# Primary Care Reform Collaborative: PC

June 15, 2020

# Agenda:

- Approval of Minutes
- Data/ Technical Subcommittee
- Workplan
  - Benchmarking report
  - OVBHCD
  - ▶ Funding recommendations
- Legislative Update
- ► Future Meetings

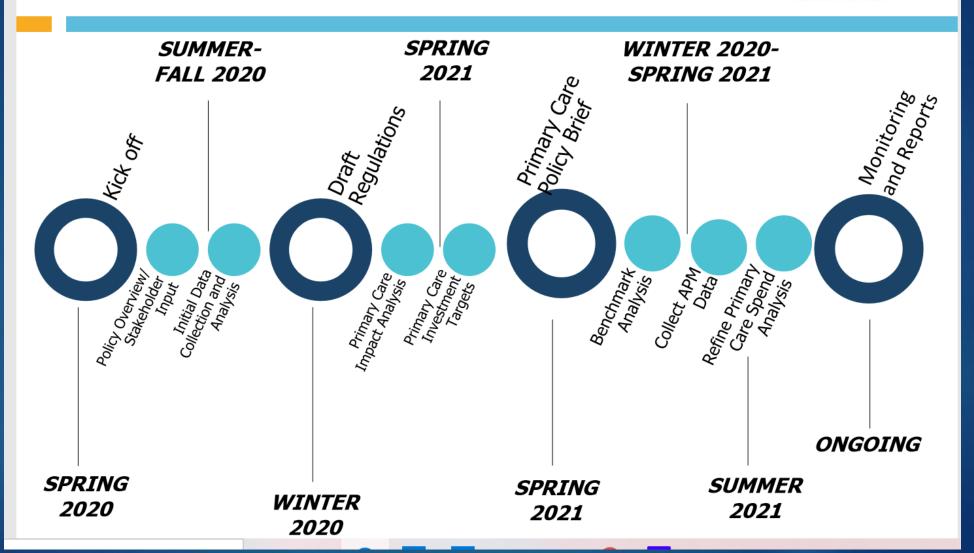
# DATA/TECHNICAL SUBCOMMITTEE

- Responsibilities:
  - Will work directly with OVBHCD
  - Reports back to PCRC
- Jackie Ball Aetna
- Lisa Schaffner Highmark
- Jamie Clarke Nemours
- Dr. James Gill
- Large Employer/self insured representative



# Project Timeline





# Next Steps for PCRC

- Defining the data driven metrics: value, accountability, risk
- PC post COVID>>Funding proposals
  - Innovative, flexible and sustainable
  - Telehealth
  - ► APM upfront investments
- Capacity including addressing lack of parity for BHI and nonphysician clinicians
- DHIN presentation

### Current Comments:

- Determine and monitor outcome measures to evaluate the benefit of increasing PC investment
- Develop a broad "inclusive" definition of Primary care in terms of health care specialties/ professionals
- Assist/Issue to the Insurance Commissioner an annual report on increasing primary care investment
- Use of DHIN to measure PC investment and monitor amount of PC spend with claims and non-claims based payments
- Collaborate with "provider partners" to reallocate funds, on an increasing scale, which have been contributing to a higher cost of care

# Current Comments: Increase PC spend without increasing overall health care costs

- Reduce spend on hospital inpatient services to the same level in PA
  - Decrease hospital rates by 10% of Medicare rate each year until 190% as that in PA, probably over 5 yrs
  - Overall represent decrease 1% in total spend to be shifted to PC spend

# Current Comments: Increase PC spend without increasing overall health care costs

- ▶ Global Reference Based Pricing
  - Montana: 2016>>234% Medicare rates across all service types with \$13.6 m savings/3 yrs
  - Oregon: 2017 legislation effective 2020>>200% Medicare
  - North Carolina: 2019, effective 2020
    - ▶ 155% of Medicare hospital inpatient/200% for critical access hospitals
    - ▶ 200% for hospital outpatient/ 235% for critical access
    - ▶ 160% Medicare for professional services

## PAST PROPOSALS:

Delaware Primary Care Funding Model Proposal

Proposed Funding Model

#### 3 funding streams:

- Delegated Care Management Fees
- 2. Shared Savings
- 3. Pay for Performance

#### **Health Plan**

**ACO** 

#### Care Management

- Upfront PMPM CM Fees with task accountability
  - Used to fund CM staffing and infrastructure
  - Amount related to % premium with both a cost of service and ROI perspective
  - Included as an expense in calculating shared savings/risk pool

#### Shared Savings to Shared Risk

- Savings split between ACO and Plan
- Transition to Shared Risk over Time
- Stop-loss for high dollar cases
- Risk corridor when transition to risk
- Quality gate
- Guard against price increases eliminating savings from improved utilization

### Pay for Performance

- Key measures associated with Plan withhold or quality goals
- Metric choice aligned across payers for similar populations
- Number of metrics allows providers to focus their QI programs
- Improvement and attainment goals achievable

# Past Proposals

#### AAFP APC-APM

#### Advanced Primary Care Alternative Payment Model (APC-APM)

#### Primary Care Global Payment

- · Per patient per month
- Covers a defined set of face-to-face evaluation and management services
- Prospective, risk adjusted payment

#### Performance-Based Incentive Payment

- Paid prospectively quarterly; reconciled annually
- Based on performance measures, including quality and cost.



#### Population-Based Payment

- · Per patient per month
- Covers non-face-to-face patient services
- Prospective, risk adjusted payment

#### Fee-For-Service Payment

- · As medically/clinically needed
- · Based on relative value units





#### CATEGORY 2

FEE FOR SERVICE -LINK TO QUALITY & VALUE

#### A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

#### В

#### **Pay for Reporting**

(e.g., bonuses for reporting data or penalties for not reporting data)

#### C

#### Pay-for-Performance

(e.g., bonuses for quality performance)



#### CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

#### 1

#### APMs with Shared Savings

(e.g., shared savings with upside risk only)

#### - 1

#### APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

Risk Based Payments

NOT Linked to Quality



#### CATEGORY 4

POPULATION -BASED PAYMENT

#### 1

#### Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

#### B

#### Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

#### C

#### Integrated Finance & Delivery System

(e.g., global budgets or full/percent of premium payments in integrated systems)

#### 4N

Capitated Payments NOT Linked to Quality

n.org/workproducts/apm-refresh-whitepaper-final.pdf

# Future Meetings:

- THIRD MONDAY OF EACH MONTH:
- **7/20/20**
- **9/21/20**
- **10/19/20**
- **11/16/20**
- **12/21/20**