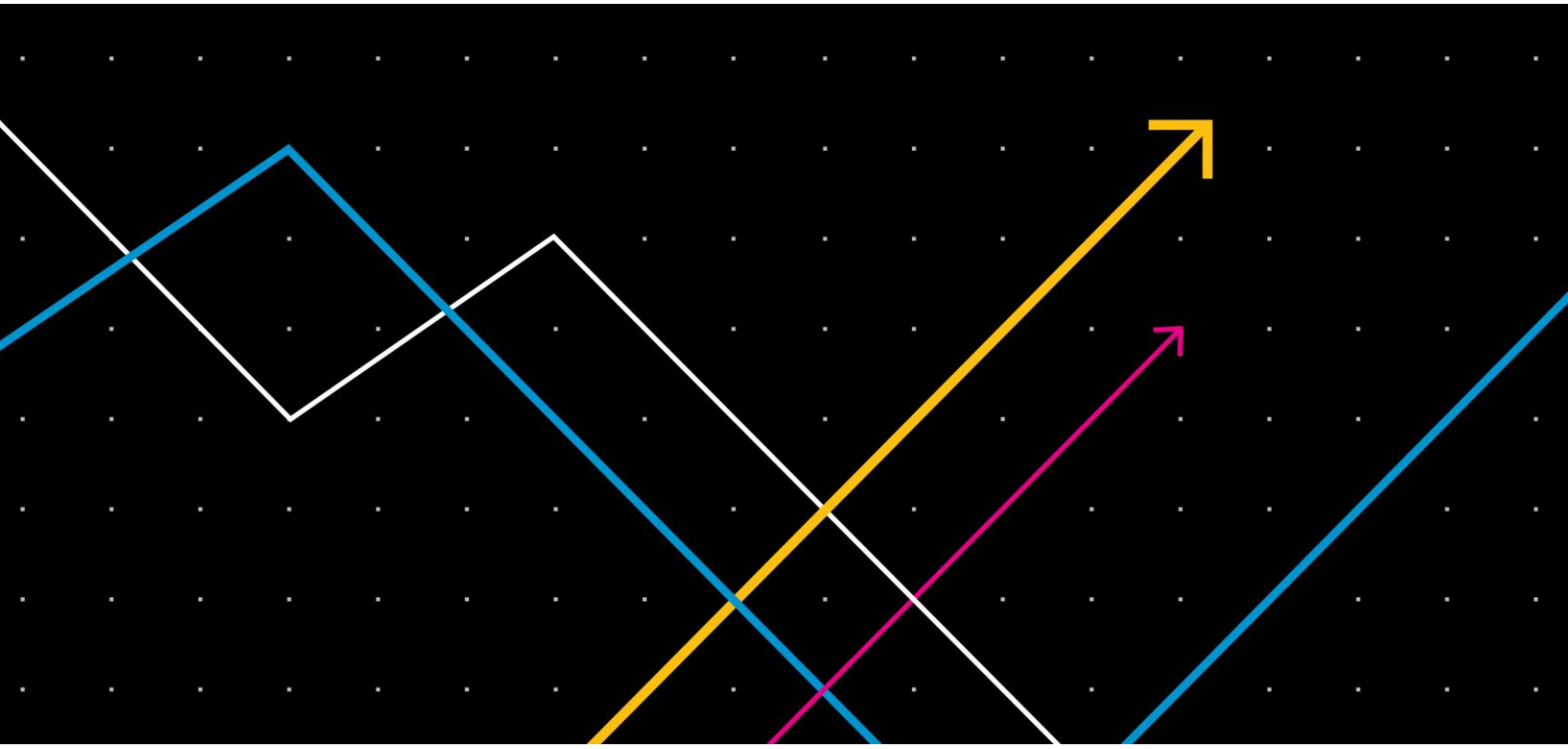

RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

The Patient-Centered Medical Home—Advanced Primary Care

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OUR HEALTH CARE SYSTEM NEEDS CPR

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the three pairs of interactions between payment methods and benefit designs discussed in the report *Matching Payment Methods with Benefit Designs to Support Delivery Reforms*. All reports and chapters can be found on our project page: Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care.

The Patient Centered Medical Home—Advanced Primary Care

The patient-centered medical home (PCMH) is a redesign of primary care delivery emphasizing population health management, multidisciplinary teams, and care management for at-risk patients. Many PCMHs today receive payment according to a base of standard fee schedules, along with incremental payments for care coordination. However, a hybrid approach, which demotes the incentive to overgenerate face-to-face visits inherent in fee-for-service and promotes beneficial activities that previously did not qualify for payment (e.g., care coordination, robust e-mail and phone communication), may be more effective. Two examples of payment approaches that might best support a PCMH include (1) a base method that includes a hybrid of a reduced price fee schedule and capitation, with additional incremental payments, such as payment for performance (P4P) and shared savings and (2) primary care capitation as the base method with some incremental payments using P4P and shared savings methods.

While we can change supply-side incentives to focus less on generating visits and more on coordinating care, we can change incentives for consumers to use providers in these primary care models. Physicians are also less willing to take on risk if they lack control over patients' use of health care services. Therefore, a narrow network design could be beneficial, as it essentially restricts consumers' access to providers to those in-network and to whom they are referred. Second, for PCMHs with capitated base payments, moderate cost-sharing, usually co-payments, for consumers could temper the likelihood to seek health care services they do not need. Value-based insurance design can align both consumers' and providers' interests in primary preventive care and in care outcomes. Capitated payments can also support the use of alternative sites of care—such as retail clinics and telehealth—in the PCMH. Additionally, other utilization management approaches can support providers subject to risk-based payment arrangements in their management of patients and patients' pursuit of health care services.

Introduction

The PCMH is a redesign of primary care delivery, which emphasizes population health management, multidisciplinary teams, and care management for patients at risk of frequent hospitalizations. Many, including the primary care specialties that originated the current medical home movement, consider supportive payment reform as a requirement intrinsic to advancing the concept and implementation of the medical home. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 identifies alternative payment models that would provide additional payment to physicians who qualify as patient-centered medical homes. However, consumers need incentives to use these primary care models and help them succeed; certain benefit designs can encourage use.

The Basic Payment Approach

PCMHs are presumed to be one of the approved alternative payment models in MACRA; this creates a dilemma, because the medical home is in fact a model for how to deliver care, not a payment method. PCMHs are supported by a variety of payment methods, and there is active debate about how best to do this. In PCMH demonstrations, payers have adopted a mix of payment methods, typically built on a base of standard fee schedules.

For example, in the eight-state Multi-Payer Advanced Primary Care Demonstration, the common central approach was to pay standard fee schedule payments. All states then provided the medical home with an incremental per capita payment for care management activities for each patient (with the payment variously adjusted for age, number of chronic conditions, the level of medical home achievement, or another factor). However, each state's approach then varied: some had P4P bonuses related to performance on quality metrics, and one used a shared savings approach related to total cost of care analysis.

Complementary Payment Approaches

As noted above, most payment approaches to the medical home start with standard fee schedules, which are typically modeled closely on Medicare's. Fee schedules have some positive attributes, including the ability to incentivize performance of specific targeted activities and to price items such as vaccines in a way that accounts for price fluctuations. However, fee schedules are the prototypical volume-based payment method, rewarding additional services (needed or not), interfering with efforts to reward greater attention to care coordination across providers and other social service supports, and shortchanging activities—central to the PCMH concept—that cannot be readily recognized and paid on a fee-for-service basis, such as frequent e-mail and telephone exchanges between practices and patients and their caregivers.

Some think the unimpressive results from PCMH pilots to date stem from base and incremental payments being insufficient to permit clinicians to reengineer care delivery, providing primary care services while emphasizing access, continuity, comprehensiveness, and coordination. In addition, the current approaches to layering small, incremental payments on top of a standard fee schedule do not alter primary care practices' incentives to generate face-to-face visits. Accordingly, there is interest in payment methods that move away from a base of standard fee schedule payments, so that physician practices are less constrained in how they deploy resources to achieve the PCMHs' promise to improve patient care.

Two approaches with great potential to support PCMHs include (1) a base method that incorporates a hybrid mix of a reduced fee schedule and capitation, with some additional incremental payments, such as P4P and shared savings and (2) primary care capitation as the base method with some incremental payments using P4P and shared savings.

The first method, reducing the fee schedule payment amounts, could move the incentives in the PCMH to greater neutrality, such that physicians would no longer see face-to-face visits as their only major source of revenue. Capitation—a per member per month, perhaps case-mix-adjusted payment—would support activities that medical homes seek to undertake but that current fee schedules typically do not recognize. Nearly 25 percent of activities undertaken by primary care practices are not covered by fee schedule payments (Chen et al. 2011; Gilchrist et al. 2005). Presumably, under a full or partial capitation payment approach, even a greater percentage of work activity would reflect activities unrelated to visits.

A modified approach to maintaining fee schedule payments would be to include generous payments for activities that need emphasis, such as immunizations and other preventive services; these are the same services typically subject to external measurement and reward or penalty. Another approach could be to support chronic care management for certain patients through a monthly payment in addition to the monthly capitation payment.

The second method, primary care capitation, was a dominant method in 1980s and 1990s health maintenance organizations (HMOs). The payment method was supported by benefit designs that required members to select a physician practice for routine care and referrals—the so-called gatekeeper. The advantage is that physicians are completely at liberty to decide how to deploy resources—and how to apportion their own time—to best serve the population for whom they are responsible. The concern is that physicians might stint on services or respond to their effective fixed budget by overreferring to other physicians, thereby defeating one core purpose of the medical home. Hence, measuring performance on basic parameters of access and use and possibly adopting incremental payment approaches, such as P4P and shared savings, may be necessary to discipline some potential adverse impacts of pure capitation. Under a predominantly primary care capitation approach, it is still possible to pay fee-for-service for important services, labeled carve-outs or bill-aboves, creating a direct payment incentive for practices.

Of note, compared to the ‘80s and ‘90s, we are in a better position to adjust case mixes to determine more accurate capitation rates. We also have better ability to use quality measures to detect providers’ stinting on some services, particularly primary and secondary prevention services.

Finally, these alternative payment methods for PCMHs are quite compatible with population-based payment methods, such as shared savings, shared risk, and capitation; they all move away from the volume-based incentives inherent in basic fee schedule payments. For example, it would be conceptually and operationally logical for the intermediary, accountable-care-style organization

receiving a globally capitated payment to in turn subcapitate its physicians. Similarly, the organization could adopt the hybrid model to assure the flow of accurate encounter data, which is essential to ACO data monitoring and external oversight.

Complementary Benefits Designs

In general, benefit designs should facilitate ready access for consumers to their medical homes, reducing any financial barriers. The approach will be most successful if the PCMH retains the responsibility for managing referrals, high-cost testing, procedures, and drugs. Therefore, a narrow network would be an appropriate mechanism to limit consumers to seeking care from the PCMH providers and their referrals. With a narrow network approach, patients would not receive coverage for care out of the network, supporting providers' ability to manage their patients' care. Providers would likely be more willing to accept risk-based payment approaches if they were better able to manage patient care. In tiered or broad network products, patients can and will be more likely to seek care from other providers.

As under traditional HMO benefit designs, PCMHs' requiring consumers to share in the costs of services may help reduce the likelihood patients will seek care they do not need. A high deductible health plan (HDHP) could also temper overuse of services from the PCMH, as most services will be subject to the deductible. Primary preventive services, however, would receive first-dollar coverage due to the requirements of the Affordable Care Act (ACA). This could align consumers' and providers' incentives. However, high deductibles might compromise the PCMH's ability to manage the patient's care and to perform well on quality measures, such as those associated with secondary preventive services. Additionally, HDHPs do not work well with primary care capitation. HDHPs generally require a fee-for-service chassis to determine how much of the deductible is subject to the care a patient receives.

Value-based insurance design (V-BID) would support PCMH goals by reducing financial barriers to care for high-value services, thereby aligning patients' interests with the practice's. Additionally, because V-BID lowers consumer cost-sharing for services with well-established, positive effects on the quality of care, the provider can perform well on delivering preventive care—practice patterns that may serve as the basis for bonuses.

Benefit designs that recognize the value of alternative sites of care, such as retail clinics, as covered alternatives to physicians' offices can either support or work against the PCMH, depending on the

specific payment approach used. Providers under capitated payments would have a greater incentive to refer to retail clinics for simple preventive and diagnostic services, such as checking for ear infections, whereas providers paid by fee schedule face incentives to perform those services directly, whether convenient for the consumer or not.

If payment migrates from the fee schedule to capitation, whether to support telehealth moves from a benefit design issue to one of practice preference. Under primary care capitation, practices should be open to the robust, lower-cost use of telehealth technologies to communicate with patients and with other health professionals.

Finally, under PCMH payment approaches that place an independent practice at financial risk, the practice would have an interest in assuring that inpatient care recommended by others is really needed. In an HMO environment, the medical home "gatekeeper" typically has control over non-urgent referrals and hospitalizations. That control lessens in a preferred provider organization (PPO), in which patients can gain access to specialists with moderately greater cost-sharing. Further, many hospitalizations and subsequent high-cost procedures occur urgently and outside the PCMH's purview. An effective utilization management program including precertification (i.e., review by the health plan) and continued stay review (if payment is based on per diems rather diagnosis related groups) would support the medical home's objectives regarding both clinical appropriateness and cost control.

Environmental Factors

In general, only HMOs are legally allowed to take on financial risk-sharing, such as primary care capitation, for health care providers. Most states have regulations that ban substantial capitation for providers outside HMOs, because of concern that those providers cannot handle the risk financially and that fixed payments impart incentives for stinting on care. Similarly, Medicare also limits the amount of risk-sharing a Medicare Advantage HMO can take on, having provided detailed guidance on what is considered "substantial financial risk"[1] and therefore not permitted. In short, as of now, substantial use of capitation to support the PCMH would seem prohibited in PPOs.

Although there is hope that innovations riding atop fee schedule-based payments will support medical homes, capitation may better support the medical home concept. Yet, today, primary care capitation is typically used only in HMOs—only HMOs can use a gatekeeper system in which a consumer selects a single primary care practice for services and for access to specialty care.

Conclusion

On the supply side, some payment methods will discourage providers from generating face-to-face visits, shorten their time with individual patients, and encourage the provision of care that was not previously paid, such as care coordination and communications with patients via e-mail or telephone. On the demand side, benefit designs, such as narrow networks, can encourage consumers to seek care from providers in a medical home. Moderate cost-sharing and value-based insurance design encourage consumers to be more cost sensitive and to seek necessary services. Alternative sites offer consumers cheaper, more convenient places to receive their care than their provider. And utilization management approaches give providers and payers the authority to monitor and manage their patients' care.

Note

1. Federal Register Vol. 63, No. 123, Rules and Regulations, 42 CFR 422.208/210, June 26, 1998.

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