



# PC Collaborative

November 12, 2019

# Update on Value Based Payment

- ▶ Medicaid/MCO will provide info at next meeting
- ▶ Commercial payors: what do you track and are these metrics valuable:
  - ▶ Total overall percentage participation
  - ▶ How many are in PCMH/ PCMH type models
  - ▶ Number of quality metrics
  - ▶ Challenges>>what measures are in place to increase participation
  - ▶ Successes>>have you deliberately increased percentage spend on PC through VBM
  - ▶ Ability to provide a PCF-like track

# 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

Figure 4: The Updated APM Framework

			
CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	FEE FOR SERVICE - LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION - BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations <small>(e.g., care coordination fees and payments for HIT investments)</small>	APMs with Shared Savings <small>(e.g., shared savings with upside risk only)</small>	Condition-Specific Population-Based Payment <small>(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</small>
	B	B	B
	Pay for Reporting <small>(e.g., bonuses for reporting data or penalties for not reporting data)</small>	APMs with Shared Savings and Downside Risk <small>(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</small>	Comprehensive Population-Based Payment <small>(e.g., global budgets or full/percent of premium payments)</small>
	C		C
	Pay-for-Performance <small>(e.g., bonuses for quality performance)</small>		Integrated Finance & Delivery System <small>(e.g., global budgets or full/percent of premium payments in integrated systems)</small>
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Source: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

# Health Plans

## ACO

### Care Management

### Shared Savings to Shared Risk

### Pay for Performance

## Proposed Funding Model

### 3 funding streams:

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

- 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

- 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

- 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

# A clinical model plus a payment approach to enable the model can lead to improved outcomes

- ▶ Common elements of successful models include:
  - ▶ – Clear goals for outcomes with a vision for how care will be delivered
  - ▶ – Timely and accurate data sharing
  - ▶ – Risk adjustment to account for differences in patient panels
  - ▶ – Prospective payments to allow practices to make upfront investments
  - ▶ – Payments connected to a focused set of metrics and performance on the 4 C's (contact, continuity, comprehensiveness, and coordination)
  - ▶ Use of multidisciplinary care teams

# Previous Comments: This past Spring

- ▶ Value of PCMH: Total Cost savings was greatest with mature PCMH or higher risk populations
- ▶ important characteristics:
  - ▶ upfront investment without being additive to total cost
  - ▶ Accountability=risk
  - ▶ Building of infrastructure: data; care coordination at practice level; pre-defined targets for outcomes, cost savings, accountability
  - ▶ Role of established ACOS in state

# Questions for ACOs

- ▶ Percentage of practices participating as PCMH certified or PCMH type of practice model
- ▶ Percentage of practices in concierge (if any)
- ▶ Percentage of practices participating in other VBM (multipayor) using the ACO platform
- ▶ Interest in PCF with RFP out and delay of deadline
- ▶ Where are they on the "track" - majority