MaineHealth Primary Care Payment Reform Program: Exploring the financial sustainability of PCMH models

Stephanie Peters
MHMC ACI Committee Meeting
May 20th, 2013
Goals for today

- Set the accountable care and payment reform context at MaineHealth

- Review how MaineHealth has invested PCMH payments across the system
  - How do we make our PCMH work financially sustainable over time?

- Describe how the MaineHealth Primary Care Payment Reform Program is exploring this question
  - Economic modeling for our Primary Care practices under FFS and Capitation scenarios

- Questions and discussion?
The success of MaineHealth in the future depends in part on our ability to thrive under new models of payment:

- Fee For Service, Volume Based Payment
- Shared Savings: Upside Only
- Shared Risk: Savings & Losses
- Partial Capitation
- Global Capitation
MaineHealth is pursuing a four point strategy to achieve the Triple Aim.

**Deliver on Primary Care**
Implement the Medical Home model and ensure adequate supply of primary care for all ACO patients

**Focus Care Coordination on Patients who Need it Most**
MaineHealth will assess, consolidate and/or reorganize system-wide care coordination resources to ensure right focus on right patients

**Establish a Culture of Learning and Transparency**
A physician-led peer review program will focus on reducing unwarranted variation in care

**Invest in Information for Patient Care and Population Health**
Successfully implement a shared medical record across our ACO AND harness the power of information for population health
Patient-Centered Medical Homes

*putting the patient first*

The Medical Home

- Team Based Care
- Integrated Behavioral Health
- Care Coordination
- Community and Home Outreach
- Electronic Health Record

**Why:**

1. Complex patients require care coordination among many providers
2. Behavioral health needs exist in many patients with chronic disease
3. Patient Care is most efficiently provided by a team
4. Care needs must be anticipated – not just reactive to patient visit needs
5. Linkages to community organizations are essential
6. Health care cannot be one-size fits all
From Strategy to Program Implementation: elements of MaineHealth’s work in primary care

MaineHealth 2012 – 2014 Strategic Plan: Accountable Care:
"Successfully implement our member organizations’ strategies for creating a strong primary care network within each hospital service area and transform our own practices incorporating the principles of the patient centered medical home."

Emerging: PCMH Financial Sustainability - FFS and Cap

Ongoing: PCMH and Primary Care Investment Analysis

Next: Patient Centered Medical Home NCQA Accreditation Effort

First: Behavioral Health Integration Program
Under new reimbursement models, how do we ensure that PCMH payments flow to the practices?

- Anticipated revenue for NCQA designation by practice and community:
  - Expected per member per month payments based on NCQA PCMH recognition from specific payers

- Anticipated revenue regardless of NCQA designation:
  - FY12 and 13 MaineHealth investments
  - Enhanced Medicaid payments
  - Anthem contract payments

- Estimated variable revenue available to Primary Care practices through application of new coding and program opportunities:
  - Transitions of care codes (Medicare and some commercial insurers)
  - Enhanced payments for Mental Health codes (Medicare)
PMCH System Wide Investment: How are practices using these payments?

- Approximately 55 practices in 7 communities provided detailed budget information on incremental investments in primary care made in FY13 and estimates for FY14 and FY15

<table>
<thead>
<tr>
<th>Team Based Care</th>
<th>Whole Person Orientation</th>
<th>Enhanced Access</th>
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</thead>
<tbody>
<tr>
<td>Integrated Behavioral Health</td>
<td>Patient Advisory Councils</td>
<td>Extended hours</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>Patient Experience Surveys</td>
<td></td>
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<tr>
<td>Registered Nurses/Care Managers</td>
<td>NCQA Recognition</td>
<td></td>
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<tr>
<td>Advanced Practice Professional</td>
<td></td>
<td></td>
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<tr>
<td>Team meetings</td>
<td></td>
<td></td>
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<tr>
<td>Policy Development/Training</td>
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Resulting questions that we are exploring through the Primary Care Payment Reform Program…

What are the implications for ongoing financial sustainability of PCMH investments?

- FFS
- Capitation

How does team based care advance practice productivity?

- Panel size
- Population health management
Conduct financial analysis and real world experimentation to confirm the clinical, administrative, and financial changes required to ensure that MaineHealth PCMH practices are sustainable under future reimbursement models.

1. Financial Analysis:
   - Model the financial impact of team based care under different scenarios
     - FFS
     - Capitation

2. Lab Practice Implementation:
   - Partner with select employed practices to make specific investments in care team models
   - “Shadow” new physician compensation & reimbursement model
   - Scale in the future
Developed a financial model of various scenarios under FFS and Capitation…

Fee for Service

- Limited Savings Incentives
- Improve Population Health
- Physician centered/Billing optimization

Capitation

- Reduce Total Cost of Care
- Improve Population Health
- Patient centered/Team based

Population Health Gains

- (+ Impact)
- Services per Patient

Panel Size

- (+)

HOW?
This work has initiated system wide panel size and population health management discussions…

**Panel Size**
- What are the implications for current panel sizes now and in the future?

**Productivity**
- How does team based care advance population health management?
Example Lab Practice Financial Modeling

- **Investment:** Lab practice investments are focused on “Optimum” care delivery team model based on literature and conversations with practice leadership
- **Panel Size:** Fulcrum of practice economic models. Analysis is based on current data and opportunity to optimize
- **Services Per Patient:** Positive impact in both scenarios but very different care delivery considerations

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Current</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment</td>
<td>$</td>
<td>$223,119</td>
<td>$227,581</td>
<td>$232,133</td>
</tr>
<tr>
<td>% Panel Size Increase</td>
<td>0%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>3.3%</td>
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<tr>
<td>Practice Panel</td>
<td>9,963</td>
<td>10,292</td>
<td>10,631</td>
<td>10,982</td>
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<tr>
<td>Services per Patient</td>
<td>4.9</td>
<td>5.2</td>
<td>5.4</td>
<td>5.4</td>
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<tr>
<td>Average Paid per Service</td>
<td>$66.1</td>
<td>$66.1</td>
<td>$66.1</td>
<td>$66.1</td>
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<tr>
<td>2011 Total Paid Amount</td>
<td>$3,201,538</td>
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<table>
<thead>
<tr>
<th>% Payer</th>
<th>Example Primary Care Cap Rate</th>
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<tbody>
<tr>
<td>Commercial</td>
<td>22% $ 20</td>
</tr>
<tr>
<td>Medicare</td>
<td>60% $ 42</td>
</tr>
<tr>
<td>MaineCare</td>
<td>5% $ 18</td>
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</tbody>
</table>

Example Primary Care Cap Rate = total paid claims/number of patients by payer (system wide)

**Panel Size:** Target 10% Growth Over 3 Yr

**CPP:** Target 5% Increase under FFS

Total paid amount data is from APCD
For Each Potential Lab Practice: Calculated ROI based on three scenarios:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Target Panel/Current Services</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Incremental Investment</td>
<td>223,119</td>
<td>$ 227,581</td>
<td>$ 232,133</td>
</tr>
<tr>
<td></td>
<td>Incremental Revenue</td>
<td>$ 105,651</td>
<td>214,762</td>
<td>327,488</td>
</tr>
<tr>
<td></td>
<td>Return on Investment</td>
<td>$ (117,468)</td>
<td>$ (12,819)</td>
<td>95,355</td>
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</table>

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Target Panel/Target Services</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incremental Investment</td>
<td>223,119</td>
<td>$ 227,581</td>
<td>$ 232,133</td>
</tr>
<tr>
<td></td>
<td>Incremental Revenue</td>
<td>335,952</td>
<td>593,236</td>
<td>718,464</td>
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<td></td>
<td>Return on Investment</td>
<td>$ 112,833</td>
<td>365,655</td>
<td>486,331</td>
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<table>
<thead>
<tr>
<th>Scenario</th>
<th>Target Panel</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incremental Investment</td>
<td>$ 223,119</td>
<td>$ 227,581</td>
<td>$ 232,133</td>
</tr>
<tr>
<td></td>
<td>Incremental Revenue</td>
<td>$ 121,343</td>
<td>246,691</td>
<td>376,175</td>
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<tr>
<td></td>
<td>Return on Investment</td>
<td>$ (101,776)</td>
<td>19,109</td>
<td>144,042</td>
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</table>

*Total Cost of Care Savings Scenario 2:

<table>
<thead>
<tr>
<th>8). Potential Savings Target Panel</th>
<th>10,982</th>
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</thead>
<tbody>
<tr>
<td>Target Panel Size</td>
<td></td>
</tr>
<tr>
<td>PMPM Savings</td>
<td>23.67</td>
</tr>
<tr>
<td>Potential PMPY Cost Savings</td>
<td>$ 3,119,397</td>
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<tr>
<td>75% of PMPY Cost Savings</td>
<td>$ 2,339,547</td>
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Key Learnings…

• Payment models matter:
  – FFS: PCMH investments require an increase in population health activities or optimizing total panel size to be sustainable
  – Partial/Total Capitation: PCMH investments WILL be sustainable where decreases in total cost of care accrue to our health system

• Transforming practice processes and workflows to empower the delivery of team based care improves patient experience and clinical outcomes

• Developing a financially sustainable PCMH model is imperative to our ability to improve the population health of our communities and to thrive under alternative payment models
Questions?
Appendix
Primary Care Payment Reform Program: Process to Date

- Monthly meetings of “Core Group” with consultant assistance
- Agreed on approach including global payment model based on panel size
- Identified baseline PCMH staffing levels for potential “Lab Practices”
- Identified “optimum” care delivery team for each practice
  - Based on literature
  - “Tweaked” by practice leads to reflect reality and needs of specific geographies
- Completed quantitative analyses using claims data to build draft economic models and practice scenarios

1. Financial model (current vs proposed staff)
2. Scenario Modeling (panel size and claims per patient)
3. Financial Net Impact (FFS and Capitation)
Primary Care Payment Reform Program: “Lab practice” Plan

• Work with volunteer MaineHealth member organizations to develop advanced patient-centered medical home (PCMH) “lab practices”
  – Focused investment to achieve optimum team model, shadow capitation, and explore an alternative physician compensation model

• Explore alternative practice team configurations for their potential to:
  – Maximize patient access to care, enhance productivity, improve patient and provider satisfaction

• Embed a practice improvement specialist to facilitate practice transformation with physician lead
  – Train providers to operate at the top of their license, update work flows, streamline processes, implement new workflows

• Evaluate productivity, quality, and financial performance under this new process design
We are also modeling potential population health management gains…

• Implementing the “optimum” care delivery team provides the opportunity for other team members to complete population health management activities
  – 60% of preventative care and 30% of chronic care can be delegated to other team members

• “Population Health Management” involves
  – Proactive outreach to patients to close clinical gaps
  – Actively working all gaps during office visit
    • Reviewing charts before the visit and completing necessary preventative screening while the patient is in the office
    • Opens the schedule to be able to see new patients or patients with more acute needs

* Does **NOT** mean “churning” patients through the practice
* DOES mean improving the health of patient panels

### Break Even Analysis: Panel size and population health management

<table>
<thead>
<tr>
<th>Panel Size</th>
<th>Target Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>$ 9,000</td>
</tr>
<tr>
<td>4.9</td>
<td>$ (649,564)$</td>
</tr>
<tr>
<td>5.0</td>
<td>$ (500,074)$</td>
</tr>
<tr>
<td>5.2</td>
<td>$ (471,094)$</td>
</tr>
<tr>
<td>5.4</td>
<td>$ (329,098)$</td>
</tr>
<tr>
<td>5.6</td>
<td>$ (210,118)$</td>
</tr>
<tr>
<td>5.8</td>
<td>$ (91,138)$</td>
</tr>
<tr>
<td>6.0</td>
<td>$ 27,842$</td>
</tr>
<tr>
<td>6.2</td>
<td>$ 146,822$</td>
</tr>
<tr>
<td>6.4</td>
<td>$ 265,802$</td>
</tr>
<tr>
<td>6.6</td>
<td>$ 384,782$</td>
</tr>
<tr>
<td>6.8</td>
<td>$ 503,762$</td>
</tr>
</tbody>
</table>

For the given panel sizes and target claims, we can calculate the break even points at different per patient claims and at different target claims per patient. The break even points will help in understanding the financial viability at different population and panel sizes.
Primary Care Payment Reform Lab Practice Implementation Timeline

- **Strategic Decisions Finalized**
  - 1st iteration of Pilot Comp model confirmed
  - Financial Modeling (ROI Analysis & Business Plans)
  - Practice Investment Decisions
  - Implementation Support Approach Confirmed

- **2014**
  - Recruit staff
  - Implement Care Delivery and Compensation Model
  - Outline Improvement specialist role in implementation
  - Finalize Implementation/Measurement Plan:
    - Lab Practice budget
    - Recruitment strategy and timeline
    - Data Management Strategy

- **2015**
  - Lab Practices Confirmed
  - Establish Baseline Data
  - Recruit staff
  - Implement Care Delivery and Compensation Model
  - Strategic Decisions Finalized
  - 1st iteration of Pilot Comp model confirmed
  - Financial Modeling (ROI Analysis & Business Plans)
  - Practice Investment Decisions
  - Implementation Support Approach Confirmed

- **Explore System - wide Implementation decisions**
  - Evaluate performance (team satisfaction)
  - Distribute incentive pay
  - Shadow Capitation

MaineHealth
**Practice Transformation Implementation Timeline**

**½ Day Kick Off Event**
- Engage practice MD/Admin Champions
- Present “future” model
- Define future roles

**Measure staff satisfaction**

**Role Activity Analysis: Physician**
- Document current role
- Identify gaps
- Define new role
- Create standard processes

**Train MAs to perform newly defined role**

**Role Activity Analysis: MA**
- Document current role
- Identify gaps
- Define new role
- Create standard processes

**Role Activity Analysis: RN**
- Document current role
- Identify gaps
- Define new role
- Create standard processes

**Train RNs to perform newly defined role**

**Role Activity Analysis: PSR**
- Document current role
- Identify gaps
- Define new role
- Create standard processes

**Role Activity Analysis: RN**
- Document current role
- Identify gaps
- Define new role
- Create standard processes

Weekly meetings at each practice site with coach/MD Champion
Bi-monthly meetings of Core Group, Practice MD/Admin leads
Data collection/feedback
Data feedback