



The Collaborative Payer Model

New Hope for Medicare and Primary Care

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November 24th, 2008

Abstract

Background

Current payment systems have driven primary care into decline and stifled reform. Primary care is central to managing costs and delivering quality, but has become fiscally and politically impotent, dissatisfying to all, and unattractive to new physicians. Policymakers and regulators have been unable to realize effective reform.

Discussion

The Collaborative Payer Model (CPM) delivers pre-paid, risk-adjusted funding by way of the primary care doctor-patient relationship. It pays for comprehensive care, not volume. In so doing, the CPM realigns interests and incentives, but also creates new relationships, with transparency as its foundation, and reciprocal responsibilities formalized through collaborative contracting. Shared planning leverages information and funding streams to promote continuous improvement.

A CPM payer has responsibility to promote transparency, to provide usable administrative and clinical information, to foster information technology capabilities, and to provide education. In the CPM, medical organizations are responsible for physician compensation formulas that reward comprehensive management and preventive services. CPM physicians are responsible for proactive care and care coordination.

The CPM offers Congress and The Centers for Medicare and Medicaid Services (CMS) appropriate use of risk-adjusted funding, collaboration by payer and physicians, elevation of primary care, and deterrence of care that brings no benefit. The CPM gives patients better access and more time with their doctor, earlier attention to health problems, enhanced benefits and affordability. The CPM gives medical leadership transparency of premiums flow, access to rich administrative information, rational innovation planning, and support for organizational development. The CPM frees physicians from historical constraints on the time, manner and place of care, enabling coordinated, comprehensive, effective care, enhanced by information tools and decision support. Aligned incentives reward proactive, preventive care and attention to wellness.

Summary

Early CPM results demonstrate very strong appeal both to physicians and to seniors, and strong but early evidence of good health outcomes and superior cost management. These trends predict substantial growth of the CPM within an evolution of Medicare. By enabling the CPM, CMS and Congress can realize the promise of risk-adjusted global payment, lost in its initial implementation, and provide a risk-adjusted capitation template for coverage of the uninsured and employer-led family plans.

Background

The Economics of Payment

In traditional Medicare fee-for-service, the government pays for “services,” but payment is actually limited to visits, tests and procedures. This longstanding “piece work” payment system has resulted in a narrow, encounter-based approach to care. Specialists perform more and more procedures, while primary care physicians run faster on their hamster wheels, striving to generate more encounters per day [1-2]. These desperate behaviors reinforce each other in a vicious cycle, accelerated by Medicare’s Sustainable Growth Rate formula [3].

Such forces discourage the work considered essential for optimizing health and managing chronic illness. Primary care physicians devote less time and resources to the proactive and preventive care that could most effectively impact the bulk of health care spending. In addition, this encounter-based system provides no compensation for time spent by PCP’s providing the kind of care coordination essential to counteract supply-driven services that have little or no impact on patient health status.

Primary Care in Decline

In the end, no one finds this kind of care satisfying. New doctors are increasingly shunning primary care [4-5]. Patients (when they can find a primary care doctor) feel that the hamster wheel doctor-patient relationship is rushed and incomplete. At present, PCPs are overwhelmed, with estimates that a family physician with 2,500 patients must spend 10.6 hours per day on chronic disease management, 8.4 hours per day on preventive care, 4.6 hours per day on acute care and two hours per day on care coordination [6-10]. As a consequence, trainees are choosing specialty practice [11], and doctors already in primary care practice are looking to get out. In a recent survey, 49% of PCPs were planning to reduce their practice hours or retire within the next three years [12]. The resulting shortage of PCPs is a catalyst for profoundly adverse consequences [13].

Perhaps the most profound consequence of these payment patterns is primary care’s political and fiscal impotence. The current mechanisms for setting payments suffer from severe under-representation by primary care interests [14]. In addition, morale among primary care doctors could not get much lower, leaving many with little motivation to continue practice, much less organize for change [15]. Finally, practice volumes stretched to the limit in order merely to maintain revenue leave little margin of time or capital for re-engineering processes of care, especially at the small practice scale where most of our nation’s care is delivered [16].

Primary Care is Essential to Reform

Despite these hardships, primary care has an essential role to play. Primary care is demonstrated to have a central impact on cost and quality [17]. For example, an increase in the number of general practitioners is associated with a significant increase in quality of health services as well as a reduction in costs per Medicare beneficiary. Conversely, increasing the number of specialists is associated with lesser quality and higher costs [18]. Starfield et al concluded that “Efforts to improve the [health care] system to achieve better health at lower

cost are rapidly becoming imperative. Primary care offers an effective and efficient approach to achieve that goal. Evidence of the benefits of a health system with a strong primary care base is abundant and consistent.” [19]

Two immediate improvement targets are ripe for action through the primary care physicians: excess health services, driven by provider supply; and disease prevention through proactive care.

Considering the first target, Fischer and Wennberg have established that over 50% of all Medicare spending is “supply-sensitive,” driven predominantly by the supply of providers within a community. More importantly, half of this supply-sensitive care has no demonstrable value [20-21]. Sorting wheat from chaff, and convincing patients that some physician-recommended services will not help them, are challenging prospects. PCP-based care coordination, which considers patient needs and preferences in a setting of continuity and comprehensiveness, entails the trust required to limit this ineffective care.

To address the second target, disease prevention, the continuity of the primary care relationship remains the logical place to identify, modify and monitor risks for the development of disease. Reforms to date have not aligned both incentives and resources to allow PCPs to deliver on the potential found here.

Little in the Way of Payer Innovation

Finally, little has been asked of payers in the models of reform proposed. Whatever the cause, very little innovation has been brought to the payer funding component of the care delivery system. With its central position in the flow of funds and information, and potent network advantages and economies of scale, no other participant has as much leverage and potential to re-align interests in the delivery of care.

In the face of this potential, a question begs asking: what if the role of the payer was reinvented as collaborative, transparent ally of the government, physician and patient?

Discussion

We propose a new model of payer: the Collaborative Payer Model. In describing how it works to re-align of health care's varied interests, and tip the playing field to the advantage of coordinated, proactive, and preventive care, this discussion has four parts: a description of how the model works; a sample of advantages the model delivers; specific benefits to different stakeholders; and some limited metrics from the field thus far.

I. How the Collaborative Payer Model Works

Funding Reform From Within the Doctor-Patient Relationship

Funding the Doctor-Patient Relationship

The CPM seeks to reinvigorate primary care and the doctor-patient relationship by funding care from within the primary care relationship. This renewal is achieved, first, by a structure of payment that removes constraints on the time, manner and place of primary care services. Under fee-for-service Medicare, a PCP's Medicare revenue averages about \$30 per-member-per-month (pmpm). Fully expressed, the CPM's risk contracting can deliver over \$100 pmpm in pre-paid, monthly revenue. (Here, full expression entails sufficient enrollment to cover annual expenses, and an expanded role for the PCPs: stewardship of health service, embodied in care coordination, proactive disease management, and enhanced patient access. For a derivation of this revenue figure—and to understand it in context of other primary care funding proposals—please see Supplement A.) No longer driven by the encounter-based piecework of Medicare FFS, doctors will have the flexibility to meet their patients' needs in the most rational and efficient ways available, with a positive business case for continuous innovation.

Second, the CPM reinvigorates the primary care doctor-patient relationship through a member benefits package that makes appropriate care affordable. While modest copayments are retained, few, if any, administrative barriers will be put between the patient and appropriate care. Collaborative planning and shared risk promote joint efforts to improve quality, and replace spending control enacted through administrative barriers.

Funding Health Care Reform

The CPM asserts that the failure of innovation can be attributed to inability of the payment system to deliver return on investment to physicians for health service reforms. From health information systems, to evidence-based decision support, to all the models for change in how we deliver care for health services, the investment required is borne by doctors, while the benefit a reform generates, especially financial, accrues elsewhere. Under the CPM, globally capitated, risk adjusted payment creates a tight, positive relationship between the effectiveness of clinical services and reimbursement. Any and every care enhancement that improves the value of patient care also brings a financial return to the medical organization.

An Alignment of Payer, Physician and Patient Interests

In place of a mercenary confrontation of payer with physician and patient, the CPM aligns the economic fates of payer and the physicians by forcing them to share both risk and reward for optimizing the patient's health status. Perhaps more importantly, the flow of funds through the payer is open to scrutiny by the medical organizations, and the terms of funds distribution are subject to negotiation between payer and the organization, as they try to create incentives for improved patient care.

Under the CPM, the payer reveals the premium-based revenue stream and the supporting data, disavowing the exploitation of information asymmetry. After paying all claims except for compensation for PCP services, a fund remains, representing both revenue and working capital for program improvement in the medical organization. To distribute this fund, the payer works with the medical organization to negotiate contract incentives for achieving collaboratively-planned improvement goals. As the medical organization implements their improvement initiatives, incrementally greater revenue from this fund is passed through to the doctors.

2 Initiatives can take many forms (for example, cultural change efforts; data infrastructure and reporting projects; delivery reforms such as the Patient-Centered Medical Home; population health status outcomes ...). The only limits on inclusion are the imagination of the medical organization's leaders, the constraints of their setting, and regulatory constraints on collaboration among health care entities. The negotiation's shared objective is promoting achievable improvement goals that will result in better population outcomes, and subsequent plan performance. Indeed, these negotiated incentives can be structured to reward incremental progress over several contract cycles. Moreover, they can be re-negotiated as progress plays out, to reward smaller steps or changing priorities.

This re-alignment and re-invention of the relationship between payer and physician organizations is a fundamental part of the CPM's innovation, and no small change in the culture of health care. It calls on physicians to look on the CPM payer with new eyes and expectations. More importantly, it calls on physicians to organize in systematic ways to deliver on improvement initiatives. Such organization requires an emerging physician leadership, not as a defensive consolidation of status quo power, but rather as a leveraged means to move forward. In this leadership development, a CPM payer, its physician partners, CMS and patients all have an interest.

Alignment Fortified by Reciprocal Responsibility and Accountability

A medical organization's trust in a CPM payer should not require a leap of faith, and vice versa. Consequently, the CPM's mutual and reciprocal responsibilities will be clearly embodied in contract terms and incentives.

The Payer's Responsibilities

The payer's first responsibility is transparency, both in financing and in plan operation. Transparency in financing entails eliminating information asymmetry by giving complete plan financial data to the medical organization. This principle is furthered by contract contingencies

that reward incremental progress, rather than idealized end-states. In addition, a CPM contract specifies a sharing of the payer's economies of scale.

Transparency in plan operation entails ever-improving efforts at clear communication about the workings of a benefits package. For members, this principle asks the payer to use its network advantage to develop member materials which provide a complete and open description of the plan benefit. Through such clarity, a CPM payer ensures fundamental fairness and appropriate access to care. For physicians, the CPM payer is obliged to develop the medical organization's understanding of the level of financial risk associated with the benefit package offered, and how such risk is managed. In addition to providing fairness on this side of the benefits package, such knowledge is vital to rational physician practice planning and sustainable delivery of these member benefits.

The payer's second responsibility is providing information. This duty entails, first, mobilizing the tremendous resource of care management information contained within the transactional charge data through which payers operate. The record of health delivery for individuals and populations within charge data can and must be brought to the coordination of care in the clinics. In addition, the payer is ideally positioned to deliver information tools and analytical services to make that information clinically useful.

A second aspect of the payer's responsibility for information revolves around decision support. For clinicians and practice administration, the payer, with its network of organizations and contracts, is well-positioned to act as a clearinghouse not only of relevant research and guidance, but also of field experience about putting this information to use. All involved share an incentive to make this work, but only the payer is situated to amplify the impact of this information on care.

A third payer responsibility centers on information technology in the clinic. Here again, the payer, working across its network of plans, has an economy of scale for providing IT infrastructure and support. In complementary fashion, close cooperation with the network of clinical partners enhances the development of information tools and analytics.

A fourth responsibility exists in education and training. All participants share an interest in expanding the health service capability of partner medical organizations, but, here, again, the payer's advantageous position all but obligates a role in the coordination of learning.

One particular area of training deserves special mention and carries with it actual obligation. Along with the opportunities found in Medicare Advantage's risk adjusted capitation come a liability: a change in the meaning of compliance. The importance of this liability cannot be overstated. Even innocent errors in coding practice, systematically applied, can have large financial and legal repercussions. Changing from E&M/CPT coding to an ICD-9 payment methodology in risk adjusted reimbursement requires a dramatic shift in longstanding physician coding habits.

Previous E&M coding rules were, in general, poorly executed by physicians. In addition, striving for precision and completeness in the use of ICD-9 diagnostic codes was generally considered a poor use of precious time,

especially in light of ICD-9's limited usability and marginally more useful secondary guidance. In Medicare Advantage, payment is driven by risk adjustment based on the history of disease derived from the ICD-9 diagnoses coded for that patient. Adequate funding for patient care depends heavily on accurate and comprehensive coding of disease conditions and their severity. Even greater peril lies in the compliance regime that is required to check the moral hazard of exaggerating or padding the diagnoses assigned.

In order to accurately and safely codify high risk conditions in Medicare beneficiaries, PCPs need effective education about three things: the proper use of the ICD-9-CM coding system and its associated documentation; the established clinical criteria for the use of a diagnosis code; and even greater education around diagnostic criteria not specified within coding rules, where the medical literature often shows controversy.

While giving these important conditions such administrative attention, the payer cannot miss an opportunity to touch on important aspects of their clinical management, such as: evidence-based strategies for screening and identification of patients with high-risk conditions, be they asymptomatic or complicated by multiple comorbidities; evidence-based treatment strategies for high-risk conditions in the elderly; diffusion of knowledge about drug therapy in those over 65 (who are generally excluded from major therapeutic trials); and treatment plans that respect authentic patient preferences, informed by their stage in life, treatment burdens and comorbidities. To introduce Medicare Advantage into a physician's practice without such training not only subverts the foundational principle of the program, but is also negligent in an almost reckless way.

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The Medical Organization's Responsibilities

Medical organizations have responsibilities in the CPM, first, in physician compensation. The CPM's risk-adjusted capitation works best with internal compensation formulas that maintain the alignment of the interests for payer, medical organization, clinician and patient. In this setting, quality and efficiency in patient care is powerfully and simply advanced when a clinician's compensation for care of CPM patients is in some part "at risk." Good management of sicker patients can and should, to a palpable extent, reward the individual clinician.

On the other hand, many of the benefits of proactive care—and some morbidities from its neglect—are remote in time. With some benefits of good management left to the future, but with the costs of this management accruing in the present, risk-adjusted funding could incentivize PCPs to make short-term, inappropriate decisions about services, especially preventive care. To counteract such short-term thinking, a medical organization in the CPM has a responsibility to modify its internal compensation formula to provide incentives for preventive care and other services whose impact is lost in the timing or details of risk-based payments.

The medical organization also has a responsibility to "meet the payer halfway" in the communication that drives care coordination. When the payer delivers appropriate, timely and work-flow sensitive messages, the organization must work to ensure the systematic application of that information to patient care.

Finally, the medical organization has a responsibility to go beyond an acceptance of change and, instead, to lead it. The CPM's emphasis on proactive care and global risk, when contrasted with the volume demands of traditional fee-for-service, places clinicians in an awkward struggle between two modes of operation. Serving as the coordinator of care and investing in the long term health of the patient will feel professionally comfortable I

for most clinicians. Unfortunately, this approach will be at odds with an established, hectic culture of “productivity” based on procedures and encounters. To drive the requisite cultural shift, medical organization leadership must recognize their own role in leading change.

The Physician’s Responsibilities

Individual physicians also have responsibilities in this model. Four aspects of their clinical leadership role stand out. First, the entire collaboration—patient, physician, organization and payer—needs the PCP to aggressively undertake proactive care. Such care implies using information technologies for screening and interval monitoring of chronic disease, for reminder and alert systems and registries, and for finding gaps in patient adherence. Under the CPM, the funding should reach the PCP in ways that not only enable, but also encourage, this effort.

Second, the PCP must show clinical leadership by coordinating care throughout the varied settings of health services. The PCPs must communicate to specialists their expectations about the patient at the time of referral. When the patient returns, the PCP will be in a position to explain the care, translating its implications for the patient, and to help promote adherence.

Third, the PCP’s role is transformed from piecework into stewardship, a personal responsibility for the well-being of the patient that extends manipulating physiology. For example, the hectic pace of work, driven by fee-for-service funding, too easily allows physicians to abdicate from already uncomfortable conversations with patients about lifestyle choices and authentic end-of-life preferences. While the CPM provides incentive and resources to have such conversations, optimization of patient quality of life requires physicians to commit their creativity and diligence to breaking the conspiracy of silence around such topics.

Finally, individual physicians must sincerely engage in the processes and training created to promote quality, efficiency and compliance. To such programs, the payer will bring standards and analysis co-developed with local physician input, but this collaboration presumes that physicians become active developers, rather than passive consumers, of quality improvement processes.

II. Potential Advantages of the Collaborative Payer Model

If payers, physician organizations, physicians and patients can work together as described above, many advantages follow. Here is a sampling.

Managing Medicare Costs While Improving Quality

Appropriate Use of the CMS Risk Adjustment Model

The financial transparency of the CPM helps ensure that the risk-adjusted revenue is driven to and through the doctor-patient relationship in the form of better member benefits and better PCP compensation. This funding enables PCPs to improve their care processes and deliver proactive care for high risk conditions, while patients can afford the care their doctors recommend.

This model offers much more than current implementations of risk adjustment in which payers merely augment revenue by auditing charts for additional diagnosis codes that boost premiums. Keeping the incremental revenue, they neither inform the PCPs of the existence of these conditions, nor ensure that requisite care for conditions is provided.

Better Management of Supply-Sensitive Care

Private Medicare payers are criticized for the costs of their administrative overhead, relative to fee-for-service. Factoring in the costs of supply-sensitive care will tilt the scales in favor of CPM payers, who are ideally positioned to manage appropriate utilization.

As noted previously, Wennberg has meticulously demonstrated that about 25% of Medicare spending in patients with chronic illness is driven solely by differences in the supply of providers [21]. The CPM, driven by PCPs who are motivated, armed with information and decision support tools, and empowered with a collaborative relationship with the payer, provides a practical method for better distinguishing supply-sensitive care from necessary care. Perhaps more importantly, the discussion of value within supply-sensitive care is brought to the community where the care is delivered. Questions of value for patients are settled “on the ground,” rather than in a remote, abstract and categorical administrative process.

Elimination of the Adversarial Payer-Physician Relationship

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We are unable to quantify the value that is destroyed by adversarial relationships between physicians and payers. This destruction plays out in rationalization of marginal practices, deception [22], payment delays [23], micromanagement, rationing care through inconvenience [24], brinksmanship, and bitter litigation [25]. While the CPM promises change and innovation springing from a shared interest and a collaborative mindset, one should not underestimate the gains to be realized simply by transcending ideologically-entrenched adversarial positions.

The Elevation of Primary Care

The CPM elevates the work of primary care physicians in three ways. First, the CPM liberates the PCPs and their patients from volume-driven, “hamster wheel” health care. Physician compensation is based on the value of health care provided, instead of the quantity of face-to-face visits and number of relative value units generated.

Second, the CPM effects an essential change in how care is delivered. Such change may entail non-face-to-face encounters or services by the PCP, using the telephone, email or other remote, asynchronous, or time-shifting technologies that have not been reimbursed in traditional fee-for-service. In addition, the PCP may delegate tasks to a team of caregivers both in and out of the clinic. The PCP will sometimes function as the quarterback of a care team and sometimes as a direct provider of service. In the end, any configuration of service and service teams that enhances health outcomes in that setting, can and should be deployed.

Third, the CPM revives primary care as a career choice for young physicians. Burdened by educational debt, trainees must consider the financial prospects of their career choice.

In addition, the balance of work and home introduce financial, work day and psychic stress concerns. Finally, the innate professional satisfaction in the nature of the work must be addressed. The CPM tips the scales back toward primary care as a career for young physicians.

Support for Innovation

The CPM provides a foundation for innovation that goes unsupported in the current funding paradigm. Clinical practice innovation ranges from teamlets [26], to advanced access scheduling [27], to expanded care teams and shifting roles. Under the CPM, the sole threshold criterion is the potential contribution such innovation makes to the effectiveness and efficiency of care. Incentives are aligned for payer, physician and patient, such that all should work to try to make these efforts successful.

Federal programs that try to innovate at this operational scale are inherently limited. Slowed by the rule-making process, they are also, by dint of their national application, a blunt tool for the diverse settings of health care. Federal actions directed at individual clinics, by necessity of categorical funding design, are burdened by participation requirements and program qualifications that can stifle the creativity such action is meant to foster. More subtly, funding in this form can lead to development responses whose goal is funding rather than innovation. The floor of qualification becomes the ceiling of aspiration. Promoting reforms through CPM risk-adjusted global payment creates incentive that delivers both increasing reward for better results and discipline to limit costs, while leveraging local knowledge and local “ownership” of the program.

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Transformation of Capitation

A current discussion of capitation is burdened by its failed history. Its promise faded as payers squeezed physicians, decreasing the funding in global risk contracts by as much as 20 to 25% [28]. Many medical organizations found they were not up to the administrative demands that capitation entailed. In addition to being underfunded, the payments were not prospectively risk-adjusted, and physicians lacked access to the financial and clinical data that drove the system. Finally, information systems were immature, providing little clinical decision support at the point of care.

The past problems of capitation are mitigated by a number of features within the risk contracting of the CPM [29]. First and perhaps foremost, the risk-adjustment removes the economic benefits of “cherry picking.” For Medicare Advantage HMOs, CMS’s annual benefit bid process limits the profits they may take. Incremental savings are returned to the members in the form of more generous benefits. Next, the CPM reverses the physician “squeeze” by sharing margins with the medical organizations, especially as enhanced revenue for PCPs. Finally, capitation’s conflicts of interest for PCPs are mitigated by the CPM’s call for physician compensation formulas that include ethical financial incentives [30].

Finally, the CPM transforms physicians from gatekeepers into stewards of care. Despite having closed-network panels of specialists, the low member out-of-pocket expenses will mean a de facto expansion of care for most seniors, since FFS Medicare coinsurance may constrain access to care for seniors with fixed incomes and limited savings. Where specialist panels are limited, physicians will have the primary responsibility for determining specialist inclusion not simply on price, but also on service and outcomes.

III. Specific Benefits to Various Stakeholders

To CMS and the Congress: the CPM offers flexible funding for health care reform, with continuous incentive for both cost-containment and quality. It surpasses current payment methods and reform proposals to deliver:

- Appropriate use of the CMS Risk Adjustment model;
- Elimination of the adversarial payer-physician relationship;
- Funding of the primary care team as the coordinator of care; and
- Better management of supply-sensitive care,

To Patients: while aligning all participants around optimized patient health status, it also offers

- Better physician access;
- More time with their PCPs;
- Earlier medical attention to their incipient problems; and
- A greater ability to afford the care their doctors recommend.

To Medical Organization Leadership: the CPM offers unprecedented open collaboration in plan design, supported by

- Complete visibility into plan funds flow and administrative data;
- Mutual incentive and infrastructure for bidirectional data exchange;
- The opportunity to innovate better care based on rational business plans; and
- Payer support for the development of the organization's leadership and cultural capacities.

To primary care physicians: the CPM opens new possibilities in the time, manner and place of care. Along with driving new funding, it envisions new opportunities in primary care:

- Stewardship of the patient's health and health resources;
- Care coordination;
- An embrace of clinical decision support tools; and
- A reason to make the personal and financial investment in information technology.

To other providers: the CPM's emphasis on comprehensive management, better communication and care coordination by PCPs encourages specialists, hospitals and other service providers to focus on "line of service" value. As they focus on the technical issues of delivering continuously improving service, they see:

- Payment determined by working with a medical organization firmly-rooted in their community;
- Medical organizations encouraged to extend collaborative payment models, rewarding value creation, perhaps by extending risk reimbursement; and
- Negotiation of payments based not simply on price, but on service and outcomes for patients and fellow physicians, and consideration for the particular needs of that community.

IV. Preliminary Metrics

Implementation of the CPM beyond its initial market (St. Louis) is in its early phases. Consequently, the data does not allow a discrimination of correlation from causality. Thus, it is unclear to what extent the following results are caused by the Collaborative Payer Model, and to what extent they are the result of the collaborative payer partnering with high-performing medical organizations (who would deliver superior care for any payer). Nonetheless, preliminary data are encouraging.

CPM Delivers the Best Benefits

Within Medicare Advantage, an important measure of benefit is the Maximum Out Of Pocket (MOOP) expense limit [31]. The MOOP limits how much money a Medicare beneficiary will pay out of their fixed income and limited savings if they experience substantial illness or injury in a given year.

Table 3: Comparison of Medicare HMOs in all CPM markets, 2009				
Location	Plan Name	Plan Number	Premium	MOOP
Kentucky Louisville	CPM MAPD HMO	H8778-001	\$0	\$1,250
	Next Best Plan in market	H1849-005	\$0	\$3,500
Indiana Clark County	CPM MAPD HMO	H8778-001	\$0	\$1,250
	Next Best Plan in market	H1511-001	\$0	\$3,500
Illinois St. Clair County	CPM MAPD HMO	H2610-005	\$0	\$ 800
	Next Best Plan in market	H1416-018	\$0	\$2,000
Missouri St. Louis County	CPM MAPD HMO	H2610-005	\$0	\$ 800
	Next Best Plan in market	H2663-005	\$0	\$2,800
Washington Snohomish	CPM MAPD HMO	H1837-002	\$0	\$1,350
	Next Best Plan in market	H9302-007	\$0	\$3,350

In each market, the CPM payer has the most generous MOOP benefit (Table 1). For example, in Louisville Kentucky, the CPM Medicare Advantage plus Part D (MAPD) HMO plan has a maximum out of pocket annual expense of \$1,250. The next most generous benefits in that market from any other plan have a MOOP of \$3,500 per year. This pattern persists in all markets entered thus far.

CPM Delivers Highest Member Satisfaction of Missouri MA plans

Each year CMS contracts with an independent company to administer surveys to members in each Medicare Advantage Plan. Table 2 lists of some of the metrics in which a CPM payer ranked first in the state of Missouri. No results are available for KY, IN and WA.

Table 2: Some metrics in which a CPM plan ranked first among all Missouri MAPD Plans in the 2008 CAHPS survey:

Overall Rating of Health Plan
Overall Rating of Care Received
Getting Care Quickly
Getting Seen By Health Care Provider Within 15 Minutes of Appointment
Overall Rating of Prescription Drug Coverage
Getting Needed Prescription Drugs
Ease of Getting Prescribed Medicines
Ease of Filling Prescriptions
Willingness of Members to Recommend Plan For Drug Coverage

CPM HEDIS Measures

The most recent HEDIS measures on the CPM plan for which data is available indicate high scores in comprehensive diabetes care (see Table 3). Also note the very low rate of ER visits and low outpatient prescription costs. These patients also achieved high access to preventive and ambulatory services, and low rates of ER visits and hospital bed-days.

Table 3: Some 2007 HEDIS Results for CPM Payer

Top Decile nationally:

- Annual Monitoring for Patients on Persistent Medications (high)
- Comprehensive Diabetes Care: Rate of HbA1C testing (high)
- Comprehensive Diabetes Care - Rate of Poor HbA1c Control (low)
- ER visits per 1000 members ≥ 65 years old (low)
- Outpatient Prescriptions, total average cost per member year (low)

Top Quartile nationally:

- Access to Preventive/Ambulatory Health Services (high)
- Ambulatory / ER visits per thousand members ≥ 65 years old (low)
- Inpatient bed days /1000 member years ≥ 65 years old (low)

Summary

The Collaborative Payer Model (CPM) is a dynamic partnership between a payer and a medical organization, built on aligned incentives, shared control, transparency and heightened reciprocal accountability. This model's restructured payment system, and its culture of shared purpose and mutual accountability, can tip the dysfunctional economic balance within health care in favor of the health of patients, while fostering stewardship of health care resources.

The promise of this model is built on three features that distinguish it from the current state of health care finance [32]. First, the CPM seeks to improve care through its most important driver: payments to physicians. Second, the model structures this funding to create an alignment of interests among payer, physicians and patients. Third, aligning these interests within the patient's care replaces traditional mistrustful micromanagement with a common interest in improved performance, demonstrated with shared data. Moreover, new mutual, reciprocal responsibilities and their accountability are enforced in the plan contract.

If implemented within the framework of a Collaborative Payer Model, Medicare Advantage Plus Part D HMO plans have the potential to change fundamental economic and clinical dynamics of the American healthcare system.

Such potential is wasted when this model is meekly attached to the fee-for-service contracts of a traditional payer-physician relationship inside MAPD. In this form, Medicare Advantage serves only as a new revenue opportunity for the insurer. Even worse, execution in this manner creates new and challenging testing, documentation and coding requirements for the clinician, with no commensurate financial incentive, or relief from the time pressures incumbent to fee-for-service work. Where payers divert assessment and coding to case managers in disconnected disease management programs, primary care physicians become increasingly underfunded and siloed.

Early CPM results demonstrate very strong appeal both to physicians and to seniors, and strong but early evidence of good health outcomes and superior cost management. In the authors' view, these trends predict substantial growth of the CPM within MAPD plans in the coming years. For all these reasons, the CPM deserves serious consideration in the discussion of the governance and evolution of Medicare

The CPM may also provide an excellent risk-adjusted capitation system for expansion of coverage to the currently uninsured, and modernization of employer-led family plans. Results and lessons from the first wave of CPM health plans should be watched closely by regulators, legislators, and health care leaders.

Competing Interests

The authors are all salaried employees of Essence Healthcare, which operates the Collaborative Payer Model in the U.S. Each author also has equity investments and/or stock options in the company.

Authors' Contributions

TDD, JRB, DKG and FAI made substantial contributions to conception and design. TDD and JRB analyzed and interpreted the data. TDD, JRB and FAI drafted and revised the manuscript for important intellectual content. TDD, JRB, DKG, FAI have given final approval of the version to be published.

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Appendix A: Revenue Distribution Through Medicare Advantage in the CPM

Tracking funds from CMS to PCP step-by-step best demonstrates how per-member-per-month (pmpm) revenues can reach \$100. All dollar figures are pmpm.

To start, consider the Average 2008 MAPD Revenue figure. The U.S. national average is \$820 pmpm. Under Medicare Advantage, the revenue tracked to an individual physician could be calculated by applying a risk adjustment factor (RAF—also known as the average HCC score), an aggregate measure of “how sick” that doctor’s patient panel is. For the demonstration, we assume an RAF of 1.00, a simple but realistic assumption. With these figures, the Risk Adjusted Revenue can be calculated:

Risk Adjusted Revenue	=	Average 2008 MAPD Revenue	X	Risk Adjusted Factor
	=	\$820	X	1.00
Risk Adjusted Revenue	=	\$820 pmpm		

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In its most evolved relationships, ESSENCE Healthcare, the authors’ Medicare Advantage health plan and working laboratory for the CPM’s principles, retains 14% of the Risk Adjusted Revenue for its costs, such as customer service, quality improvement and marketing, leaving the Revenue after Health Plan Costs:

Revenue After Health Plan Costs	=	Risk Adjusted Revenue	X	14% of Risk Adjusted Revenue
	=	\$820	X	\$115
Revenue After Health Plan Costs	=	\$705 pmpm		

From the Revenue After Health Plan Costs, next subtract the costs of health services other than those delivered by the PCP. Such Non-PCP Costs in ESSENCE MAPD are running about 70% of 2008 MAPD Revenue.

From the Revenue After Health Plan Costs, next subtract the costs of health services other than those delivered by the PCP. Such Non-PCP Costs in ESSENCE MAPD are running about 70% of 2008 MAPD Revenue.

Non-PCP Costs	=	Average 2008 MAPD Revenue	X	70%
	=	\$820	X	70%
Non-PCP Costs	=	\$574 pmpm		

The funds left after subtracting Non-PCP costs are called the Residual.

Residual	=	Revenue After Health Plan Costs	X	Non-PCP Costs
	=	\$705	X	\$574
Residual	=	\$131 pmpm		

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This Residual grows when the medical organization and the payer help the PCP manage the quality and efficiency care. Consequently, this Residual is split between the medical organization and the payer, based on incentives and contingent payments collaboratively established by payer and medical organization, with up to 80% going to the medical organization. Calculating at 80% gives the PMPM PCP Revenue:

PMPM PCP Revenue	=	Residual	X	80%
	=	\$131	X	80%
PMPC PCP Revenue	=	\$105 pmpm		

The authors believe this result is a conservative and, thus, sustainable estimate of what can be achieved in a mature CPM relationship.

Providing this kind of revenue—at several multiples of current FFS funding—may seem counterintuitive when our country so clearly needs to restrain Medicare costs. It should be noted that such a figure is consistent with other reform models. In a recently completed demonstration program, CMS paid disease management companies fees in the range of \$80-150 pmpm in the Medicare Health Support demonstration project. Another program, the Medicare Coordinated Care Demonstration (MCCD), spent between \$80 and \$444 pmpm. [1] Analysis of this controlled trial of mostly nurse-driven care coordination for chronic disease did not produce the desired results. Nonetheless, two programmatic features were demonstrated: care coordinators are effective only when working face-to-face; and care coordinators must collaborate closely with patients’ physicians.[2]

Looking ahead, the proposed Care Management Fee under the Medicare Medical Home Demonstration Project (see Table 4), which includes the possibility of even further returns with no downside risk to the PCP[3].

Table 4: Proposed Medical Home Demonstration Project PMPM Payments (base level compensation only)

Medical Home Tier	Patients with HCC Score <1.6	Patients with HCC Score ≥1.6	Blended Rate
1	\$27.12	\$80.25	\$40.40
2	\$35.48	\$100.35	\$51.70

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The Comprehensive Payment for Comprehensive Care model calls for increasing primary care physician revenue from its average of around \$400,000 annually to the \$1 to \$1.25 million range [4]. Again, the bulk of this incremental revenue is devoted to the incremental costs of comprehensive care. Finally, in 2009, the British NHS will pay all general practitioners revenue average bonuses of \$210,000 in addition to their base salaries, under their Pay for Performance program [5].

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