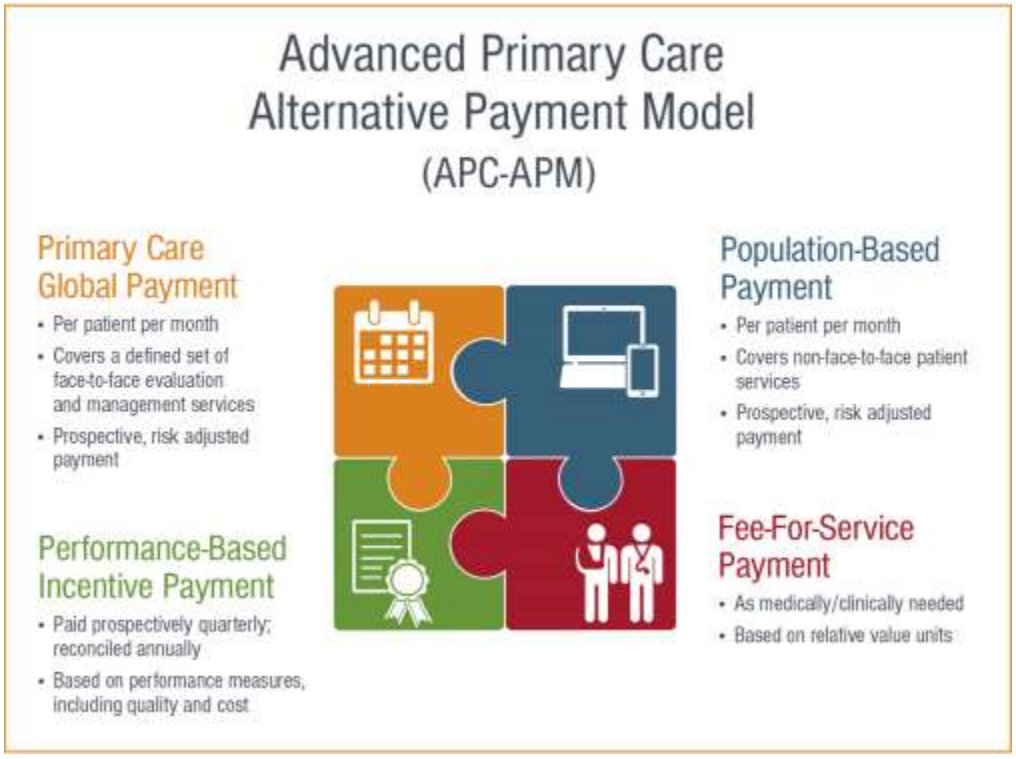
Medical Society of Delaware
LEADING THE WAY TO A HEALTHY DELAWARE

Proposed "Value-Based" Model for Primary Care Collaborative

Presented at March 4, 2019 Primary Care Collaborative Meeting



Proposed Independent Model – based on AAFP's APC-APM

The AAFP's Advanced Primary Care – Advanced Payment Model (APC-APM) was proposed to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and recommended by them to CMS about a year ago.

It assumes practices can attest to the basic functions of advanced primary care, as defined in the joint principles of the patient-centered medical home (PCMH); this includes sufficient care coordination, per-member-per-month, as previously supplied to the Collaborative.

As one may see, the model is divided into four quadrants. The long-term goal would as shown in the schematic, specifically:

1. Quadrant one (orange): global capitation for most face-to-face services (acute, chronic and preventive visits in the office).
2. Quadrant two (blue): global capitation for non face-to-face services, specifically care coordination.

3. Quadrant three (green): Performance-based incentives, which will include bonuses for quality/utilization/cost metrics, or reduction of care-coordination payments if minimal standards are not met.
4. Quadrant four (red): Fee-for-service payments for services not included in quadrants one and two (*e.g.*, office procedures and testing, immunizations, hospital visits and services, etc).

A key remains an overall measure that the aggregate payments for all four quadrants, globally totaling by insurer 12 percent of each's total health care spend. Currently, this is estimated at $10,700 per person per year in the United States.

Of course, measuring the primary care spend would need to be and given to an objective source and standardized. We recommend the Department of Insurance, after a proper investment in the staff necessary in their discretion to oversee such a process. We also would continue to recommend using the standardized measures developed and published by David Balint, *et. al.* in the Milbank-funded study. If primary care definitions are expanded beyond the traditional definition of primary care (family medicine, primary care internal medicine, primary care pediatrics), then the total spend measure for primary care would need to be increased. Within the AAFP model, this does not preclude that payments could be adjusted based on patient risk.

The timeline would assume this would be in place by January 2022 as per the specifications of SB 227.

We would recommend a step-wise approach to adopting this model:

1. Begin monthly prospective PMPM care coordination payments, as shown in the blue quadrant of the APC-APM. This should be in the range of $15-20 PMPM, but we have again previously provided a general sketch for this calculation. Overall, this range is what was found to be required by the definitive national studies (Commonwealth Fund and AHRQ) and what is paid in CMS's CPCI. It is also justified by our calculations.

   However, critical to moving forward as care coordination is a threshold item, we need to agree on what is "base" PMPM. That is, the cost of doing the PMPM as defined in our calculations. Whatever that base is, payments cannot go below that number until a "risk-based model" is put into place where the practice is willing to take risk and the payer offers an "upside" that is greater than the downside risk. This will be described below under quadrant three. Note that the

AAFP recommends that these payments not be subject to quality, utilization or cost benchmarks since there is already an inherent "risk" in accepting a PMPM since it may cost you more for many patients but you don't get paid more.

Care coordination payments would begin immediately.

2. Begin performance-based incentive payments (quadrant 3/green). In the AAFP model, this is where quality incentives come in, as well as bonuses for meeting cost and utilization measures. This is where payments can be adjusted up for meeting performance measures, or adjusted down for not meeting minimal benchmarks (*i.e.*, implementing "risk").

   For this risk-based model, it would likely be ACO's assuming the risk rather than the practices themselves, since practices cannot afford to hire care coordinators and then not get paid for their cost, based on lower quality/utilization results. However, individual practices that want to take on risk could also participate.

   That said, if any risk is assumed, there would need to also have meaningful "upside gain" for performance beyond performance measures.

   By way of example, assuming a baseline of $17 PMPM. Then the baseline is $17, but if you are willing to accept risk, your payment would be: $19 PMPM for minimal measures (perhaps "copper star"), $24 PMPM for "silver star" and $28 PMPM for "gold star".

   Then if the metrics go below copper, you get less than the $17 PMPM, maybe down to $13 PMPM. But that $4 PMPM cut could be borne by a larger entity such as the ACO, since the practice will have already invested the $17 PMPM for the staff and other overhead for conducting care coordination.

   Metrics for determining copper/silver/gold should be determined by a group of clinical experts. But as a start we could consider:

   1. 1-2 measures on primary care quality (*e.g.*, access, coordination)
   2. 1-2 measures that are modified from HEDIS, in a way that looks at physician performance, not patient performance (*e.g.*, was a mammogram ***ordered***)
   3. 1 measure of patient satisfaction
   4. 1 measure of utilization (perhaps emergency department utilization, but since practices currently have little control over whether patients go to the

ED, we might consider making clinicians responsible ONLY if the payer requires our approval to go to the ED).

An important point is that these measures should not require any additional administrative work from practices, understanding that additional work would unintentionally increase the overhead necessary for the delivery of the services themselves. An unnecessary cost-driver. Any measures that cannot be obtained from current claims or electronic data should not be included in a set of metrics until such automated measurement is feasible. Also note that while the AAFP's graphic says performance based incentives should be "paid prospectively quarterly, reconciled annually", the current AAFP thinking is that it may be better to just pay these retrospectively, in order to avoid the "clawback" phenomenon, which can be very damaging to practices.

Another important point is that the measurements need to be "transparent." That is, the rules are published and clear to everyone. The data upon which the measures are made are made available to the ACOs (and individual practices) for confirmation of validity.

As to risk adjusting, care coordination payments will be adjusted for patient illness (*i.e.*, case-mix). Again, we need to determine how to do this without requiring burdensome tasks such as submitting codes to achieve HCC scores.

Regarding timeline, this might be able to be put in in 12-18 months from the start.

3. Performance incentives for cost, or shared savings. This can be upside or both upside/downside (it cannot be downside only, *i.e.*, reducing payments if cost benchmarks are not met). Doing appropriate shared savings will require much more attention and time to be able to measure and control costs appropriately. It will require dovetailing with the state's benchmarking process. Assuming procedure costs inside of facilities, including urgent care and medical aid units, that are outside of the primary care's discretion and control are decoupled from the risk, it may be reasonable to start the process sooner than the benchmarking process is complete. We would estimate this might be implemented in eighteen months to two years.

Performance incentives can also include incentives for the characteristics of the practice. *E.g.,* practices that achieve a higher level of sophistication (perhaps PCMH level 3) could get higher care-coordination payments given the same case-

mix. Important to note here that PCMH certification should not be based mainly on NCQA, which are too burdensome and costly, and are not well aligned with the principles of the PCMH. We should develop our own PCMH-certification process that is easier and more aligned with the principles of the PCMH.

Part of the shift at this point is also to move APC-APM quadrant 1 payments to capitation. This will require a lot of preparation. The general thinking is that it will include the main primary care services – acute, chronic and preventive care visits. But it will not include special procedures (*e.g.*, minor surgery, casting/splinting, higher level testing) or items for which there is a high cost of purchasing supplies (*e.g.*, immunizations). Nor will it include services outside of the office such as hospital visits. All of these will remain in quadrant 4. Moving things from quadrant 4 to quadrant 1 might be a stepwise approach, as determined by other policies such as PCP direction of patient care between settings. Eventually even these payments could be at "risk". But again, if at risk, the payments need to be higher to create balance and the risk should be where it can be borne, likely an ACO. Of course, this ACO would also get a compensatory cut of the higher payments.

We would assume that fully changing to capitation would not be in place for a matter of two to three years.

Overall, ACOs are likely going to be critical components in achieving these goals. Practices will be much more successful if they band together with the help of these ACOs which will be relied upon to assume risks. Also critical is the use of data systems and usable data that are wed to the metrics and measurements a practice is placed under.

We must also remember two other critical components that are not often mentioned.

First, we need to be cautious to safeguard independent specialty care. As the goal herein, in part, is to direct spending to where the patients and ultimately all citizens see the best use health dollar investments, independent specialty care is a virtue and cost-saving to the system as well. As primary care is given better tools to coordinate patient care, evaluate care through data, and lower high-cost setting utilization, the link between these two independent settings should and must only grow stronger. The savings achieved through this close relationship will

benefit the patient and the system. Losing sight of that could potentially undermine the benchmark goal of bending the global cost curve.

Second, there will always be practices, hopefully in drastically-shrinking numbers as opportunities to grow through processes created herein and through the collaborative' s work open, that, for a variety of reasons, may not be able to avail themselves. Likely as they are winding down or are unable to take on substantial risk. These practices will continue to have value and will continue to have little bargaining power in the market. We suggest continued discussions on how best to ensure they are not unintentionally left behind.

We remain grateful to the Collaborative for all of its hard work and diligence. We are thankful to the stakeholders for their additional input. Thank you for including our voice.