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

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MHMC ACI Committee Meeting

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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?

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The success of MaineHealth in the future depends in part on our ability to thrive under new models of payment

MaineHealth is pursuing a four point strategy to achieve the Triple Aim.

Invest in Information for Patient Care and Population Health

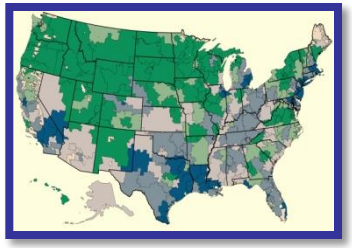
Successfully implement a shared medical record across our ACO AND harness the power of information for population health

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

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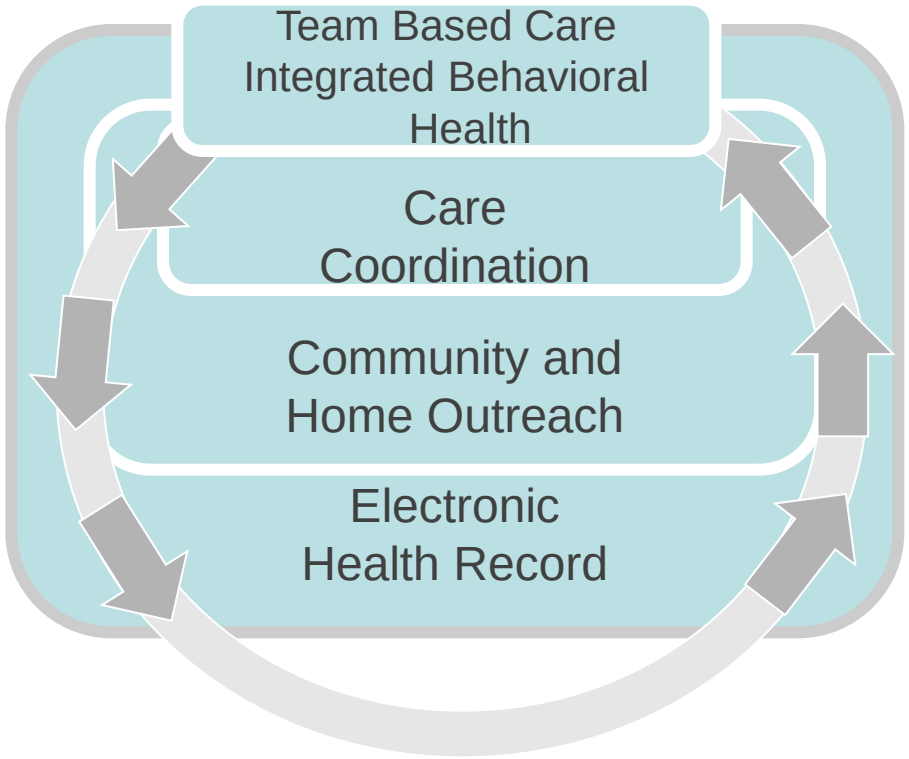
Patient-Centered Medical Homes

putting the patient first

The
Medical Home



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

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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

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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

Team Based Care	Whole Person Orientation	Enhanced Access
Integrated Behavioral Health	Patient Advisory Councils	Extended hours
Medical Assistants	Patient Experience Surveys	
Registered Nurses/Care Managers	NCQA Recognition	
Advanced Practice Professional		
Team meetings		
Policy Development/Training		

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

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Primary Care Payment Reform Program

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

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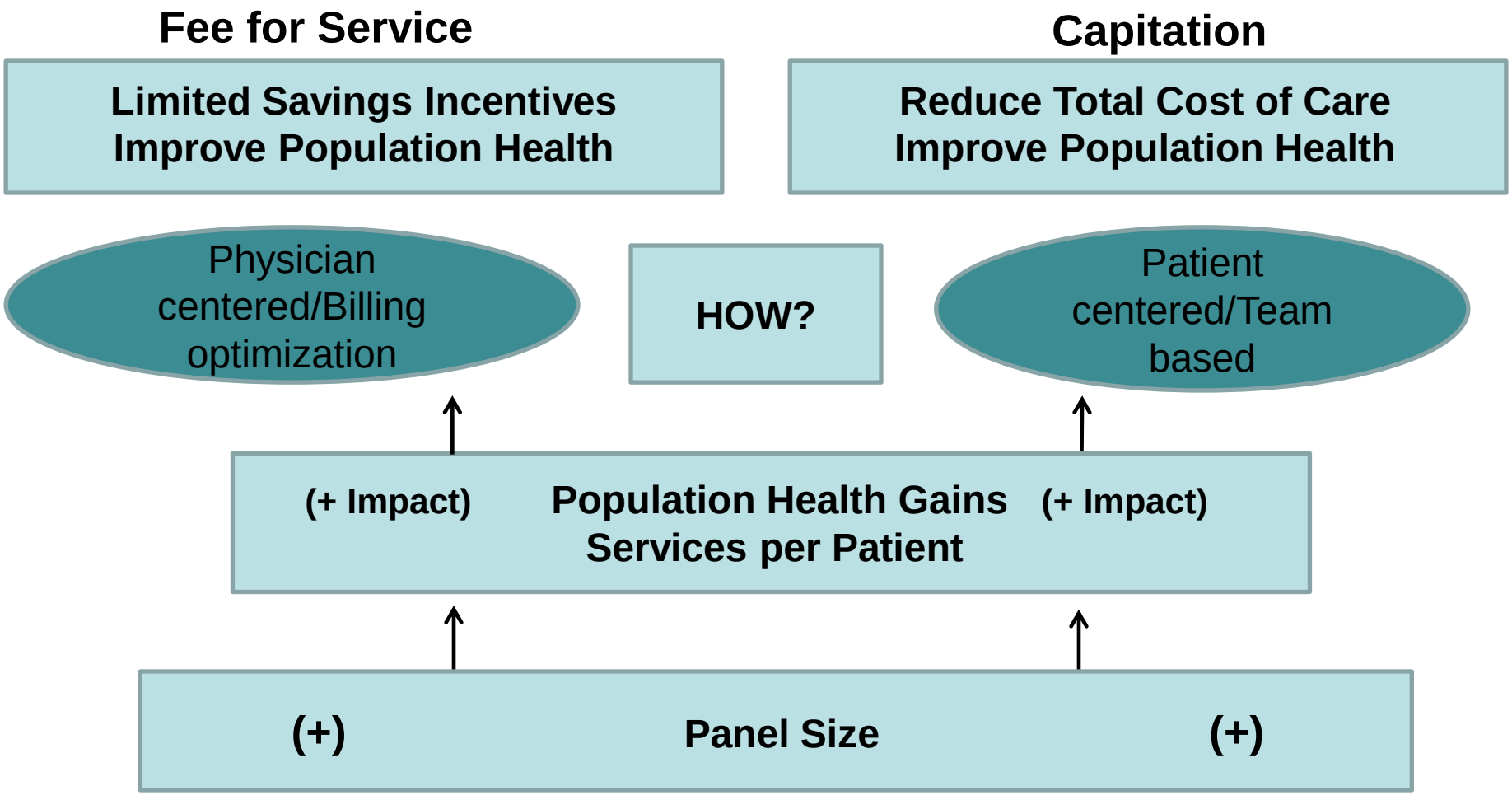
Developed a financial model of various scenarios under FFS and Capitation…



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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?

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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

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

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

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

Total paid amount data is from APCD

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

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For Each Potential Lab Practice: Calculated ROI based on three scenarios:

FFS Scenario 1:	**Target Panel/Current Services**	**Year 1**	**Year 2**	**Year 3**
	Incremental Investment	223,119	$ 227,581	$ 232,133
	Incremental Revenue	$ 105,651	214,762	327,488
	Return on Investment	**$ (117,468)**	**$ (12,819)**	**95,355**
FFS Scenario 2:	**Target Panel/Target Services**	**Year 1**	**Year 2**	**Year 3**
	Incremental Investment	223,119	$ 227,581	$ 232,133
	Incremental Revenue	335,952	593,236	718,464
	Return on Investment	**$ 112,833**	**365,655**	**486,331**
Capitation Scenario 1:	**Target Panel**	**Year 1**	**Year 2**	**Year 3**
	Incremental Investment	$ 223,119	$ 227,581	$ 232,133
	Incremental Revenue	$ 121,343	246,691	376,175
	Return on Investment	**$ (101,776)**	**19,109**	**144,042**

***Total Cost of Care Savings Scenario 2:**	8). Potential Savings Target Panel		
	Target Panel Size		10,982
	PMPM Savings	$	23.67
	Potential PMPY Cost Savings	$	3,119,397
	75% of PMPY Cost Savings	**$**	**2,339,547**

* Michael L. Paustian, Jeffrey A. Alexander, Darline K. El Reda, Chris G. Wise, Lee A. Green, and Michael D. Fetters. Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs. HSR: Health Services Research 49:1, Part 1 (February 2014). PMPM specific to the Adult Commercial population.

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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?

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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

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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

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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

[1]Altschuler, J., Margolius, D., Bodenheimer, T., Grumbach, K. *Estimating a Reasonable Patient Panel Size for Primary Care Physicians with Team Based Task Delegation.* Annals of Family Medicine. Volume 10. No. 5. September/October 2012.

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Break Even Analysis: Panel size and population health management

Panel Size	Target Claims											
0	4.9	5.0	5.2	5.4	5.6	5.8	6.0	6.2	6.4	6.6	6.8
9,000	$ (649,564)	$ (590,074)	$ (471,094)	$ (329,098)	$ (210,118)	$ (91,138)	$ 27,842	$ 146,822	$ 265,802	$ 384,782	$ 503,762
9,400	$ (521,031)	$ (458,897)	$ (334,629)	$ (186,322)	$ (62,054)	$ 62,214	$ 186,482	$ 310,750	$ 435,018	$ 559,286	$ 683,554
9,500	$ (488,898)	$ (426,103)	$ (300,513)	$ (150,628)	$ (25,038)	$ 100,552	$ 226,142	$ 351,732	$ 477,322	$ 602,912	$ 728,502
9,600	$ (456,765)	$ (393,309)	$ (266,397)	$ (114,934)	$ 11,978	$ 138,890	$ 265,802	$ 392,714	$ 519,626	$ 646,538	$ 773,450
9,700	$ (424,631)	$ (360,514)	$ (232,280)	$ (79,240)	$ 48,994	$ 177,228	$ 305,462	$ 433,696	$ 561,930	$ 690,164	$ 818,398
9,800	$ (392,498)	$ (327,720)	$ (198,164)	$ (43,546)	$ 86,010	$ 215,566	$ 345,122	$ 474,678	$ 604,234	$ 733,790	$ 863,346
9,900	$ (360,365)	$ (294,926)	$ (164,048)	$ (7,852)	$ 123,026	$ 253,904	$ 384,782	$ 515,660	$ 646,538	$ 777,416	$ 908,294
9,922	$ (353,296)	$ (287,711)	$ (156,542)	$ 0	$ 131,169	$ 262,338	$ 393,507	$ 524,676	$ 655,845	$ 787,013	$ 918,182
9,963	$ (340,121)	$ (274,266)	$ (142,555)	$ 14,635	$ 146,346	$ 278,057	$ 409,768	$ 541,478	$ 673,189	$ 804,900	$ 936,611
10,100	$ (296,098)	$ (229,337)	$ (95,815)	$ 63,536	$ 197,058	$ 330,580	$ 464,102	$ 597,624	$ 731,146	$ 864,668	$ 998,190
10,200	$ (263,965)	$ (196,543)	$ (61,699)	$ 99,230	$ 234,074	$ 368,918	$ 503,762	$ 638,606	$ 773,450	$ 908,294	$ 1,043,138
10,300	$ (231,832)	$ (163,749)	$ (27,583)	$ 134,924	$ 271,090	$ 407,256	$ 543,422	$ 679,588	$ 815,754	$ 951,920	$ 1,088,086
10,400	$ (199,699)	$ (130,955)	$ 6,533	$ 170,618	$ 308,106	$ 445,594	$ 583,082	$ 720,570	$ 858,058	$ 995,546	$ 1,133,034
10,500	$ (167,565)	$ (98,160)	$ 40,650	$ 206,312	$ 345,122	$ 483,932	$ 622,742	$ 761,552	$ 900,362	$ 1,039,172	$ 1,177,982
10,600	$ (135,432)	$ (65,366)	$ 74,766	$ 242,006	$ 382,138	$ 522,270	$ 662,402	$ 802,534	$ 942,666	$ 1,082,798	$ 1,222,930
10,700	$ (103,299)	$ (32,572)	$ 108,882	$ 277,700	$ 419,154	$ 560,608	$ 702,062	$ 843,516	$ 984,970	$ 1,126,424	$ 1,267,878
10,800	$ (71,166)	$ 222	$ 142,998	$ 313,394	$ 456,170	$ 598,946	$ 741,722	$ 884,498	$ 1,027,274	$ 1,170,050	$ 1,312,826
10,900	$ (39,032)	$ 33,017	$ 177,115	$ 349,088	$ 493,186	$ 637,284	$ 781,382	$ 925,480	$ 1,069,578	$ 1,213,676	$ 1,357,774
11,000	$ (6,899)	$ 65,811	$ 211,231	$ 384,782	$ 530,202	$ 675,622	$ 821,042	$ 966,462	$ 1,111,882	$ 1,257,302	$ 1,402,722
11,021	$ 0	$ 72,852	$ 218,556	$ 392,446	$ 538,150	$ 683,853	$ 829,557	$ 975,261	$ 1,120,965	$ 1,266,669	$ 1,412,373
11,500	$ 153,919	$ 229,937	$ 381,973	$ 563,420	$ 715,456	$ 867,493	$ 1,019,529	$ 1,171,565	$ 1,323,601	$ 1,475,637	$ 1,627,674
12,500	$ 475,251	$ 557,880	$ 723,136	$ 920,360	$ 1,085,616	$ 1,250,873	$ 1,416,129	$ 1,581,385	$ 1,746,641	$ 1,911,897	$ 2,077,154

Current panel size and current claims per patient

Break even point at current claims per patient

Break even point at target claims per patient

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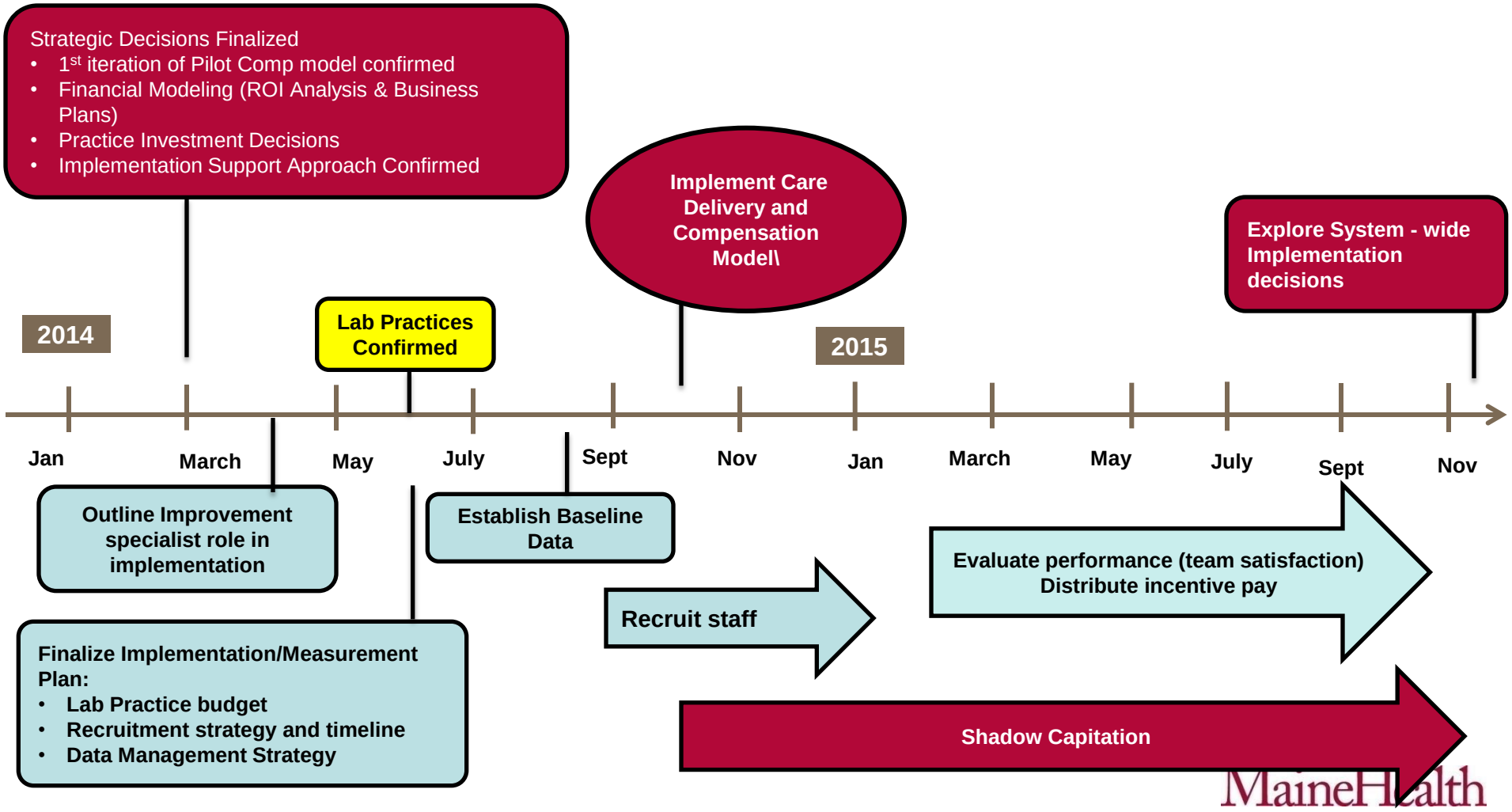
Primary Care Payment Reform Lab Practice Implementation Timeline



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Practice Transformation Implementation Timeline