AMGA
Advancing High Performance Health

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November 16, 2016

To: Health Care Plan Learning and Action Network (HCPLAN)

From: AMGA

Re: HCPLAN "Primary Care Payment Models" White Paper

On behalf of AMGA we appreciate the opportunity to comment on the HCPLAN's "Primary Care Payment Models" White Paper. AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups are particularly interested in payment arrangements that improve primary care. AMGA members have a strong desire to improve the quality and effectiveness care delivery, or in achieving the triple aim of improving the experience of care, improving the health of populations, and reducing spending or the per capita costs of health care.1

AMGA has two overarching comments in response to the draft White Paper.

The draft White Paper is admittedly aspirational. The 39-page paper contains 148 transitive verb phrases or "will" statements. For example, at page eight, the authors state, "aligning payment from all payers will create a more stable and predictable environment for primary care practices." On balance, AMGA does not disagree with the Primary Care Payment Model (PCPM) "characteristics" and "mechanisms" (page 10) outlined in the seven principles and 19 recommendations (pages 10 and 11). For example, per recommendation number one, that PCPMs "will be team based, population focused, and patient-centered." However, while the draft White Paper states the "principles and recommendations **aspire** [emphasis added] to meet the aims of patient-centered and equitable care, healthier people, smarter spending and professional growth and satisfaction" (page 10), the paper completely fails to explain how primary care providers are to abide by any of these principles or implement any of these recommendations. For example, among other things, the paper calls for: expanded use of telehealth in primary care (page 12); improvements in patient risk adjustment, coordination with community services and patient-provider relationships (or the therapeutic relationship) (page 13); achieving positive outcomes on quality measures (page 16); integrating behavioral health (page 22); and, executing care plans that reflect patients' goals, preferences and values (page 25). Again, how primary care providers are to accomplish any of this is not discussed.

The failure to explain how primary care providers are to abide by these principles and

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implement these recommendations is compounded by the fact the draft White Paper assumes *the* "catalyst for transforming primary care" are value-based payment arrangements (page 6). AMGA members are not opposed to participating in value-based payment agreements. Many AMGA members participate in the Medicare Shared Savings Program, in Accountable Care Organization (ACO) demonstrations, in bundled payment and other CMMI pay for performance demonstrations, and in Medicare Advantage. That said, the statement that "value-based arrangements can drive system transformations" (page 6) is too simplistic.

First, the evidence in support of value-based agreements is unclear. The most recent synthesis report by the Cochrane Collaborative concerning financial incentives in the primary care setting concluded, "There is insufficient evidence to support or not support the use of financial incentives to improve the quality of primary care."2 The United Kingdom is about a decade ahead of the US in implementing primary care pay for performance. Evaluative evidence concerning the National Health Service's Quality and Outcomes Framework (QOF), that began in 2004, shows incentive payments have produced uncertain results. For example, a 2014 Nuffield Trust report that reviewed the QOF found "there is a lack of evidence for the impact on patient outcomes" and "there is a case for caution regarding what payment reform can achieve."3 In the US, Medicare's Premier Hospital Quality Incentive demonstration failed to improve quality measures and patient outcomes compared to the control group over the five year trial period.4 More recently, a 2015 published study of Fairview Health Services' primary care compensation model, that tied 40 percent of physician compensation to quality outcomes, found no effect in improving quality metrics over comparable Minnesota medical groups.5

Added to indeterminate outcome evidence, primary care physicians, for example family medicine physicians and internists are comparatively modestly compensated, if not under valued. The draft White Paper admits this by stating, "it is not sufficient to base prospective PBP [Performance Based Payments} rates on current spending levels for primary care in FFS [Fee for Service] payment systems." According to Medscape's 2016 compensation report, these physicians annually earn, for example, half that of orthopedists.6 Absent substantial changes in how primary care compensation is calculated, or substantial changes to primary care Relative Value Units (RVUs) are made, financial incentives are likely largely irrelevant in achieving pay for performance outcomes. The draft White Paper is silent on this issue.

That primary care providers are under-compensated likely explains why, as the draft White Paper states, "80 percent of family medicine physicians are not aware of what percentage of their practice's revenue comes from value-based payments (page 6)." This fact also likely explains why, according to a 2014 Physician Foundation survey, only 16 percent of primary

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care physicians believe ACOs will enhance care quality and reduce costs.7 These points aside, financial rewards can be counterproductive by, among other things, undermining intrinsic motivation and producing adverse crowd out effects. In a 2012 Health Affairs blog post, researchers provided evidence showing monetary incentives or rewards can actually backfire as the Fairview study noted above suggests.8

Lastly, the draft White Paper appropriately recognizes a "practices' ability to take on additional accountability for costs, and to absorb financial risk associated with spending . . . is largely a function of the number of patients for which they are responsible" (page 9). The paper states further, "in order to assume increasing levels of risk and accountability for cost, practices will need to join together to overcome the effect of outlier patients." However, the draft White Paper fails to address both what is an appropriate number of patients or what is an appropriate practice group size to succeed under value- based payment arrangements and the potential and real adverse consequences of an increasingly concentrated provider market – that the draft White Paper appears to be promoting.

In sum, AMGA is forced to question how this draft White Paper contributes to achieving successful value-based payment arrangements in either the commercial or the social insurance primary care provider markets.

Thank you for your consideration of AMGA's comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,

Donald W. Fisher
Ph.D. President and CEO

Endnotes

1. AMGA has commented on three other HCPLAN draft white papers this year, i.e., elective joint replacement (March 26); performance measurement (May 23); and, coronary artery disease (June 20).
2. A. Scott, et al., "The Effect of Financial Incentives on the Quality of Health Care Provided by Primary Care Physicians," Cochrane Collaborative (September 7, 2011). At:

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http://www.cochrane.org/CD008451/EPOC_the-effect-of-financial-incentives-on-the-quality-of-health-care-provided-by-primary-care-physicians.
3. Nuffield Trust, "The NHS Payment System: Evolving Policy and Emerging Evidence," (February 2014), at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140220_nhs_payment_research_report.pdf. See also, for example, "Robert Fleetcroft, et al., "Incentive Payments Are Not Related to Expected Health Gains in the Pay for Performance Scheme in UK Primary Care: Cross-Sectional Analysis," BioMed Central (April 16, 2012), at: http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-94, Paramjit Gill, et al., "Pay-For-Performance and Primary Care Physicians: Lesson From the UK Quality and Outcomes Framework for Local Incentive Schemes," Journal of the Royal Society of Medicine (2015), at: https://www.rbfhealth.org/sites/rbf/files/J%20R%20Soc%20Med-2015-Gill-80-2.pdf, and Ruth McDonald and Martin Roland, "Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences," Annuals of Family Medicine (March 2009): 121-127. At: https://www.ncbi.nlm.nih.gov/pubmed/19273866.
4. See: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalPremier.html.
5. Jessica Greene, et al., "Large Performance Incentives Had The Greatest Impact on Providers Whose Quality Metrics Were Lowest At Baseline," Health Affairs (April 2015): 673-680. At: http://content.healthaffairs.org/content/34/4/673.abstract.
6. See: http://www.medscape.com/features/slideshow/compensation/2016/public/overview#page=2.
7. The Physicians Foundation, "2014 Survey of America's Physicians," (2014). At: http://www.physiciansfoundation.org/uploads/default/2014_Physicians_Foundation_Biennial_Physician_Survey_Report.pdf.
8. Steffie Woolhandler and Dan Ariely, "Will Pay for Performance Backfire? Insights From Behavioral Economics," Health Affairs Blog (October 11, 2012). At: http://healthaffairs.org/blog/2012/10/11/will-pay-for-performance-backfire-insights-from-behavioral-economics/.