

Maine Alliance for Primary Care

Primary Care Payment Reform Provider Roundtables

Read Ahead Document

In late January, the [federal government announced](#) an ambitious set of goals to dramatically change provider reimbursement over the next three years. These goals may lead to profound changes in the way primary care providers are paid - not only for Medicare patients but also for those covered by commercial insurance. As the largest purchaser of healthcare services, federal government changes of this kind often accelerate similar action in the nation's commercial insurance marketplace.

As providers on the front lines of patient care, we need your help creating principles that should underlie changes in the way primary care providers are compensated. You'll have the chance to help shape payment changes at an upcoming "provider forum," very likely at your association meeting.

Setting the Stage for Provider Forums in Maine

While there is growing agreement that primary health care is the critical foundation of any high quality health care system, payment for primary care services in the U.S. and in Maine remains stalled at a crossroads. Our health care system remains fragmented, with costs higher than any other country in the world (nearly 18% of GDP) and is growing at unsustainable rates.

At the same time, Maine's aging population and ever-increasing prevalence of chronic illness are driving an increased need for care. Despite those challenges, investments in primary care services remain a relatively small fraction of overall U.S. health care spending (estimated at 5-7% in Maine and nationally), and we have yet to implement dramatically different approaches to primary care delivery and payment that are needed to transform to this system.

Given all this, it is more important today than ever before for primary care providers to help shape new payment models. *No one---the federal government, payers, employers, health systems and others---disagrees that several decades of underpayment to primary care providers has led to many undesired outcomes, including:*

- Fewer providers entering primary care because of poor pay
- A growing number of established providers and staff leaving primary care for more lucrative specialties and other professions
- Early retirement among experienced providers who are dissatisfied with increasing workloads and reporting requirements---- and stagnant or even decreasing levels of compensation
- Growing inequity in compensation between primary care and physician specialties
- A sense, particularly among employed providers, that payment incentives received by hospitals and systems are not being adequately passed along to front line providers
- The virtual extinction of independent providers as they struggle with growing costs for technology, staff support and increased and confusing reporting requirements and pressure to reduce costs.

There now appears to be widespread and growing agreement on this critically important fact: primary care is perhaps the single most important component in systems reform.

There also is growing acknowledgment that the payment model for primary care is broken and needs immediate attention. In fact, a growing number of decision-makers now understand that without affordable, accessible primary care in communities all across the state, Maine cannot manage and improve the care of tens of thousands of patients suffering from chronic illness. They understand that we cannot hope to reduce unnecessary and expensive utilization of emergency services. Nor can we be effective in our work to prevent the conditions that lead to hospitalizations.

While we are pleased to have supported efforts such as the Maine Patient Centered Medical Home (PCMH) Pilot and emerging Accountable Care Organization (ACO) arrangements, we recognize that those models are still built on a largely Fee For Service payment system; as such, they represent only small, initial steps towards a much-needed and fundamentally different payment system. Other investments that are needed also more appropriately support and reward high-value, patient-centered primary health care.

These changes will require a great deal of listening and dialog, as well as bold leadership and a commitment to collaboratively finding a way forward.

Looking Ahead---Provider Engagement Is Vital To Shaping New Payment Models

As the transformation of Maine's health delivery system moves forward, insurers and employers who provide coverage for their workers--as well as Maine's emerging Accountable Care Organizations---are poised make key decisions that will affect how providers are reimbursed for the essential care they provide for Maine people.

In response to this movement and pressing need for primary care leadership in shaping the direction of change, several Maine physician and provider organizations came together in the fall of 2015 to form the Maine Alliance for Primary Care (MAPC)¹. The MAPC, with funding support from the Robert Wood Johnson Foundation, is sponsoring a series of "Provider Roundtable" discussions that will be held during existing statewide meetings of more than a half-dozen physician, provider, and primary care associations from February through October, 2015. Each Roundtable will be professionally facilitated by the Maine-based Daniel Hanley Center for Health Leadership, which has been engaged for this purpose by MAPC and take place over a 60-90 minute period.

We will **not** be exploring payment models for changing the way in which care is delivered. The upcoming Provider Forum will engage primary care providers in **responding to, adding to or changing a set of draft principles** that can be used by payers, employers, ACOs and others as foundational to the redevelopment of payment to primary care providers. The process will only be rich if providers are sitting at these decision-making tables. ***Decisions must be driven by a set of core principles that will assure payment reform will lead to substantive changes that will improve primary care and lead to greater satisfaction by Maine's provider community.***

¹The Maine Alliance for Primary Care includes the Maine Academy of Family Physicians; the Maine Chapters of the American College of Physicians and American Academy of Pediatricians; the Maine Medical Association; Maine Osteopathic Association; Maine Nurse Practitioners Association; Maine Association of Physician Assistants; the Maine Primary Care Association; and representatives of several residency teaching programs.

To prepare for the Roundtables, PLEASE take a few minutes to review a draft set of principles prepared by the Maine Alliance for Primary Care. These draft principles have been drawn from work done by several organizations over the past four years, including:

- The American Academy of Family Physicians (AAFP) 2011
- The National Commission on Physician Payment Reform (NCPPR) 2013
- The California Primary Care Association (CPCA)
- The Maine Health Management Coalition (MHMC) 2015

This is not a complete list, but rather a starting point to spur thinking and discussion about a set of principles that would support the values and needs of Maine primary care providers. How would you change them or what would you add to improve clarity and effectiveness?

DRAFT Principles for Discussion

Primary Care Payment Reform should support payment that...

1. Is simple to understand and administer.

- The link between financial incentives and performance benchmarks should be clear and direct.
- Payments should be feasible within existing administrative capabilities.

2. Balances risk for both provider and purchaser.

- Risk to the provider should connect directly results they can control.
 - In the short-term, this may mean focusing incentives on process and structure improvements.
 - In the long-term, the focus should shift to patient outcomes and overall costs.
- Results should be predictable for the provider, i.e., “If I do this, then I will earn that.”
- Purchasers should provide financial support for the practices, but should not incur excessive risk or costs before improvements are achieved

3. Recognizes necessary short-term investments.

- At inception, practices need to make investments in care improvements that may not generate immediate savings.
- Practices may need support to make improvements; such support should be specific and time-limited.

4. Is aligned across multiple purchasers.

- Models that require different rules for each purchaser and for different practices add to the burden for all stakeholders.
- Innovative payment models for practices should be aligned with other innovative payment models (e.g., ACOs)

5. Recognizes the value of whole-person care delivered, including physician and non-physician work such as:

- a. face-to-face evaluation and management services
- b. patient care management that falls outside of payment for face-to-face visits, e.g. proactive preventive and chronic care management

- c. “medical neighborhood” care coordination (e.g. among hospitals, consultants, ancillary providers, and community resources)
 - d. remote monitoring of biometric clinical data and patient support
- 6. Promotes accountability by rewarding activities that improve patient outcomes and reduce total health care spending through incentives that:**
- a. allow providers to share in savings from reduced hospitalizations, emergency room overuse, and high cost procedures
 - b. reward measurable and continuous quality improvements
 - c. support providers in engaging patients as partners through shared decision-making and the development of strong, enduring, healing relationships
 - d. support the efficiencies of team-based care
 - e. support the use of evidence to guide clinical decision making
 - f. prioritize the provision of comprehensive primary care services
- 7. Compensates the practice’s investment in technology and services which enhance patient access and improve care coordination** such as:
- a. improved patient care communication, for example through a secure, Web-based patient portal that supports synchronous or asynchronous e-mail and virtual visits and telephone consultation
 - b. acquisition and use of health information technologies (e.g. patient registry systems, evidence-based clinical decision support, electronic health records, etc.)
 - c. investment in infrastructure for practice transformation and innovation, e.g. staff training, work flow redesign and practice recognition requirements
- 8. Encourages caring for and managing those with complex medical problems, multiple social support needs, and those who are traditionally medically disadvantaged.**