In light of the devastating impact that the coronavirus pandemic has had on the United States, a focus on the ability to improve population health may be appropriate when evaluating payment reform. Specifically, in addition to focusing on cost and quality, policy makers must consider a new epidemic mitigation standard: whether current and future payment reforms will improve the ability of the health care delivery system to work with patient populations and public health systems to help treat infectious disease outbreaks and prevent them from becoming society-paralyzing pandemics. Of current CMMI payment models, CPC+ is an example that meets this standard. The impact of a robust primary care–focused system will have benefits during normal times and better prepare us to mitigate the impact of the next epidemic.

In the coming months, there will be many after-incident analyses of what went wrong (and right) in the run-up and response to the Covid-19 pandemic. Hopefully, we will learn lessons that will inform future federal, state, and local public health efforts and pandemic planning. But what about lessons for the U.S. health care delivery system? Did it have the right set of health providers with the right tools to prevent and respond to the pandemic?

It’s well-documented that the per-service way we pay health providers in the U.S. favors specialty care technical procedures, and encourages additional utilization of services.\textsuperscript{1,2} And it is increasingly clear that the traditional fee-for-service model left many provider organizations terribly vulnerable. The impact of the coronavirus pandemic is profound: We see practices furloughing personnel and cutting salaries.\textsuperscript{3} We see practices still dependent upon ancillaries (e.g., lab tests) are struggling. The sudden shift to telemedicine to limit the spread of infection reveals that few providers were really ready for efficient virtual visits.

But would a different payment methodology lead to a more pandemic-responsive health care delivery system? For 10 years, the federal government has been experimenting through the Centers
for Medicare and Medicaid Innovation (CMMI) with alternate payment mechanisms for health care providers. The bar for success for those value-based payment reforms has been narrow and high. For adoption by Medicare, the CMMI demonstrations must show significant improvements in either cost or quality of care — with no negative effects on either — based on evaluations with methodologies similar to therapeutic trials. To date only four of more than 37 payment reform models have cleared that bar. But an additional research question might be: What do these payment models, and the increased focus on population health management that they engender, mean for the broader U.S. health system?

In light of Covid-19’s devastating impact on our country, a third standard of epidemic mitigation may be appropriate when evaluating payment reform. Specifically, policy makers could ask if the current and future payment reforms improve the ability of the health care delivery system to work with patient populations and public health systems to help treat infectious disease outbreaks and prevent them from becoming society-paralyzing pandemics.

What would a health care system capable of epidemic mitigation look like? It would use established, trusted patient relationships to amplify public health education efforts to prevent infection and limit spread, as well as reassure concerned and uninfected populations. It would test for and report positive cases systematically. It would participate in contact-tracing efforts to lower infection rates. It would treat positive cases based on best evidence and in settings that limit further infection. It would coordinate the care of these cases effectively so as to minimize demands on limited acute care resources (Table 1).

Critics could question whether epidemic mitigation is an attainable goal for payment reform, and whether it’s as high a priority as the traditional quality and cost goals. An epidemic mitigation standard could also be considered too reactive or topical. Finally, some might ask if mitigation is the job of the delivery system. Most health care knowledge acquisition, training, and resources have been focused on the work of treating disease — not of preventing or mitigating it.

While these critiques are valid, we must attend to the impact of Covid-19. The toll of the current pandemic in human and economic suffering is so vast that any payment reform that could reasonably result in a health care delivery system that could help mitigate or prevent this event in the future should be considered. Health care should help produce health, and pandemics have dramatic negative effects on health.

| Capacity                                    | Benefits                                                                 |
|---------------------------------------------|--------------------------------------------------------------------------|
| Use established, trusted patient relationships | Amplify public health education efforts to prevent infection, limit spread, and reassure people |
| Test for and report positive cases systematically | Helps to minimize the spread of Covid-19                                  |
| Participate in contact-tracing efforts       | Lowers infection rates                                                   |
| Treat positive cases with the best evidence and in a safe setting | Improves patient care and minimizes the spread of infection               |
| Telehealth and virtual visit capacity and capabilities | Ability to provide effective, efficient care to patients in their home     |
| Practice coordination of care of cases       | Minimizes demands on limited acute care resources                         |

Source: The authors
In considering CMMI’s payment reforms, an epidemic mitigation standard leads one directly to the Center’s efforts to strengthen primary care. Efforts to coordinate specialty care do not result in assigned patient populations or enhanced capacities to work with public health.

Primary care, by contrast, has long been considered a partner for public health activities. Many local public health agencies run primary care clinics and those that do not coordinate with private offices and federally qualified health centers. High-functioning primary care could take on the work of patient education, testing and reporting, contact-tracing, and low-acuity treatment and coordination. High-functioning primary care would also include telehealth and virtual care.

CMMI has developed seven primary care–focused payment models. Of these the Comprehensive Primary Care Plus (CPC+) initiative, started in 2017, is the largest, with more than 3,000 participating practices in 17 geographic markets. None of the other six models were of sufficient size, scale, or focus to merit widespread adoption.

CPC+ model components include a hybrid payment model consisting of monthly per-person payments for each patient attributed to the practice, reduced fee-for-service payments, performance incentives, training resources to help practices transform, and a requirement for multi-payer participation in a market for Medicare to participate.

An evaluation of first-year Medicare results in CPC+ showed a 2% to 3% increase in costs due to care transformation payments and small increases in quality. Some participating commercial insurers report lowered costs and quality improvements over time. Summarizing the lessons from CPC+ and its predecessor Comprehensive Primary Care initiative, evaluators of the program called for the following improvements: high per-capita payments using simple methods with stronger performance incentives, more multi-payer collaboration, tailored learning supports, and better data feedback and training.

While CPC+ will not end until 2022, CMMI has already announced a new, broader payment model, Primary Care First (PCF), to start in 2021. PCF will target CPC+ “graduates” and more sophisticated primary care practices, with greater opportunities for gainsharing based on total costs of care.

The CPC+ payment model, while not yet fully satisfying CMMI standards for mandatory adoption by Medicare, does well by an epidemic mitigation standard. A guaranteed per-capita revenue stream at current CPC+ rates allows primary care providers to transition more readily to telehealth visits, which often reimburse less lucratively than in-person visits but reduce infection rates. Per-capita payments also require patient empanelment, which allows for a far more productive conversation with public health agencies about infectious disease testing and contact-tracing. Practice education and transformation efforts similarly create a population-based accountability and set of skills for the practice, which are also necessary in times of an epidemic.

Finally, there is anecdotal evidence that health insurers participating in CPC+ have responded to primary care providers in the Covid epidemic in more aligned ways: paying for telehealth services
at par with in-person visits and advancing interim payments to ensure cash flow and practice viability.

Even if CPC+ holds promise for helping to create a more epidemic-ready health care delivery system, concerns remain about its broader implementation. The cost and quality standards that CMMI operates under are in law; the Center cannot adopt an epidemic mitigation standard unilaterally. As it has not proven to be cost-neutral in the short run, there could be incremental costs for Medicare, at least initially. Even if these barriers were surmounted, mandatory implementation of a CPC+ payment model for all primary care would be a massive undertaking, facing resistance from practices accustomed to the current model. Finally, CPC+ is hardly perfect. How could its broader implementation still offer the opportunity for further model iterations and improvements in the future?

These concerns should not prevail, however. We can learn from the Covid epidemic and Congress could create a third statutory or regulatory standard for CMMI’s payment reforms focused squarely on supporting our system’s capacity and capabilities to improve population health. This would build on the Medicare Payment Advisory Commission (MedPAC) and others who have called for Medicare to invest per-member-per-month payments to support primary care and a system for population health. This standard could leverage Medicare as the country’s largest payer to foster a health care system that not only improves the value of health care services, but that is also much better positioned to work with patient populations, communities, and government authorities to prevent and mitigate the spread of crippling infectious diseases and support broader population health goals. CMMI has had a population health group from its beginning, but the emphasis on population health has varied over time.

In the meantime, in addition to its commitment to the PCF model, CMMI could focus on smaller practices still paid on a fee-for-service basis and use its existing authorities to allow all willing primary care practices in markets with committed commercial and Medicaid payers to enroll in a new wave of CPC+, perhaps modified to address the lessons learned so far, including the need for larger investments in primary care in general. Administrative approval for an expansion or a new modified model should not be delayed. The change by the administration would have a ripple effect. In provider payment policies, Medicare has proven to be the “straw that stirs the drink” — both its innovations and standards are typically soon followed by commercial payers.

A robust primary care system supported by population-based payments is critical to a higher-performing health system. The health of our communities demands a delivery system that is not only expert at treating diseases, but that also collaborates with patients, their families, communities, and others to prevent them, limit their spread, and improve population health.

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