Connecticut Health Policy Project

CT Medicaid primary care redesign: What the evidence says

Part 2: Primary care payment reform

October 12, 2023

Connecticut Medicaid is considering reforms to primary care delivery and payment. The CT Health Policy Project is collecting evidence from other states and programs to help inform that planning. Part 1 focused on Connecting with community services to improve health.

A major part of DSS's planning for reform is to consider changing how Connecticut Medicaid pays for primary care. DSS's goal in reconsidering the current payment model is to:

> Provide sufficient payment to enable and integrate care delivery redesign and performance measurement opportunities and ensure that payment adequately supports and advances biopsychosocial health and drives accountability for outcomes[1]

In Connecticut and nationally, there is a great deal of interest in moving all healthcare payment, including for primary care, away from a system that pays for individual services to value-based purchasing (VBP) that rewards quality and places providers at financial risk to lower costs. Unfortunately, despite many trials across the US devoting years and massive resources to the idea, there is no evidence that value-based purchasing (VBP), including primary care payment reform, either improves the quality of care or reduces spending.

Findings from the literature:

The largest test of primary care payment reform so far evaluated, is the federal Center for Medicare and Medicaid Innovation's (CMMI) CPC+ program engaged 2,610 primary care practices across the US in multi-payer payment and care delivery reform. The final CPC+ program evaluation was very disappointing. Independent evaluators found ED visits and acute hospitalizations down slightly, however those impacts were offset by increases in other services. When the costs of the program's enhanced payments were included, the program lost over $400 million. CPC+'s record on quality improvement was small and mixed.

- Berwick, et. al. conclude that "CMMI has devoted more attention to testing new payment models than to fostering specific care models." They recommend "Rebalance CMMI model tests toward delivery system redesigns, not just new payment models."
- Berenson, et. al. notes that "Despite more theoretical, often creative, proposals and a range of primary care payment demonstrations, we are not much closer to a consensus payment model".

[1] PCPAC Meeting 2, Presentation, May 4, 2023

- Milad, et. al. stated, "evidence from this review suggests that success in improving quality, reducing spending, and improving appropriate utilization after a shift to greater risk-sharing is far from guaranteed."
- Markowitz, et. al. "conclude that CPC+ did not improve spending or quality for private-plan enrollees in Michigan, even before accounting for payouts to providers. This analysis adds to existing evidence that CPC+ may cost payers money in the short term, without concomitant improvements to care quality."

Recommendations:

The evidence points to first supporting specific primary care functions that are proven effective, such as sharing raw data, care coordination resources, and learning collaboratives, and then designing payment and accountability to support the functions. (Friedberg, et. al., Berwick, et. al., Pandey, et.al.)

The literature also highlights the need for monitoring of unintended, but predicable, consequences such as stinting on care (Ubl). **Especially troubling is evidence of reduced primary care utilization, including in Medicaid ACO programs** (Rosenthal, et. al., McConnell, et. al.). This is especially troubling as improving access to primary care is a prime goal of primary care reform across all stakeholders. While moving away from paying fees for each service to per-patient payments could theoretically reduce unnecessary office visits, it was expected that those new care openings would be filled by patients with unmet needs. This would result in no change in utilization but better access to care for more patients. As that didn't happen, it is very possible that de-linking payment from service delivery and paying regardless of whether patients got care led to reduced access.

In a related concern, Catel, et. al. urges **carefully designed and monitored risk adjustment** systems to avoid "perverse incentives" for providers to select more lucrative patients to drive profits.

Sources:

Centers for Medicare and Medicaid Services, Center for Medicare & Medicaid Innovation, Mathematica. (2022) *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Fourth Annual Report*.
https://www.cms.gov/priorities/innovation/data-and-reports/2022/cpc-plus-fourth-annual-eval-report
The largest test of primary care payment reform so far evaluated, CPC+ engaged 2,610 primary care practices across the US in multi-payer payment and care delivery reform. The program, run by CMS, did not include Connecticut. The program included payments for care management, performance payments, and, for some, partially capitated payments that were higher than what they would have received under fee-for-service.

This final CPC+ program evaluation looked at the impact on the Medicare program. They found ED visits and acute hospitalizations down slightly, however those impacts were offset by increases in other services. **When the costs of the program's enhanced payments were included, the program lost over $400 million. CPC+'s record on quality improvement was small and mixed, some positive and some negative.**

From the report: (PY is program year, Track 1 is without and Track 2 is with capitated payments) "Over the first four years, CPC+ reduced key utilization measures and improved some claims-based quality-of-care measures. As expected according to the CPC+ theory of change, reductions in outpatient ED visits emerged early and persisted across the four years, with a nearly 2 percent average annual reduction in both Tracks 1 and 2. Reductions in acute hospitalizations emerged in later years starting in PY 3 (with a 1.7 percent reduction) for Track 2 practices and in PY 4 (with a 1.8 percent reduction) for Track 1 practices. The reductions in acute hospitalizations in the later years also translated into reductions in expenditures on acute inpatient care starting in PY 3, with a 1.5 percent reduction for Track 1 practices and a 2.3 percent reduction for Track 2 practices. **However, these reductions were offset by increases in expenditures on other services** (inpatient rehabilitation facilities, physician and nonphysician Part B noninstitutional services in any setting, and hospice), **yielding estimated effects on total Medicare expenditures without enhanced payments that were small and not statistically significant** in either track in any of the four years. Medicare expenditures with enhanced payments (from CPC+ and the Medicare SSP) increased by 1.5 percent in Track 1 and by 2.6 percent in Track 2." (Bold added, p. 24)

From the report: "CPC+ led to improvements in some quality-of-care measures. Over the first four years, the percentages of beneficiaries who received all recommended services for diabetes and females who received breast cancer screening increased by about 1 percentage point. Consistent with the emphasis on patient and caregiver engagement in CPC+, hospice use increased by 0.1 percentage point (or 3 percent). These improvements emerged early (in PY 1 or PY 2) in both tracks and persisted through PY 4. Average annual reductions in the potential overuse of prescription opioids of 0.4 percentage point in Track 1 and 0.5 percentage point in Track 2 were driven by reductions that emerged in PY 3 and persisted through PY 4. **CPC+ did not have meaningful effects on measures of appropriate use of recommended medications, continuity of care, or incidence of readmissions and unplanned acute care and the few statistically significant effects that we observed for certain measures of appropriate use of recommended medications were not in the expected direction and seemed to indicate unfavorable (though small) effects of CPC+ on these measures**. Given that the set of claims-based quality measures that we examined is limited (we could not use electronic clinical quality measures (eCQMs) because of lack of comparable data between the CPC+ and comparison practices), **the magnitude of estimated improvements is small, and there is emerging evidence for unfavorable effects on some measures, we cannot draw definitive conclusions about the impact of CPC+ on quality."** (Bold added, p. 146)

Markowitz, A., Murray, R., & Ryan, A. (2022) Comprehensive Primary Care Plus Did Not Improve Quality Or Lower Spending For The Privately Insured, *Health Affairs*, 41 (9): 1255 – 1262. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01982
As a multi-payer initiative, CPC+ also covered non-Medicare patients. This report looked at the program's impact on commercially insured patients served by CPC+ primary care practices. From the report -- **"We conclude that CPC+ did not improve spending or quality for private-plan enrollees in Michigan, even before accounting for payouts to providers. This analysis adds to existing evidence that CPC+ may cost payers money in the short term, without concomitant improvements to care quality."** (Bold added)

Berenson, R., Shartzer, A., & Murray, R. (2020) *Strengthening Primary Care Delivery through Payment Reform*. Urban Institute.
https://www.urban.org/sites/default/files/publication/104443/strengthening-primary-care-delivery-through-payment-reform_0.pdf
The authors review what has been learned after 20 years of experiments to better pay for primary care.
From the report -- **"Despite more theoretical, often creative, proposals and a range of primary care payment demonstrations, we are not much closer to a consensus payment model**—whether based on an undiluted method or blended into a more complex payment model—that deserves to be promoted and widely adopted. Indeed, given the growing diversity of primary care delivery models—ranging from remaining solo and small independent groups, to multispecialty group practices and clinicians employed by hospitals—the cliché 'one size does not fit all,' seems particularly apt."
"Indeed, we believe that every payment method, including fee schedules for primary care clinicians, can be designed to produce more or less value." (Bold added)

Friedberg, M., Hussey, P.S., & Schneider, E.C. (2010) Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care, *Health Affairs*, 29 (5): 766- 772. https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0025
The authors compare the evidence linking primary care functions to health care quality, outcomes, and costs. "The available evidence most directly supports initiatives to increase providers' ability to serve primary care functions and to reorient health systems to emphasize delivery of primary care." **They find that successful systems begin reforms with the primary care functions needed. They then consider payment reforms, if needed, narrowly targeted to support those functions.**

General value-based purchasing sources

McConnell, J.K., Renfro, S., Chan, B.K.S., Meath, T.H.A., Mendelson, A., Cohen, D., Waxmonsky, J., McCarty, D., Wallace, N., & Lindrooth, R.C. (2017) Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado, *JAMA Internal Medicine*, 177 (4): 538-545.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5440252/

The authors evaluated Colorado and Oregon's experiences with Medicaid ACOs and the associated payment models over four years during planning and the first two years of operation, finding no clear effect. Oregon included downside risk in their payment model, with substantial federal funding increases, while Colorado relied on fee-for-service payments with per person care management fees. They found small savings in both states. Oregon experienced reductions in avoidable ED visits, but also in primary care visits. Colorado found no improvements in quality or access, also with a significant drop in primary care visits.

Rosenthal, M.B., Alidina, S., Ding, H. & Kumar, A. (2023). *Realizing the Potential of Accountable Care in Medicaid*, Commonwealth Fund.
https://www.commonwealthfund.org/publications/issue-briefs/2023/apr/realizing-potential-accountable-care-medicaid
The authors found a wide variety in design and payment models between state Medicaid ACO programs. They found improvements in one or more quality and preventable utilization measures in most states. Fewer achieved savings. There was little evidence of improvement in the equity of care. **In troubling findings, they found reduced primary care utilization and increased ED visits in two studies.**

Pandey, A., Eastman, D., Hsu, H., Kerrissey, M.J., Rosenthal, M.R. & Chien, A.T. (2023) Value-Based Purchasing Design And Effect: A Systematic Review And Analysis, *Health Affairs*, 42(6): 813–821.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01455
The authors find that value-based purchasing (VBP) has not improved quality and achieved only modest or no cost control, depending on the model. The authors evaluated which features of VBP are effective and found that **non-financial supports are very important to success** – e.g., sharing raw data, care coordination resources, and learning collaboratives. They also found that higher intensity VBP plans, those which were mandatory, included more nonfinancial supports, placed financial risk on providers, and tied more funding to quality measures, were slightly more likely to be successful in utilization, quality processes, and cost control.

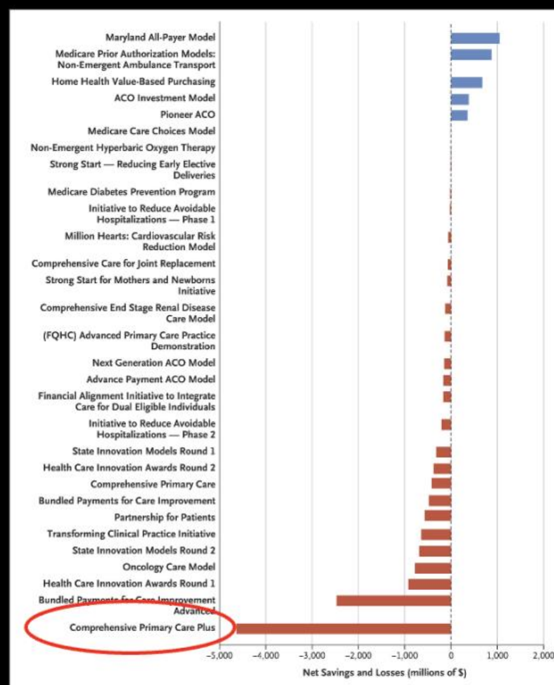
Catel, D. & Eijkenaar, F., (2020) Value-Based Provider Payment Initiatives Combining Global Payments With Explicit Quality Incentives: A Systematic Review, *Medical Care Research and Review*, 77(6): 511–537.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7536531/
The authors conducted a detailed systemic review of the few VBP evaluations to date. All initiatives focused heavily on primary care. They found great variation in the level of provider financial risk, attribution, risk adjustment methodology, and how payments were linked to quality. Most layered financial risk on top of a fee-for-service foundation. Most quality measures addressed processes rather than outcomes. Results were very mixed, with some achieving meaningful savings but many having no effect on costs. The authors found no reductions in quality, but little improvement. The authors recommend taking care in developing risk adjustment models to avoid perverse incentives for providers.

Smith, B. (2021) CMS Innovation Center at 10 Years — Progress and Lessons Learned, *New England Journal of Medicine,* 384 (8):759-764.
https://www.nejm.org/doi/full/10.1056/NEJMsb2031138

A former CMMI director acknowledges that most CMS healthcare reform experiments have not worked. CPC +, the latest primary care pilot that has been evaluated lost almost $500 million, more than any of CMMI's other fifty-three programs.

Ubl, S., ACOs: Improved Care Or Roadblocks To Innovation? Health Affairs Forefront, April 25, 2011.
https://www.healthaffairs.org/content/forefront/acos-improved-care-roadblocks-innovation
The author makes the case that, depending on how VBP and ACOs are implemented, they carry a danger of inhibiting medical innovation and progress, as well as denying necessary care for patients. The author outlines the "real danger of stinting on care" with new financial incentives untethered from service delivery and a limited number of weak, process quality metrics. The article offers policy remedies to mitigate the danger.

Net Savings and Losses Associated with Selected Models.



B Smith. N Engl J Med 2021;384:759-764.

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(Circle added to graphic)

Congressional Budget Office. (2023) *Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation*.
https://www.cbo.gov/publication/59612
From 2011 through 2020, CMMI's value-based pilots increased federal spending by $5.4 billion, rather than the $2.8 billion expected savings. CBO analysts expect higher spending at CMMI to continue through 2030.

Berwick, D.M. & Gilfillan R., (2021) Reinventing the Center for Medicare and Medicaid Services, JAMA, 325(13): 1247-1248.
https://pubmed.ncbi.nlm.nih.gov/33821891/
The authors found that only ten of CMMI's 55 pilots both improved quality and lowered costs; none of the primary care experiments did both. **They found the most likely outcome was that a program would have no impact on quality and would increase costs.** The authors conclude that "CMMI has devoted more attention to testing new payment models than to fostering specific care models." They recommend "Rebalance CMMI model tests toward delivery system redesigns, not just new payment models."

Number of pilots	Quality	Costs
10	up	down
6	No change	Down
9	up	No change
15	No change	up
5	No change	No change
4	mixed	
6	Not intended to do either or not evaluated	

Milad, M.A., Murray, R.C., Navathe, A.S. & Ryan, A. (2022) Value-Based Payment Models In The Commercial Insurance Sector: A Systematic Review, *Health Affairs*, 41(4):540–548.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01020
A review of 59 studies on VBP models in commercial insurance found mixed results. Some bundled payment and shared savings models improved quality measures. Only one study evaluated a capitated plan for impact on quality and found improvement. Spending impact was mixed for bundled payment, shared savings models, and capitated plans. Only one study included incentive payments and development costs in savings calculations. The authors concluded that **"evidence from this review suggests that success in improving quality, reducing spending, and improving appropriate utilization after a shift to greater risk-sharing is far from guaranteed."** (Bold added)