)
• Some overlap with all of the above
• At least **45-50 million patients** served by PCMH practices in the US

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PCMH Research Literature: Does This Work?
Opposing Approaches

Researchers
• Identify the optimal approach
• Randomized controlled trials
• Willing to wait
• Single answer/Triangulation

Implementers
• Opportunistic/Interventions evolve
• “real life” experiments
• Answers today
• “Experiential” learning
The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization

A SYSTEMATIC REVIEW OF RESEARCH PUBLISHED IN 2016

Summary of Outcomes: Peer Reviewed Articles

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Positive results</th>
<th>Mixed results</th>
<th>Negative results</th>
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</thead>
<tbody>
<tr>
<td><strong>Cost (n=13)</strong></td>
<td>8</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Quality (n=24)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Utilization (n=6)</strong></td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>ED Utilization (n=10)</strong></td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>PCP Utilization (n=7)</strong></td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
A Tale of Two Studies
Gartner Hype Cycle
{Most} evaluations published over the past 18 months have found positive effects, suggesting that we are on the “slope of enlightenment,” where we move past the simplistic question, “Does it work?,” to the more compelling question, “What features of the medical home model will make it more effective going forward?”

-Eric Schneider MD, MSc, Commonwealth Fund
7 Habits of Effective Practice Transformation

• Engaged Leadership
• Teams
• Daily Huddles/Weekly Meetings
• Patient Involvement at all levels
• Quality Improvement Method
• Target Setting
• Care Management
What do we know about PCMH?

• Substantial numbers of patients and providers are now in PCMH (at least 45-50 million nationwide)
• There are increasingly robust new payment mechanisms
• The majority of the peer-reviewed evidence supports PCMH transformation
• Changing practice means changing culture
• 7 habits of effective transformation
• Significant structural payment reform is on the horizon which will likely increase the impetus and pace of practice transformation
Future Trajectories for Primary Care

1. Evolution
   • Patient-Centered Medical Home
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   • Limited IT solutions

3. Revolution
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1. Retail / Minute Clinics: Convenient but Costly?

*Martsolf et al*

![Chart showing trends in ED visits for low-acuity conditions](image)

**Figure 2.** Trends in the rate of ED visits for low-acuity conditions, by growth in retail clinic penetration, 2007 to 2012.

*Martsolf et al, Ann Emerg Med, 2017*

*Ashwood et al, Health Aff, 2016*
2. Concierge Care

- 6% of PCPs (at least)

- No clear evidence about costs, quality, patient experience

- Difference between Direct Primary Care and Concierge Care
3. IT innovation for Primary Care

MEDICAL HOME

By David W. Bates and Asaf Bitton

The Future Of Health Information Technology In The Patient-Centered Medical Home

ABSTRACT Most electronic health records today need further development of features that patient-centered medical homes require to improve their efficiency, quality, and safety. We propose a road map of the domains that need to be addressed to achieve these results. We believe that the development of electronic health records will be critical in seven major areas: telehealth, measurement of quality and efficiency, care transitions, personal health records, and, most important, registries, team care, and clinical decision support for chronic diseases. To encourage this development, policy makers should include medical homes in emerging electronic health record regulations. Additionally, more research is needed to learn how these records can enhance team care.

1. Telehealth
2. Quality measurement
3. Care transitions
4. Personal health records
5. Registries
6. Team Care
7. Clinical Decision Support
Why IT has not met our needs

The HITECH Era in Retrospect
John D. Halamka, M.D., and Micky Tripathi, Ph.D.

At a high level, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 accomplished something miraculous: the vast majority of U.S. hospitals and physicians are now active users of electronic health record (EHR) systems. No other sector of the U.S. economy of similar size (one sixth of the gross domestic product) and complexity (more than 5000 hospitals and more than 500,000 physicians) has undergone such rapid computerization.

Along the way, however, we lost the hearts and minds of clinicians. Medicaid would get value from their large investment on a fixed timeline. But in the absence of business and clinical drivers for change (HITECH predated the Affordable Care Act by more than a year), meaningful use came to be used as a de facto vehicle for transforming health care delivery — a purpose for which, as a technology investment program, it was not adequate.

This approach led to complex requirements that stressed processes more than outcomes, telling providers not only what they should do with their EHRs but also how they should use them.

Soon physicians were expected to provide high-quality and empathic care in a 12-minute visit while weaning themselves from paper-based workflows, entering the numerous structured data elements required for meaningful use, rolling out new HIPAA privacy notices, implementing security protections for new electronic data, learning and incorporating new ICD-10 billing codes, and convincing their patients to use patient portals and secure e-mail, all while avoiding safety and malpractice issues. Instead of being a gift horse that reduced clinician burden, the EHR became an
Data Flows…and Limitations

Step 1: Collect and organize SDH data

Community vital signs data
Imported from public data sources about community-level information (e.g., US Census) matched to patient address

Patient-reported data
Collected by asking patients direct questions about their individual circumstances (e.g., employment, education, housing)

Point-of-care
Individual patient care

Panel management
Population of patients

Improved health outcomes?
(Research needed here)

Referrals to social services, medical specialists
Clinical decision support
Patient engagement
Clinical and social services coordination

Step 2: Present and integrate SDH data into primary care workflows

Step 3: SDH data triggers automated support and action
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Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.
Not what you think

Exhibit 3. Physician Supply and Use, 2013 or Nearest Year

- Practicing physicians per 1,000 population
- Annual physician visits per capita

Exhibit 4. Hospital Supply and Use, 2013 or Nearest Year

- Acute care hospital beds per 1,000 population
- Hospital discharges per 1,000 population

Notes:
- Data from 2012 in Canada, Denmark, Japan, and Sweden.
- Data from 2012 in Australia, Canada, the Netherlands, and Switzerland, and 2010 in the U.S.

Source:
- OECD Health Data 2015.
It’s about the prices...

<table>
<thead>
<tr>
<th>Country</th>
<th>Total hospital and physician costs, 2013a</th>
<th>Diagnostic imaging prices, 2013a</th>
<th>Price comparison for in-patent pharmaceuticals, 2010 (U.S. set to 100)b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bypass surgery</td>
<td>Appendectomy</td>
<td>MRI</td>
<td>CT scan (abdomen)</td>
</tr>
<tr>
<td>Australia</td>
<td>$42,130</td>
<td>$5,177</td>
<td>$350</td>
</tr>
<tr>
<td>Canada</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>France</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Germany</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Netherlands</td>
<td>$15,742</td>
<td>$4,995</td>
<td>$461</td>
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<tr>
<td>New Zealand</td>
<td>$40,368</td>
<td>$6,645</td>
<td>$1,005</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$36,509</td>
<td>$9,845</td>
<td>$138</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>United States</td>
<td>$75,345</td>
<td>$13,910</td>
<td>$1,145</td>
</tr>
</tbody>
</table>

b Numbers show price indices for a basket of in-patent pharmaceuticals in each country; lower numbers indicate lower prices.

Source: P. Kanavos, A. Ferrario, S. Vandoros et al., “Higher U.S. Branded Drug Prices and Spending Compared to Other Countries May Stem Partly from Quick Uptake of New Drugs,” Health Affairs, April 2013 32(4):753–61
Back to “the wayward worm”: Where we really need to focus

Exhibit 8. Health and Social Care Spending as a Percentage of GDP

Notes: GDP refers to gross domestic product.
A Famous Map (John Snow), 1854
An Even More Useful Map: Chadwick’s Map of Leeds, 1842
What is Possible: Southcentral Foundation - Alaska

Supplemental Figure 1. Monthly emergency care use overall.

Supplemental Figure 2. Bimonthly emergency care use for asthma (primary or secondary diagnosis).

Supplemental Figure 3. Monthly emergency care use for unintentional injuries.

- Monthly rate extracted from RPMS.
- Inner product of estimated coefficients and independent variables.
- Predicted value including autoregressive components.

EC = emergency care; RPMS = Resource and Patient Management System.
Costa Rica: Effective EBAIS teams

Costa Rica’s health care system is divided into seven Health Regions.

Each Health Region is divided into Health Areas. There are a total of 104 Health Areas in Costa Rica, and the number of Health Areas per Health Region depends on population and geography. On average, each Health Region has 15 Health Areas. For example, Health Region Chorotega (pictured left) has 12 Health Areas.

Each Health Area has, on average, ten EBAIS Teams. Throughout Costa Rica, there are a total of 1033 EBAIS Teams. Health Area Bagaces (pictured left) has five EBAIS Teams. In many areas with low population density, as is the case in Bagaces, one EBAIS Team travels throughout a large region, providing care in a different town each day of the week in order to reach smaller, rural populations.

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1 Thought and 3 Questions about Primary Health Care Financing

Delivery systems are often designed to support financing mechanisms, as opposed to financing systems designed to support primary care delivery reform.

1. What are we buying?

2. How do we know what we are buying?
   - Are we sure?
   - Are there unintended consequences?

3. What is the unit of transaction?
Types of Financing Mechanisms

- **FFS**: Fee for Service
- **P4P**: Pay for Performance
- **PMPM**: Per member per month
- **PMPM w/ SS**: Per member per month with shared savings
- **Ep**: Episodic Payments
- **Cap**: Capitation Payments
- **GB**: Global Budget
# MACRA – Physician Payment Reforms

<table>
<thead>
<tr>
<th>Year</th>
<th>FFS</th>
<th>P4P</th>
<th>PMPM</th>
<th>PMPM w/ SS</th>
<th>Ep</th>
<th>Cap</th>
<th>GB</th>
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<tbody>
<tr>
<td>2016</td>
<td>0.5%</td>
<td></td>
<td></td>
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<tr>
<td>2017</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>2018</td>
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<td>2020</td>
<td>0%</td>
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<td></td>
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<tr>
<td>2021</td>
<td>0%</td>
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<td>2022</td>
<td>0%</td>
<td></td>
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</tr>
</tbody>
</table>

**MIPS and APMs begin operating**

Doctors treating Medicare beneficiaries will be in one of two newly designed payment paths:

- **MIPS** (Merit-Based Incentive Payment System): Doctors will be graded on four factors...
  - Clinical practice improvement activities: 15%
  - Quality of care: 30%
  - Meaningful use of EHRs: 25%
  - Resource use: 30%

- **APMs** (Alternative payment models):

**MIPS MAXIMUM BONUS OR PENALTY (+/-)**

- 2016: +4%
- 2017: +5%
- 2018: +7%
- 2019: +9%
- 2020: +9% (continues after 2022)

**APMs ACROSS-THE-BOARD BONUS**

- 2016: 5%
- 2017: 5%
- 2018: 5%
- 2019: 5%

**Additional funding**

- $15 million available every year for measure development
- $20 million available every year for technical assistance to small practices

Up to $500 million authorized every year for MIPS bonuses of up to 10% for exceptional performance (2019–24)
Microsimulation Models for Primary Care

Effects of New Funding Models for Patient-Centered Medical Homes on Primary Care Practice Finances and Services: Results of a Microsimulation Model

Sanjay Basu, MD, PhD1,2
Russell S. Phillips, MD2,3
Zirui Song, MD, PhD3,4
Bruce E. Landon, MD, MBA, MSc2,3,5
Asaf Bitton, MD, MPH2,3,5
1Department of Medicine, Stanford University, Stanford, California
2Center for Primary Care, Harvard Medical School, Boston, Massachusetts
3Division of General Medicine and Primary Care, Beth Israel Deaconess Medical Center, Boston, Massachusetts
4Department of Medicine, Massachusetts General Hospital, Boston, Massachusetts
5Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts
6Division of General Medicine, Brigham and Women’s Hospital, Boston, Massachusetts
7Ariadne Labs, Brigham and Women’s Hospital, and Harvard T.H. Chan School of Public Health, Boston, Massachusetts

ABSTRACT

PURPOSE We assess the financial implications for primary care practices of participating in patient-centered medical home (PCMH) funding initiatives.

METHODS We estimated practices’ changes in net revenue under 3 PCMH funding initiatives: increased fee-for-service (FFS) payments, traditional FFS with additional per-member-per-month (PMPM) payments, or traditional FFS with PMPM and pay-for-performance (P4P) payments. Net revenue estimates were based on a validated microsimulation model utilizing national practice surveys. Simulated practices reflecting the national range of practice size, location, and patient population were examined under several potential changes in clinical services: investments in patient tracking, communications, and quality improvement; increased support staff; altered visit templates to accommodate longer visits, telephone visits or electronic visits; and extended service delivery hours.

RESULTS Under the status quo of traditional FFS payments, clinics operate near their maximum estimated possible net revenue levels, suggesting they respond strongly to existing financial incentives. Practices gained substantial additional net annual revenue per full-time physician under PMPM or PMPM plus P4P payments ($113,300 per year, 95% CI, $28,500 to $198,200) but not under increased FFS payments (~$53,500, 95% CI, ~$69,700 to ~$37,200), after accounting for costs of meeting PCMH funding requirements. Expanding services beyond minimum required levels decreased net revenue, because traditional FFS revenues decreased.

CONCLUSIONS PCMH funding through PMPM payments could substantially improve practice finances but will not offer sufficient financial incentives to expand services beyond minimum requirements for PCMH funding.

Microsimulation Structure and Main Findings

Figure 1. Model flow diagram.

US Census Bureau Data:
- Age, sex, race/ethnicity, income, state, and insurance

AHRQ Data:
- Provides diagnoses, associated utilization, and associated clinic reimbursements

MGMA and IBM Data:
- Salaries and benefits
  - Overhead including space, malpractice costs, answering service, and IT including electronic records

Start

Patient

Patient

Patient

Patient has ICD diagnoses, based on demographics and insurance

Patient visits clinic, based on diagnoses, demographics, and insurance

Clinic bills payer and receives reimbursements, and incurs costs associated with service delivery

Outputs

Net revenues

Time costs of service

Figure 2. Net revenue changes per full-time physician per year from clinics meeting minimum requirements to receive PCMH funding, as compared with the clinic operating under traditional fee-for-service payments.

<table>
<thead>
<tr>
<th>Change in Net Revenue Per MD FTE Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>IFFS</td>
</tr>
<tr>
<td>PMPM</td>
</tr>
<tr>
<td>PMPM + P4P</td>
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</tbody>
</table>

$250,000
$200,000
$150,000
$100,000
$50,000
$0
$-50,000
$-100,000

IFFS = increased fee for service; P4P = pay for performance; PCMH = patient-centered medical home; PMPM = per-member-per-month.

Note: The PCMH funding approaches include IFFS rates, PMPM funding, and PMPM plus P4P bonuses (Table 1). The uncertainty ranges portrayed incorporate 3 sets of uncertainty through repeated sampling from the probability distributions of the input parameters: uncertainty in levels of utilization and associated revenue, cost to the practice including staff compensation and other practice costs, and payments through the new PCMH financing approaches (eg, level of payment increase from IFFS).
High Levels of Capitation Needed for Transformative Primary Care

**ABSTRACT**
Capitated payments in the form of fixed monthly payments to cover all of the costs associated with delivering primary care could encourage primary care practices to transform the way they deliver care. Using a microsimulation model incorporating data from 969 US practices, we sought to understand whether shifting to team- and non-visit-based care is financially sustainable for practices under traditional fee-for-service, capitated payment, or a mix of the two. Practice revenues and costs were computed for fee-for-service payments and a range of capitated payments, before and after the substitution of team- and non-visit-based services for low-complexity in-person physician visits.

**SOURCE** Authors’ calculations. Notes: Net surplus per full-time-equivalent (FTE) physician per year is defined in the Notes to Exhibit 2. The minimum capitation level is the level above which 95 percent of practices would gain revenue by shifting to a team- and non-visit-based primary care delivery strategy. Appendix Exhibit 6 contains a conceptual illustration of the analysis used to determine this level (see Note 18 in text). CI is confidence interval.
Federal Initiatives

Accountable Health Communities

Preventive & Population Health Models Group
The Innovation Center at CMS

January 2016

Comprehensive Primary Care Plus
Advancing the Delivery of and Payment for Primary Care
Information for Payers
Comprehensive Primary Care Plus Initiative

Overview:
18 states, 54 payers, 4000 practices, >2 Million Medicare patients

Key reforms:
New aligned payment model, empanelment, risk-stratified care management, patient engagement, EHRs, chronic disease registries, continuous quality improvement, state-based learning environment
Comprehensive Primary Care Plus (CPC+)

**Track 1**
- Up to 2,500 primary care practices.
- Pathway for practices ready to build the capabilities to deliver comprehensive primary care.

**Track 2**
- Up to 2,500 primary care practices.
- Pathway for practices poised to increase the comprehensiveness of care through enhanced health IT, improve care of patients with complex needs, and inventory resources and supports to meet patients’ psychosocial needs.
## Comprehensive Primary Care Plus (CPC+)

<table>
<thead>
<tr>
<th>Track</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment</th>
<th>Underlying Payment Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track 1</td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>Standard FFS</td>
</tr>
<tr>
<td>Track 2</td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>

- **FFS**: Flat Fee System
- **P4P**: Payment for Performance
- **PMPM**: Pay for Performance per Member per Month
- **PMPM w/ SS**: Pay for Performance per Member per Month with Supervision Support
- **Ep**: Enhanced Practice
- **Cap**: Care Management Fee
- **GB**: Group Based
Comprehensive Primary Care Plus (CPC+)

CPC is ~10% larger than historical FFS to compensate for more comprehensive services.

2016

FFS

2019

FFS

FFS

FFS

FFS

FFS

CPCP 40%

CPCP 65%

CPCP

OR
New private payment/delivery models: Iora Health

- Sub-capitation for primary care services, contracted with purchaser (employer or insurer)
  - Essentially → a primary care bundle or year-long episode payment
- Wrap around insurance for specialist and inpatient care
- Shared savings on total cost of care
A Global Century of Primary Health Care

Improving primary health care has long been recognized as key to achieving health and development goals. Several global platforms have called for strong, accessible primary health care systems.
Many countries have identified (PHC) as an urgent priority, but they lack comprehensive data to pinpoint specific weaknesses, understand their causes, and strategically direct resources to address them. They also lack a means to improve PHC within existing vertical programs.

The processes and experiences that occur in the system, between inputs and outputs, are called the “black box” of PHC because they are not well understood and do not receive enough attention.
Across the globe, the quality of primary health care is often poor.

An average patient-provider interaction: diagnosis and treatment for a given condition (chest pain) in India.

Source: Jishnu Das, World Bank Group

- 3.89 minutes
- 2.89 questions
- 1.46 exams
- 2.34 medicines

### Diagnostic Accuracy and Treatment Accuracy

<table>
<thead>
<tr>
<th>Country</th>
<th>Diagn acc</th>
<th>Treatmnt acc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>0.711</td>
<td>0.354</td>
</tr>
<tr>
<td>Nigeria</td>
<td>0.349</td>
<td>0.266</td>
</tr>
<tr>
<td>Uganda</td>
<td>0.470</td>
<td>0.334</td>
</tr>
</tbody>
</table>
The Primary Health Care Performance Initiative (PHCPI) is a partnership that brings together country policymakers, health system managers, practitioners, advocates and other development partners to **catalyze improvements in primary health care** in low- and middle-income countries through **better measurement and knowledge-sharing**.

**Led by:**

**In partnership with:**
PHCPI was launched on September 26, 2015 during the UN Sustainable Development Summit at an event co-hosted by the governments of Germany, Norway, and Ghana.

“Primary health care is important in identifying diseases, providing health information to communities and making them aware of their health status, and collecting data...so we know what progress we are making in providing better health for our people.”

– John Dramani Mahama, President of the Republic of Ghana
Our Activities

PHCPI supports stronger PHC through four interconnected areas of work:
How We Work with Partners

PHCPI is evolving to a much broader partnership, including with:

Countries
- Identifying key policy questions and areas for improvement
- Developing new measurement and data visualization tools
- Testing new interventions through learning collaboratives like JLN
- Disseminating lessons for improvement

Development Partners
- Focusing funding and activities on PHC improvement
- Utilizing PHCPI data and tools
- Engaging in conversations to support countries that have prioritized PHC

Civil Society Organizations
- Coalition building
- Driving global and national attention to PHC
- Engaging with decision makers
6 modest predictions on the future of primary care

1. Primary care will survive...in fact it will be more important than ever
   ➔ **Providing the core functions**

2. We will provide primary care differently
   ➔ **Through teams enabled by better IT**

3. We will pay for primary care differently
   ➔ **Through a shift toward capititated, bundled, and episodic payments**
6 modest predictions on the future of primary care

4. Primary care will be oriented toward building healthy communities
   → Addressing social needs and behavioral health

5. Global health efforts focused toward primary care
   → Shift investments toward increasing the strength, stability, and capacity of primary care

6. Massive need for innovation
   → Massive opportunity for social impact
Future Trajectories for Primary Care

1. **Evolution**
   - Patient-Centered Medical Home
   - Incremental payment reform (care mgmt fees, enhanced P4P, shared savings)

2. **Devolution**
   - Minute clinics
   - Concierge care
   - Limited IT solutions

3. **Revolution**
   - Addressing Population Health and Social Determinants of Health
   - Primary Care Capitation / Global Payment / Integrated IT
Invention vs. Innovation

Kitty Hawk, 1903

Spitfire, 1931

DC-3, 1935

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Thank You!