Market Updates:
Alternative Payment Models for Primary Care

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Background

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The US healthcare system is in a period of rapid change

- Pressures from public and private payers, employers, physicians and patients driving enhanced attention to value for services

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has accelerated this movement to value by providing payment incentives to move physicians into alternative payment models (APMs) that aim to improve quality for patients while also reducing costs

Primary care is a critical foundation for system-wide transformation

- Population health-based strategies focus on relationships in primary care in order to improve the health and well-being of a population of patients
- Access and convenience for patients, as well as an emphasis on quality and superior health outcomes, result in lower costs and utilization
- Patients and families who are engaged with primary care providers benefit from shared perspectives and an holistic approach to their care that incorporates social context into the provision of care

Source: American Academy of Family Physicians, *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care, A Proposal to the Physician-Focused Payment Model Technical Advisory Committee From the American Academy of Family Physicians,* April 14, 2017

Financing

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- Increasing total spend on primary care from current levels of 6% to 12% can yield up to a 15-fold return on investment
  - Rhode Island mandated an increase in primary care spending from 5.4% to 8% between 2007 and 2011
    - The Rhode Island Insurance Commissioner reported that a 23% increase in primary care spending was associated with an 18% reduction in total healthcare spending
  - A 2016 study of Oregon’s Patient Centered Primary Care Home program found every $1 increase in primary care expenditures resulted in $13 savings in other healthcare services, including specialty, emergency room, and inpatient care
  - A 2012 Commonwealth Fund analysis projected that a 10 percent increase in payment for primary care services would yield more than a six-fold annual return in lower Medicare costs for other services, mostly in specialty, inpatient, and post-acute care
  - Evidence from other Organization for Economic Cooperation and Development (OECD) countries indicates that increased spending in primary care will lead to a decrease in overall health spending on a per capita basis

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Financing (cont.)

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- Public and private payers are investing in enhanced primary care models through multiple efforts
  - Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care Plus (CPC+) and original Comprehensive Primary Care (CPC) initiatives
  - CareFirst BlueCross BlueShield's Patient-Centered Medical Home (PCMH) Program
  - Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP)
  - Anthem's Enhanced Personal Health Care Program (EPHC)

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Five Key Functions of the CPC+ Initiative

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Access and Continuity

- Optimize continuity and 24/7 first contact access to care supported by the medical record
- Practices track continuity of care by physician or panel

Planned Care and Population Health

- Proactively assess patients and provide timely chronic and preventive care
- Develop a personalized plan of care for high-risk patients
- Utilize team-based care models to meet patient needs efficiently

Care Management

- Empanel and risk-stratify entire practice population
- Implement care management to support patients with high needs

Patient and Caregiver Engagement

- Engage patients and families in decision-making in all aspects of care
- Integrate culturally-competent self-management support

Comprehensiveness and Coordination

- Work closely with other healthcare providers to coordinate and manage care transitions, referrals, and information exchange

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The AAFP Proposal

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- On March 18, 2018, American Academy of Family Physicians Board Chair John Meigs, Jr. sent a letter to Alex Azar, Secretary of the Department of Health and Human Services
  - Requested support for more widespread testing the AAFPs **Advanced Primary Care Alternative Payment Model (APC-APM)**
    - Comprehensive primary care delivery system and payment reform proposal that aims to strengthen primary care, improve quality and outcomes, and reduce costs to the program
    - Reduces administrative burden and complexity for physicians, allowing them to focus on providing quality care to their patients
    - Approved on December 19, 2017 by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for limited testing
    - If fully implemented, it would allow more than 200,000 primary care physicians to engage in an advanced APM that promotes the value of primary care

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APC-APM Features

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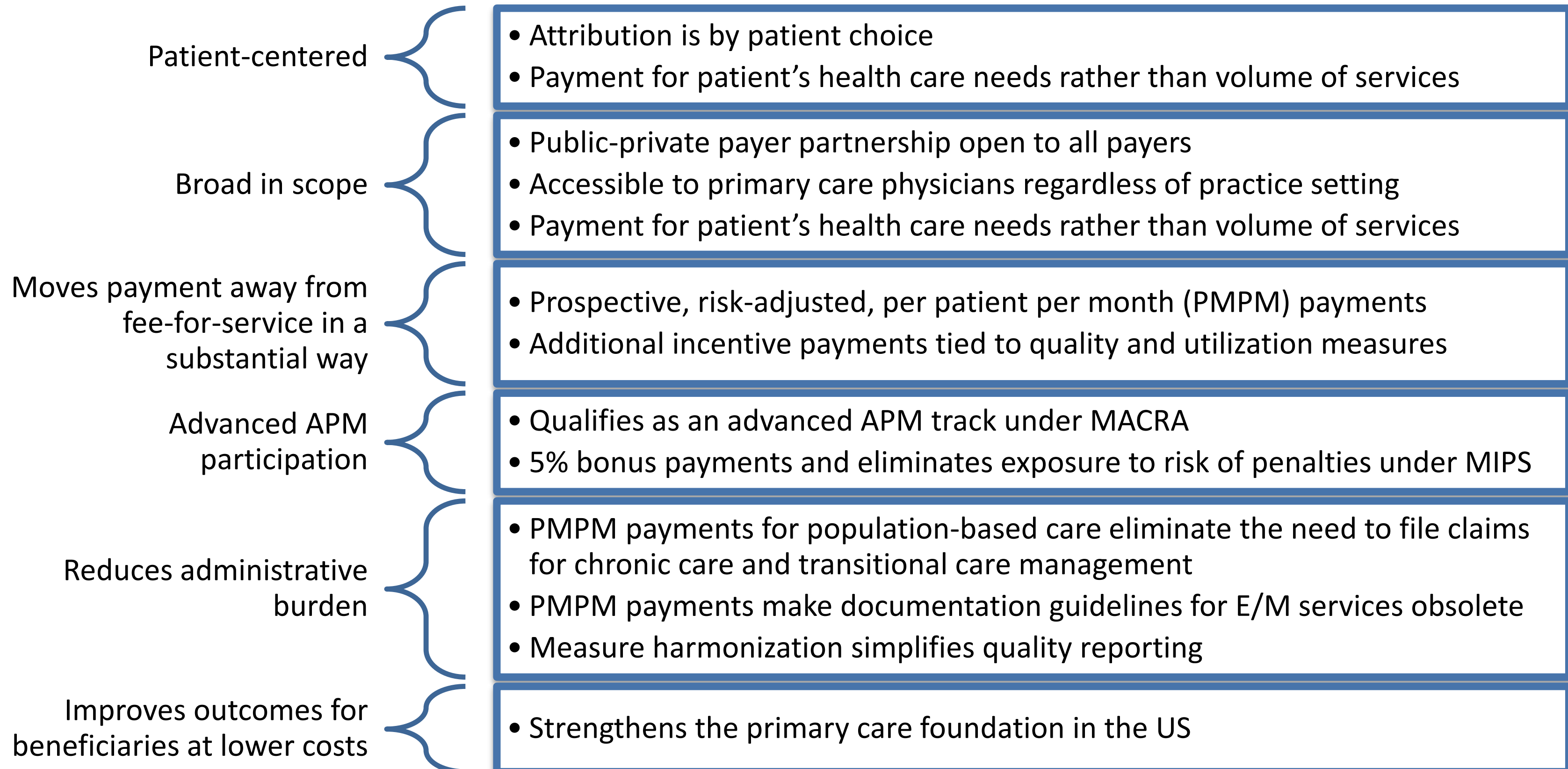
- The APC-APM aligns with the Administration's priorities in advancing value-based care and payment



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APC-APM Payment Structure

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- A prospective, risk-adjusted primary care global payment for direct patient care
- A population-based payment covering non-face-to-face patient services
- Fee-for-service payments for procedures and services not otherwise included in the primary care global payment
- Prospective performance-based incentive payments that hold physicians accountable for quality and costs
  - Performance rewards based on patient experience, clinical quality, and utilization measures
- Participation in Advanced APM under MACRA
  - Earn 5% APM incentive bonus payments
  - Exempt from reporting burdens of MIPS
  - Reduced exposure to risk of penalty payments under MIPS
  - CPC+ is currently the only Medical Home Model that qualifies as an AAPM

Source: American Academy of Family Physicians, *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care, A Proposal to the Physician-Focused Payment Model Technical Advisory Committee From the American Academy of Family Physicians,* April 14, 2017

APC-APM Payment Structure

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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

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Example of Payment Structure (CPC+ model)

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- A prospective, risk-adjusted Primary Care Global payment for direct patient care
  - Not based on historical FFS payments for E/M services
  - Instead, will be calculated to support the proposition that a percent of total spending directed to primary care should double to at least 12% of total spending
  - For example, supplementing FFS with $3 PBPM for extra staffing and $2.50 PBPM for medical home and population health activities (Community Care of North Carolina model)
- A population-based payment covering non-face-to-face patient services
  - Under CPC+ Track 1 $15 PBPM, Track 2 $28 PBPM, Complex Needs up to $100 PBPM
- Fee-for-service payments for procedures and services not otherwise included in the primary care global payment
- Care management fee TBD
  - Based on patient complexity, demographics, and socioeconomic factors
    - Minnesota Complexity Assessment Method (Appendix A)
- Prospective performance-based incentive payments that hold physicians accountable for quality and costs
  - Performance rewards based on patient experience, clinical quality, and utilization measures
  - For quality/patient experience, CPC+ Track 1, $1.25 PBPM and Track 2 $2 PBPM
  - For utilization performance, CPC Track 1 $1.25 PBPM and Track 2 $2 PBPM
- Qualifies for participation in Advanced APM under MACRA
  - Earn FFS plus 5% APM incentive bonus payments
  - Exempt from reporting burdens of MIPS/eliminates exposure to risk of penalty payments
  - CPC+ is currently the only Medical Home Model that qualifies as an AAPM

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Primary Care Core Quality Measures Set

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Performance measures established in collaboration with the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), America's Health Insurance Plans (AHIP), other health plans, and physician, consumer, and employer groups

Define core measure sets to promote alignment and harmonization of measure use and data collection across public and private payers

Recognizes high-value, high-impact, evidence-based measures that promote better patient health outcomes

Includes clinical, quality, patient safety, patient experience , and resource use measures using the National Quality Strategy as a guide

Most recent version included in Appendix B

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Appendix A:
Minnesota Complexity Assessment Model

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Working draft

Minnesota Complexity Assessment Method

University of Minnesota Dept of Family Medicine & Community Health, 4/23/09

Patient:	Age / gender:	Problem:

Domain	Current state of affairs	Complexity level
Illness (Biomedical, mental health and substance abuse sx & dx)	**1. Symptom severity / functional impairment**	
	0=No symptoms—or reversible w/out intense efforts	0
	1=Mild noticeable sx—don't interfere w function	1
	2=Mod to severe symptoms that interfere w function	2
	3=Severe symptoms impairing all daily functions	3
	2. Diagnostic challenge	
	0=Diagnosis(s) clear	0
	1=Narrow range of alternative diagnoses	1
	2=Multiple possibilities—clear dx expected later	2
	3=Multiple possibilities—no clear dx expected	3
Readiness to engage	**3. Distress, distraction, preoccupation**	
	0=None	0
	1=Mild, e.g. tense, distractible, preoccupied	1
	2=Moderate, e.g. anxiety, mood, confusion	2
	3=Severe w behavioral disturbances, e.g., harm	3
	4. Readiness for treatment and change	
	0=Ready & interested in tx; active cooperation	0
	1=Unsure/ambivalent but willing to cooperate	1
	2=Major disconnect with proposed tx; passivity	2
	3=Major disconnect; defiant/won't negotiate	3
Social	**5. Home/residential safety, stability**	
	0=Safe, supportive, stable	0
	1=Safe, stable, but with dysfunction	1
	2=Safety/stability questionable—evaluate/assist	2
	3=Unsafe/unstable—immediate change required	3
	6. Participation in social network	
	0=Good participation with family, work, friends	0
	1=Restricted participation in 1 of those domains	1
	2=Restricted participation in 2 of those domains	2
	3=Restricted participation in 3 of those domains	3
Health system	**7. Organization of care**	
	0=One active main provider (medical or MH)	0
	1=More than or less than 1 active provider(s)	1
	2=Multiple medical / MH providers or services	2
	3=Plus major involv. with other service systems	3
	8. Patient-clinician (or team) relationships	
	0=All appear intact and cooperative	0
	1=Most intact; at least 1 distrustful or remote	1
	2=Several distrustful or remote; at least 1 intact	2
	3=Distrust evident in all pt / clinician relationships	3
Resources for care	**9. Shared language with providers**	
	0=Shared fluency in language with provider	0
	1=Some shared language / culture with provider	1
	2=No shared language; professional transl. available	2
	3=No shared language; family or no translator	3
	10. Adequacy / consistency of insurance for care	
	0=Adequately insured, can pay for meds, copays	0
	1=Under-insured* with modest other resources	1
	2=Under-or intermittently-insured	2
	3=Uninsured, no other financ. resources for care	3

Instructions:

As you gather information and listen to the patient,

- Scan for sources of complexity (interference with usual care) on the left.
- *Ask questions* that help you understand what you don't know.
- *Circle a level* that reflects your understanding of complexity in each area.
- *Outline a plan of action* that takes into account the observed pattern of complexity

Plan of action:

General goals:
(for both complexity and diagnosis)

Self-check: Do I need someone in this case with me—and who?

Team / roles required:
(who does what—how it adds up)

Patient / family role:
(as part of the team)

What clinician / team will do today:
(To act on both complexity & diagnosis)

*Underinsured: Lack of coverage for hospital, medications, mental health; presence of high deductibles /copays

With all your ratings in view, decide what level and kind of action is needed in what areas—and incorporate that into your action plan.

Level	Action
0	No complexity—only routine care needed **No evidence of need to act** (beyond routine care)
1	Mildly complex—basic care planning needed **Watch / prevent—explore interacting issues**
2	Moderately complex—multifaceted plan needed **Form a well-integrated plan—set in motion**
3	Very complex—intensive care & planning needed **Immediate, intensive and integrated action**

Adapted by Peek, Baird, Coleman, & DFMCH faculty with permission from Frits Huyse, C-L psychiatrist; Dept of General Internal Medicine; Integrated Care, University Medical Centre Groningen, The Netherlands. (Huyse & Stiefel, 2006) Contact: Macaran Baird (baird005@umn.edu)

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Appendix B: Core Quality Measures Collaborative's PCMH/ACO/Primary Care Core Measure Set

Measure Title	NQF	Quality ID
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	59	001
Medication Reconciliation Post-Discharge (Replaces PQRS #130)	97	046
Breast Cancer Screening	2372	112
Colorectal Cancer Screening	34	113
Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	58	116
Diabetes: Eye Exam	55	117
Diabetes: Medical Attention for Nephropathy	62	119
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	421	128
Diabetes: Foot Exam	56	163
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	68	204
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	28	226
Controlling High Blood Pressure (See also the HEDIS measure with slightly different criteria)	18	236
Cervical Cancer Screening	32	309
Use of Imaging Studies for Low Back Pain	52	312
CAHPS for PQRS Clinician/Group Survey (NQF 0005 & 0006)	5	321
Depression Remission at Twelve Months	710	370
Persistent Beta Blocker Treatment After a Heart Attack	71	442
Non-recommended Cervical Cancer Screening in Adolescent Females (HEDIS Measure)	N/A	443
Medication Management for People with Asthma (MMA) (Replaced #311)	1799	444
Measures not in MIPS		
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	57	N/A
Depression Response at Twelve Months-Progress Towards Remission	1885	N/A
Controlling High Blood Pressure (HEDIS 2016)	N/A	N/A

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