Pathways to Comprehensive Primary Care Payment

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Disclosures

- Project manager with CFAR supporting for Family Medicine for America’s Health.
- FMAHealth was created by the 8 family medicine organizations to create a vision for family medicine
- Practicing physician at Casey Health Institute
- Commissioner on the Medicaid And CHIP Payment and Access Commission
- No financial disclosures
- I wear a lot of hats, but none present adverse bias
Family Medicine for America's Health
What is the work of the seven Tactic Teams?

Build a practice transformation framework that meets family physicians where they are and helps them get ready for the value-based world on the horizon.

Collaborate with primary care organizations, with medical schools across the U.S., and other stakeholders to reduce health disparities.

Help physicians, employers and insurers make the transition to comprehensive payment for primary care.

Work with patients and other primary care professionals to improve the value—and extol the benefit—of primary care.

Increase medical student choice of family medicine; recruit, retain, and develop faculty and preceptors.

Galvanize the research community to demonstrate primary care’s ability to meet the Triple Aim.

Build a vision for primary care technology in the value-based world and work on identifying and overcoming the barriers to getting there.
Sometimes, this is what Fee for Service feels like
But what can you do? That’s the system, right?
Comprehensive Primary Care Payment (CPCP)

- CPCP is a fixed, periodic payment for services delivered over a period of time.
- Up-front comprehensive payment to provide high-quality and high-value primary care services to a patient population.
- CPCP is adjusted for chronic disease burden, social determinants of health, quality and utilization.
- Payment in advance of care
- Also known as value based care
  - Blended payment (not CPCP, but on the way there)
Benefits of CPCP

- Reduces administrative work
- Focuses on tracking metrics that matter
- Flexibility and autonomy to provide the right care at the right time
- Partner with patients and their families in ways that are truly patient centric
- Bring back joy in practice
- Strives to achieve the quadruple aim- Better care, better quality, at lower cost with joy in practice
Review of some existing CPCP models

- MACRA
- Comprehensive Primary Care (CPC+)
- Maryland CPC
- Other state initiatives
- Direct Primary Care
- Bright Spots in transformation
  - Iora
  - Care More
  - Qliance
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Repeals the SGR
- Rewards providers for providing higher quality care and establishes 2 paths for payment
  - Merit Based Incentive Payment System
    - Quality (based on PQRS)
    - Resource use (based on VBPM)
    - Advancing Care Information (based on MU)
    - Clinical Practice Improvement Activities - NEW
  - Advanced Alternative Payment Models
    - Comprehensive Primary Care Plus (CPC+)
    - Medicare Shared Savings Tracks 2&3
    - Next Generation ACO Model
REPEALS
the flawed sustainable growth rate (SGR)
EXTENDS

LEGEND
APM = Alternative Payment Model
AAPM = Advanced Alternative Payment Model
MIPS = Merit-Based Incentive Payment System
AHI = Advancing Care Information
IA = Improvement Activities
CPC+ = Comprehensive Primary Care Plus
MSMP = Medicare Shared Savings Program (Tracks 2 & 3)
Next Gen ACO = Next Generation Accountable Care Organization
QPP = Qualifying Alternative Payment Model (APM) Participant
PQRS = Physician Quality Reporting System
VBM = Value-Based Modifier
EMR = Electronic Health Record

Aspects of the PQRS, VBM, and DIP Incentive Programs will be rolled into these four performance categories in MIPS.

Your Final Score is based on performance in all four categories. Performance in 2017 will determine your payment adjustments for 2019 in MIPS.

CMS has designated a limited number of Advanced APMs (AAPMs). GPs are physicians who see a certain percent of their patients OR receive a set percent of payments through an Advanced APM. AAPMs are not subject to MIPS. A limited number of AAPM participants become GPs.

APRIL 2016
PROPOSED RULE

2017
PERFORMANCE PERIOD

ACI
QUALITY
COST

FINAL
SCORE

DIFFERENTIATE
HIGH
PERFORMERS

VALUE-BASED PAYMENT

MACRA ready
The shift to Value Based Payment
Getting Paid Under MACRA

- Choose your path
- Merit-based Incentive Payment System (MIPS)
  - Score at threshold: no payment adjustment
  - Score above threshold: + payment adjustment on each claim the following year
  - Score below threshold: - payment adjustment on each claim the following year
  - Those in the lowest 25% will receive the maximum negative adjustment
- Advanced Alternative Payment Model (AAPM)
  - Annual 5% lump-sum bonus based on Medicare Part B payments
  - Incentives paid through existing contracts with the AAPM
MIPS Reporting Requirements

- **Quality**
  - Must report at least 6 measures (will use PQRS measures)
  - Must report at least 1 outcome measure
  - CMS will calculate all-cause hospital readmission measures for groups of 16 MIPs-Eligible Clinicians (ECs)

- **Cost**
  - No reporting requirement
  - CMS will calculate performance using claims data
  - To understand previous performance review your Quality and Resource Use Report (QRUR)
MIPS Reporting Requirements, cont

- Improvement Activities
  - Patient Centered Medical Homes will receive full credit
  - Attest to two high-weighted or four medium-weighted activities or a combination of both
  - Smaller and rural practices have lower requirements

- Advancing Care Information
  - Base score accounts for 50%
  - Performance score accounts for 50%
  - Objectives and measures are based on the 2015 EHR Incentive Program
Pick Your Pace - Options to avoid negative payment adjustment

- **Test**
  - Report at least one quality measure, one improvement activity OR the required ACI measures

- **Partial Participation**
  - Report at least 90 days of data for >1 quality measure, >1 improvement activity, OR more than the required ACI
  - Eligible for a small positive payment adjustment

- **Full Participation**
  - Report 90-365 days of data for all quality, all IA, and all ACI measures
  - Optimizes chance for moderate positive payment adjustment

- **Participate in Advanced APM**

- **Doing nothing = Automatic Negative Payment Adjustment**
MACRA Resources

- AAFP has made themselves MACRA experts
  - Website has extensive information
- Centers for Medicare and Medicaid Services
  - They created it, they have resources for it
- Transforming Clinical Practice Initiative
Final thoughts on MACRA

- Politics are in its favor, unlike the ACA it’s not going anywhere
- There are penalties if you don’t do anything
- It only applies to Medicare
- Try to become an AAPM
- Get help
Beyond MACRA- Comprehensive Primary Care Payment

- CPCP is a fixed, periodic payment for services delivered over a period of time
- Replaces encounter-based payment
- Different from previous iterations of capitation and bundled FFS that encouraged providers to avoid complex patients
- Incorporates practice infrastructure, clinical outcomes, patient demographics, and health status into a payment algorithm
- Supports team based, results driven, and patient centric model of care
- In the process of developing a calculator to determine the compensation rate for a particular patient population
CMS- Comprehensive Primary Care Plus (CPC+)

- A national advanced PCMH model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation
- Track 1 and currently expanding for Track 2, 21 regions in all
- CPC+ seeks to improve quality, access, and efficiency of primary care.
- Practices will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions:
  - Access and Continuity
  - Care Management
  - Comprehensiveness and Coordination
  - Patient and Caregiver Engagement
  - Planned Care and Population Health.
CPC+ Payment elements

- Care Management Fee
  - Non-visit based CMF paid per-beneficiary-per month
  - Risk adjusted
  - Paid quarterly

- Performance-Based Incentive
  - Prospectively pay and retrospectively reconcile performance-based measures that drive total cost of care

- Payment under the Medicare Fee Schedule
  - Track 1 - bills Medicare FFS as usual
  - Track 2 - bill as usual at a reduced rate PLUS prospective quarterly payments
    - CMS shifts a portion of FFS payments into CPCP payments paid in a lump sum quarterly absent a claim
    - CMS expects that the CPCP payments will be larger than the FFS payments they are intended to replace
CPC+ Final Thoughts

There are lots of benefits to participating in CPC+

- Increased flexibility in visit type - televisits, home visits,
- Freed from documentation to meet billing requirements
- Qualifies as an Advanced APM IF the practice has enough patients to qualify

There are some disadvantages

- It is an experiment
- It is only 5 years, don’t know if the current administration will continue it beyond that
- The biggest one of all...

It’s Not Available in Maryland
Maryland is trying to do something different

- All-Payer Model
  - CMMS Waiver that modernized Maryland’s hospital payment system
  - Implemented hospital-specific global budgets
- State implemented Multi-Payer Patient Centered Medical Home Program (MMPP)
  - CareFirst PCMH program
- Aiming to develop a state-wide Comprehensive Primary Care Model
  - Participating practices must deliver high quality, holistic care
  - Encourages patient choice
  - Gives providers more support and technical assistance to transform their practice
Relationship to All-Payer Model and Progression Plan

- The Primary Care Model
- Five key functions (same as CPC+)
- Will sustain the early gains of the All-Payer Model as targets become increasingly reliant on factors beyond the hospital.
- Complements and supports existing delivery system innovation in State particularly in the Hospital Global Budget
- Reduce available hospitalizations and ED usage through advanced primary care access and prevention
  - Components include care managers, 24/7 access to advice, medication mgmt, open-access scheduling, behavioral health integration and social services.
Builds from the CMMI CPC Plus Model

- Maryland’s CPC program will offer more flexibility to primary care practices than CPC Plus
  - Program begins with Medicare beneficiaries
  - Rolling application for practices
  - Care transformation organizations (CTOs) will support practices - Practice Transformation, Care Management, Informatics, Hospital Transitions, Social Services Integration
- CMMI will take responsibility for establishing the program and gradually transition responsibility to the State
Primary Care Functions

1. Access and Continuity
   • 24/7 patient access
   • Assigned care teams

2. Care Management
   • Risk stratify patient population
   • Short-and long-term care management
   • Care plans for high risk chronic disease patients

3. Comprehensiveness
   • Identify high volume/cost specialists serving population
   • Follow-up on patient hospitalizations
   • Psychosocial needs assessment and inventory resources and supports

4. Patient and Caregiver Engagement
   • Convene a Patient and Family Advisory Council

5. Planned Care and Population Health
   • Analysis of payer reports to inform improvement strategy
   • At least weekly care team review of population health data

Track 1

• E-visits
• Expanded office hours

Track 2

• 2-step risk stratification process

• Enact collaborative care agreements with two groups of specialists
• Behavioral health integration
• Enact collaborative care agreements with public health organizations

• Implement self-management support for at least three high risk conditions

• Same for Track 1 and 2
Care Transformation Organizations

Care Transformation Organization Design

Services Provided to PCH:
- Care Management
- Data Tools and Informatics
- Practice Transformation TA
- Social Services Connection
- Hospital Care Coordination

Provision of Services By:
- Care Managers
- Pharmacists
- LCSWs
- Transformation Agents
- CHWs
So how much can you get paid?

- AAPM annual lump sum bonus of 5% from Medicare
- Care Management Fee
  - Per patient, roughly $28/PMPM
  - Have to spend it on care management or share it with a Care Transformation Organization
  - Paid quarterly, prospectively
- Quality Incentive
  - $2.50/PMPM Track Two or $4 PMPM Track Two
  - Paid annually, prospectively, but can be clawed back if quality measures are not met
So how much can you get paid?

- **Comprehensive Primary Care Payment for Track Two**
  - % of historical E&M payments PLUS 10% in exchange for a diminished fee schedule
  - Can take up to 65% in advance
  - Paid quarterly, prospectively

- **Fee For Service Payments**
  - Diminished proportionately if in Track Two
## Payment Incentives for Better Primary Care

<table>
<thead>
<tr>
<th>Practices</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Underlying Payment Structure</th>
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</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td><strong>Payment: $28 average;</strong> including $100 to support patients with complex needs</td>
<td><strong>Payment: $2.50 opportunity</strong> Must meet quality and utilization metrics to keep incentive payment</td>
<td><strong>Payment: Standard FFS</strong> Timing: Regular Medicare FFS claims payment</td>
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<td></td>
<td><strong>Timing: Paid prospectively on a quarterly basis</strong></td>
<td><strong>Timing: Paid prospectively on an annual basis;</strong></td>
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<td><strong>Track 2</strong></td>
<td><strong>Payment: $4.00 opportunity</strong> Must meet quality and utilization metrics to keep incentive payment</td>
<td><strong>Payment: Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</strong> Medicare FFS claim is submitted normally but paid at reduced rate</td>
<td><strong>Timing: CPCP paid prospectively on a quarterly basis;</strong></td>
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<tr>
<td></td>
<td><strong>Timing: Paid prospectively on a quarterly basis</strong></td>
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| CTOs | Payment: up to 50% of Practice Care Management Fee; depends on 3 option chosen by practice (3) | Payment: $1.50+ for outcomes and population health measures opportunity | **N/A** |
| | **Timing: Paid prospectively on a quarterly basis** | **Timing: Begins Year 2 of Program** | |
Practice Eligibility in MCPC

Qualifiers

- Utilize a certified electronic health record
- CRISP level 3 connectivity --- Use CRISP Portal, ENS, Direct Messaging
- At least 150 attributed FFS Medicare beneficiaries
- Already engaged in specified practice transformation activities

Exclusions

- Charge any concierge fees to Medicare beneficiaries
- Participate in certain other CMMI initiatives (i.e., Accountable Care Organization [ACO] Investment Model, Next Generation ACO Model, and Comprehensive ESRD Care Model)
<table>
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<tr>
<th>Activity</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>Obtain Approval for Model from HHS</td>
<td>Summer 2017</td>
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<tr>
<td>Write legal agreements and applications for CTOs and practices</td>
<td>Summer 2017</td>
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<tr>
<td>Stand up Program Management Office</td>
<td>Summer/Fall 2017</td>
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<tr>
<td>Release applications</td>
<td>Fall 2017</td>
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<tr>
<td>Select CTOs and Practices</td>
<td>Late Fall 2017</td>
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<tr>
<td>Initiate Program</td>
<td>Summer 2018</td>
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<tr>
<td>Expand Program</td>
<td>2019 - 2023</td>
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Getting Ready for MCPC

Consider Track Options

- Apply for Track 1 or Track 2?
- If I choose Track 2, what is the level of engagement with capitated payments?

Assess ability to perform advanced primary care functions?

- Can I employ care managers?
- Should I use a CTO?
  - Who is available in my area?
  - What is the level of participation?
- Consider interplay between MSSP program and MCPC
Useful Videos on CPC+

- Part 2: (Care management fees) https://www.youtube.com/watch?v=NBVNQyNeKJ8&feature=youtu.be
- Part 3: (Performance Based Incentive Payment) https://www.youtube.com/watch?v=qU4hF1d9Xjl&feature=youtu.be
- Part 4: (Hybrid Payment) https://www.youtube.com/watch?v=xPeyjE8couk&feature=youtu.be
Caveats

- Change is hard
  - Change fatigue
- Not everyone wants to make the change to value based care
- It will require practice transformation
  - Doesn’t just change how we are paid
  - Transition to team-based care models
- Change in mind-set from fee for service
- Will require finding, using, and manipulating data to monitor patient outcomes
- Doing well in this model requires top down and ground up leadership, buy-in and accountability
States on the move

- Oregon
- Rhode Island
- Connecticut
- New Jersey
  - State-wide DPC initiative for the state employees union
- Maryland
Direct Primary Care

- Alternative to fee-for-service insurance billing
- Charges patients a monthly/quarterly/annual fee to cover all or most primary care services
- For patients there are substantial health care savings
- Often needs to be coupled with a high-deductible wraparound policy to cover emergencies
- Frees physicians from the burden of documentation and reporting
- DPC Variant- working directly with employers to provide care for their employees
  - Employer covers the retainer fee
Practice Bright Spots

- Iora Health
  - Prioritizes health coaching
  - No fee for service billing
  - Fully integrated behavioral health
  - Sick and well care
- CareMore
  - Medicare advantage plan
  - Fully integrated between the clinic and the Medicare plan
- Qliance
  - Had been the premier example of DPC contracting with self-insured employers
Questions?