“Primary Care First”

Mini-Summit X, Part 1

Tuesday, June 18, 2019
2:00 p.m. - 2:45 p.m.

Achieving Affordable, Accessible, Patient-Centered Primary Care

Challenges & Opportunities

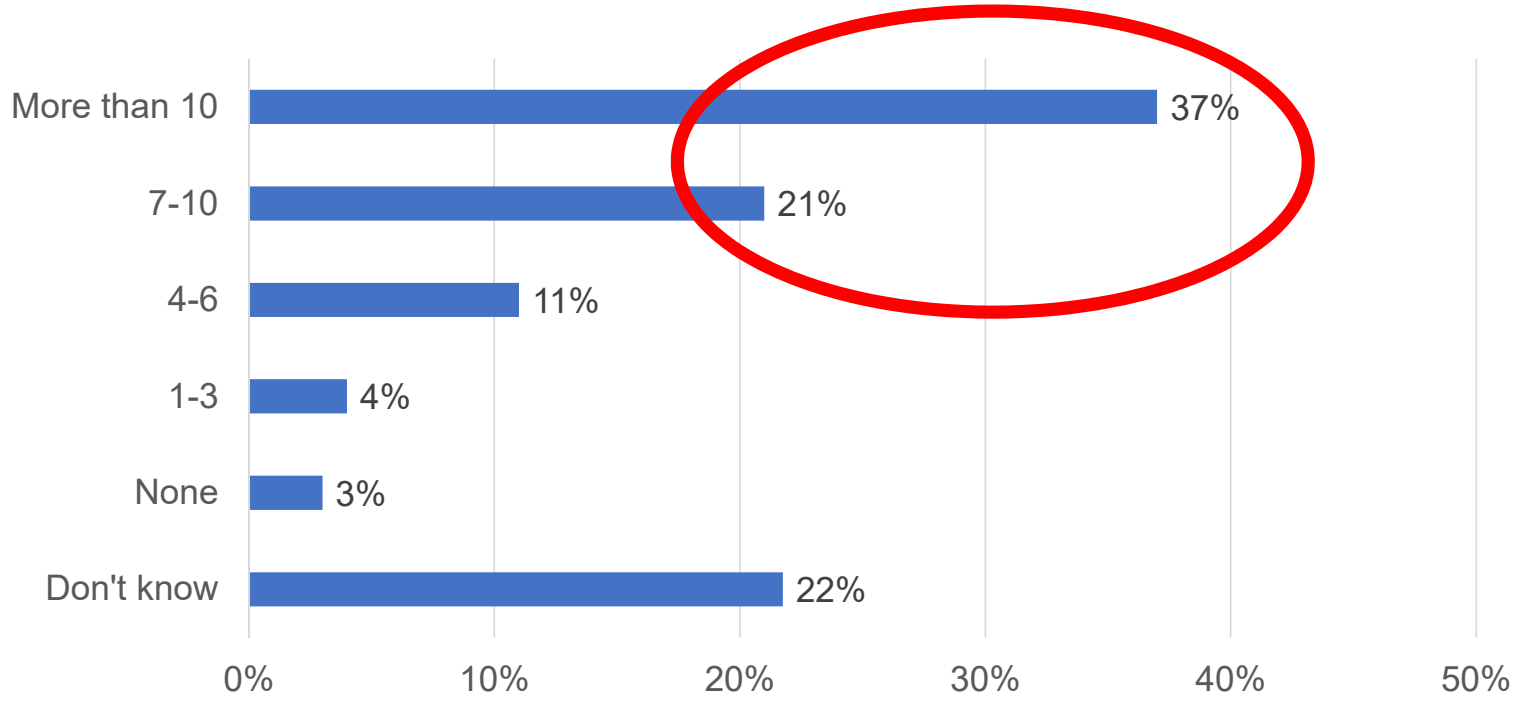
Known Knowns

- Complexity & Cost Are Damaging Primary Care
- Primary Care Is Undervalued
  - 5% to 7% of total spend
  - Medicare FFS = as low as 2%
- Dose Of Primary Care Matters
- Continuity = Higher Quality/Lower Cost
- Investment In Primary Care Contributes To Decrease In Overall Health Care Spending

Complexity is Destroying Primary Care

- Point of Care Drivers of Administrative Burden
  1. Utilization Management Programs (Prior Authorization)
  2. Documentation Guidelines
  3. Quality Reporting/Performance Metrics
  4. Electronic Health Records
- Revenue-cycle Management
- Lack of Alignment Among Payers
- Burn Rate & Opportunity Cost
- Certification/Maintenance of Certification
- Negative Practice Culture
- Patient Safety Risk

Number of Payers/Health Plans for Family Physicians



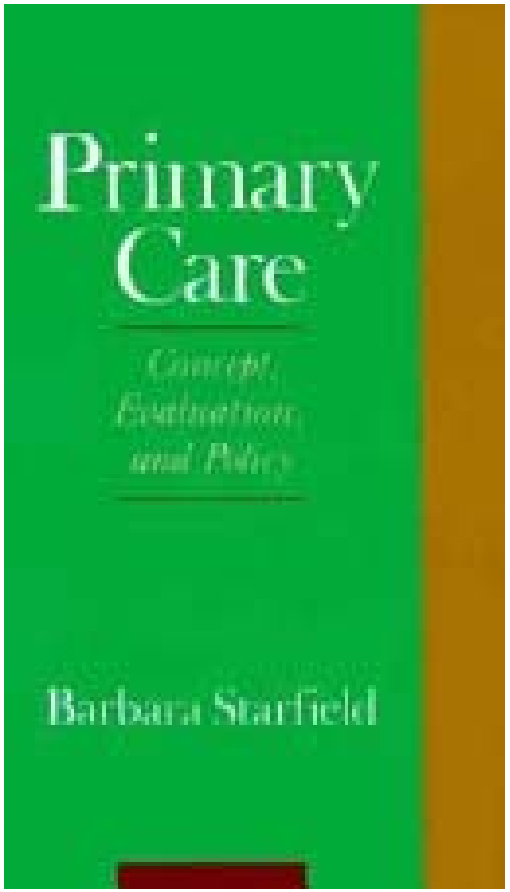
Literature Review

- "researchers found the annual administrative workload of primary care physicians costs nearly $100 000 per physician”
  - JAMA Forum: Administrative Costs and Health Information Technology
- “U.S. physician practices spend more than $15.4 billion annually to report quality measures”
  - Health Affairs March 2016
- “To fully satisfy the USPSTF recommendations, 1773 hours of a physician’s annual time, or 7.4 hours per working day, is needed for the provisions of preventive services”
  - American Journal of Public Health April 2003

Foundations of Primary Care

- Dr. Starfield's 4 C's of Primary Care
  - 1st Contact
  - **Comprehensive**
  - **Continuous**
  - Coordinated

- The AAFP's 5th C = "connected"



Is Continuity of Care the Key Indicator?

Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations

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MORE ONLINE

Conflicts of interest: authors report none.

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ABSTRACT

PURPOSE Continuity of care is a defining characteristic of primary care associated with lower costs and improved health equity and care quality. However, we lack provider-level measures of primary care continuity amenable to value-based payment, including the Medicare Quality Payment Program (QPP). We created 4 physician-level, claims-based continuity measures and tested their associations with health care expenditures and hospitalizations.

METHODS We used Medicare claims data for 1,448,952 beneficiaries obtaining care from a nationally representative sample of 6,551 primary care physicians to calculate continuity scores by 4 established methods. Patient-level continuity scores attributed to a single physician were averaged to create physician-level scores. We used beneficiary multilevel models, including beneficiary controls, physician characteristics, and practice rurality to estimate associations with total Medicare Part A & B expenditures (allowed charges, logged), and any hospitalization.

RESULTS Our continuity measures were highly correlated (correlation coefficients ranged from 0.86 to 0.99), with greater continuity associated with similar outcomes for each. Adjusted expenditures for beneficiaries cared for by physicians in the highest Bice-Boxerman continuity score quintile were 14.1% lower than for those in the lowest quintile ($8,092 vs $6,958; β = −0.151; 95% CI, −0.186 to −0.116), and the odds of hospitalization were 16.1% lower between the highest and lowest continuity quintiles (OR = 0.839; 95% CI, 0.787 to 0.893).

CONCLUSIONS All 4 continuity scores tested were significantly associated with lower total expenditures and hospitalization rates. Such indices are potentially useful as QPP measures, and may also serve as proxy resource-use measures, given the strength of association with lower costs and utilization.

Ann Fam Med 2018;16:492-497. https://doi.org/10.1370/afm.2308.

INTRODUCTION

The Institute of Medicine labeled continuity of care a defining characteristic of primary care, one that Starfield and others demonstrated as essential to primary care's positive impact on health equity, cost reduction, and improved quality of care.[1-4] Described as an implicit contract between physician and patient in which the physician assumes ongoing responsibility for the patient,[5] continuity frames the personal nature of medical care, in contrast to the dehumanizing nature of disjointed care.[6] Building on the idea that knowledge, trust, and respect have developed between the patient and provider over time, allowing for better interaction and communication,[7] continuity at the patient level is associated with a host of benefits.[8]

Primary care has more measures than any other sector under the federal Quality Payment Program (QPP), yet most of these are disease specific or process measures that do not capture the core primary care functions. Despite a variety of definitions and calculations over the last 40 years, little has been done to operationalize continuity as a quality measure linked to policy-relevant outcomes in the United States or other nations.[9] Given current US attention to provider-level, vs practice-level,

- We found a strong association between higher levels of physician-level continuity, a core tenet of primary care, and lower total health care costs and hospitalizations.
- The value associated with a 14% reduction in costs is roughly $1,000/beneficiary/year.
- Higher continuity was recently shown to be significantly associated with reduction in emergency care for elderly patients in England.
- A recent systematic review found significant, positive association between continuity and reduced mortality

Dose of Primary Care Matters

Research

JAMA Internal Medicine | Original Investigation

Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015

Sanjay Basu, MD, PhD; Seth A. Berkowitz, MD, MPH; Robert L. Phillips, MD, MSPH; Asaf Bitton, MD, MPH; Bruce E. Landon, MD, MBA; Russell S. Phillips, MD

Invited Commentary
Supplemental content

IMPORTANCE Recent US health care reforms incentivize improved population health outcomes and primary care functions. It remains unclear how much improving primary care physician supply can improve population health, independent of other health care and socioeconomic factors.

OBJECTIVES To identify primary care physician supply changes across US counties from 2005-2015 and associations between such changes and population mortality.

DESIGN, SETTING, AND PARTICIPANTS This epidemiological study evaluated US population data and individual-level claims data linked to mortality from 2005 to 2015 against changes in primary care and specialist physician supply from 2005 to 2015. Data from 3142 US counties, 7144 primary care service areas, and 306 hospital referral regions were used to investigate the association of primary care physician supply with changes in life expectancy and cause-specific mortality after adjustment for health care, demographic, socioeconomic, and behavioral covariates. Analysis was performed from March to July 2018.

MAIN OUTCOMES AND MEASURES Age-standardized life expectancy, cause-specific mortality, and restricted mean survival time.

RESULTS Primary care physician supply increased from 196 014 physicians in 2005 to 204 419 in 2015. Owing to disproportionate losses of primary care physicians in some counties and population increases, the mean (SD) density of primary care physicians relative to population size decreased from 46.6 per 100 000 population (95% CI, 0.0-114.6 per 100 000 population) to 41.4 per 100 000 population (95% CI, 0.0-108.6 per 100 000 population), with greater losses in rural areas. In adjusted mixed-effects regressions, every 10 additional primary care physicians per 100 000 population was associated with a 51.5-day increase in life expectancy (95% CI, 29.5-73.5 days; 0.2% increase), whereas an increase in 10 specialist physicians per 100 000 population corresponded to a 19.2-day increase (95% CI, 7.0-31.3 days). A total of 10 additional primary care physicians per 100 000 population was associated with reduced cardiovascular, cancer, and respiratory mortality by 0.9% to 1.4%. Analyses at different geographic levels, using instrumental variable regressions, or at the individual level found similar benefits associated with primary care supply.

CONCLUSIONS AND RELEVANCE Greater primary care physician supply was associated with lower mortality, but per capita supply decreased between 2005 and 2015. Programs to explicitly direct more resources to primary care physician supply may be important for population health.

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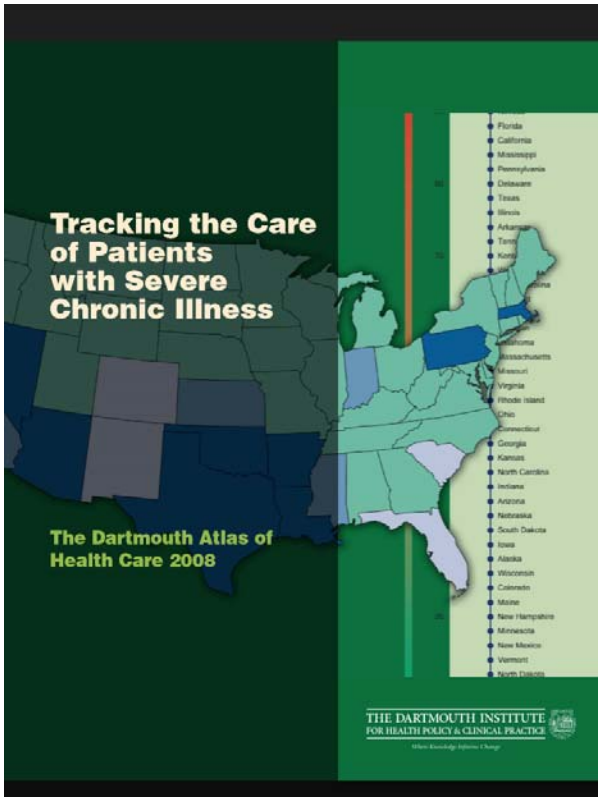
JAMA Intern Med. doi:10.1001/jamainternmed.2018.7624
Published online February 18, 2019.

- Every 10 additional primary care physicians per 100,000 population was associated with a 51.5-day increase in life expectancy.
- Greater primary care physician supply was associated with lower mortality, but per capita supply decreased between 2005 and 2015.
- **From 2005 to 2015, the density of primary care physicians decreased from 46.6 to 41.4 per 100 000 population.**

Primary Care Impacts Quality & Utilization

States That Rely More On Primary Care Have:

- Lower Medicare spending (inpatient reimbursements and Part B payments)
- Lower resource inputs (hospital beds, intensive care unit [ICU] beds, total physician labor, primary care labor, and medical specialist labor)
- Lower utilization rates (physician visits, days in the ICU, days in the hospital, and patients seeing 10 or more physicians)
- Better quality of care (fewer ICU deaths and a higher composite quality score)



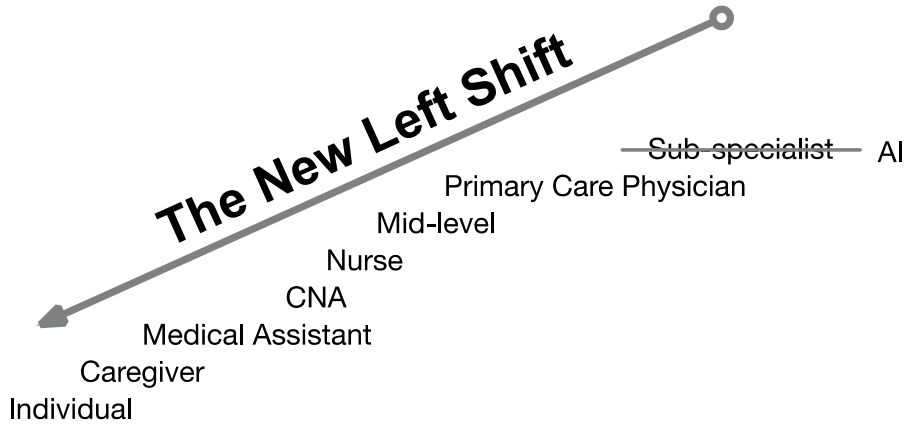
Advanced Primary Care Delivery & Payment

5 Keys to Achieving High-Functioning/Cost-Effective Primary Care

1. Prospective Payment
2. Establish & Promote Continuity
3. Reduce Complexity
4. Manage Cost
5. Evaluate What Matters Most

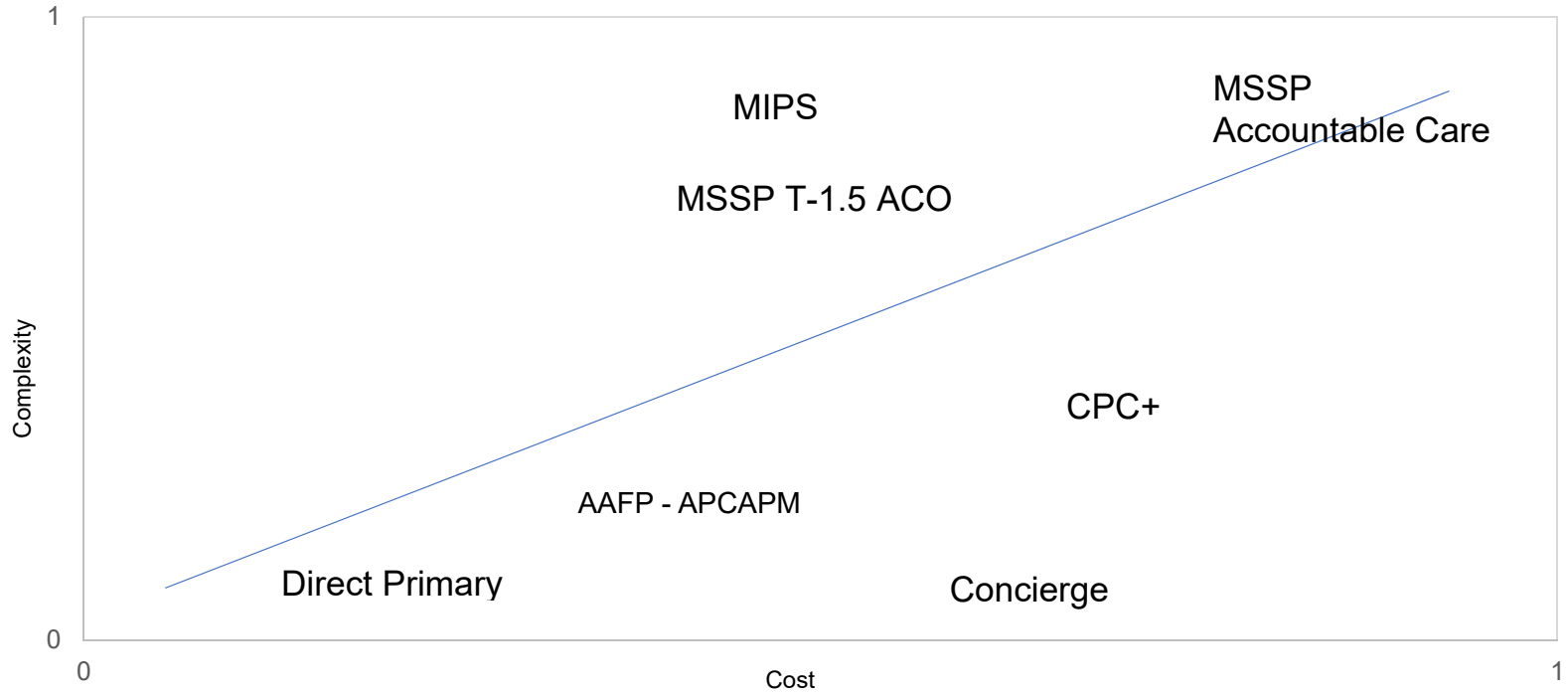
COMPREHENSIVE
Family Medicine

- Opportunity to expand scope of practice with augmented intelligence
- Potential primary care renaissance
- Be more cost effective
- Erosion of traditional scope of practice

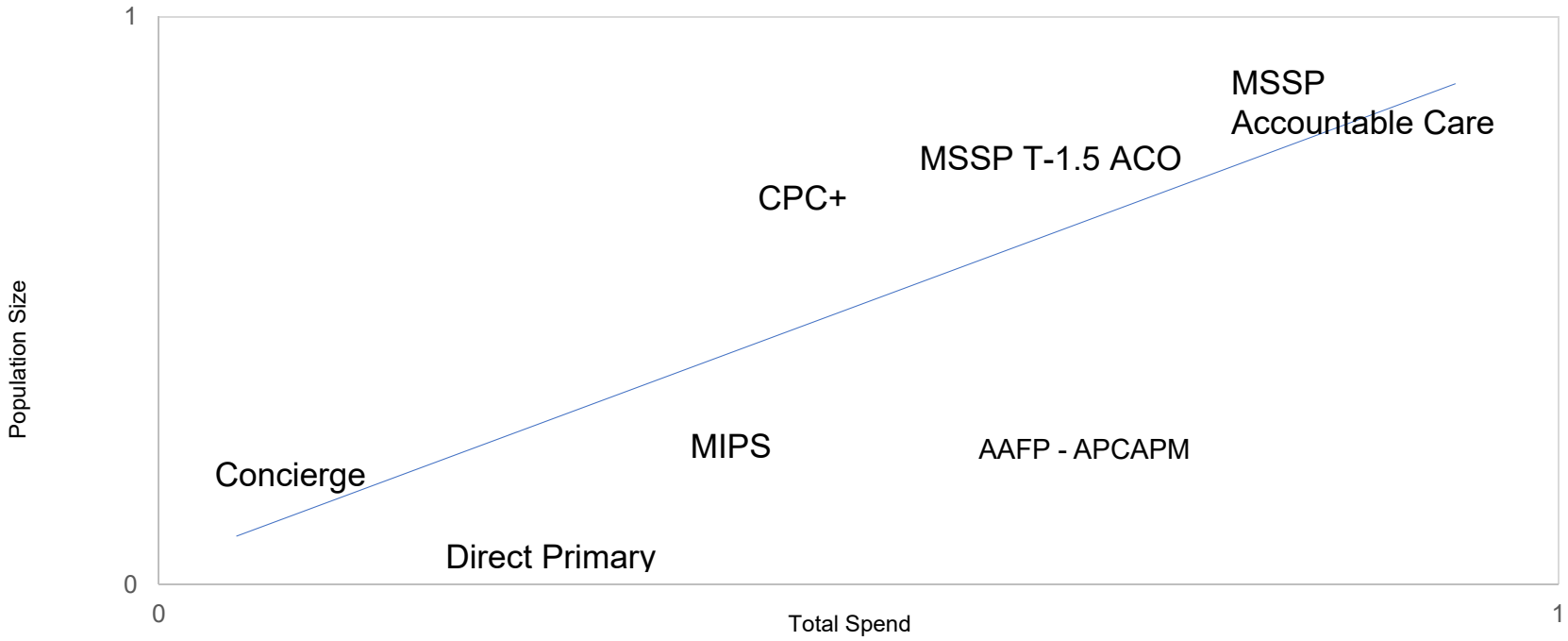


Current Primary Care Models

Cost & Complexity of Primary Care Models



Impact on Total Spend



How Should We Evaluate Primary Care?

- Quality
- Performance
- Patient satisfaction
- Utilization at the individual level
- Utilization at the population level

Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

AMERICAN ACADEMY OF FAMILY PHYSICIANS

AAFP Goals

- Promote patient-centered, continuous, comprehensive primary care
- Expand access to a multi-payer, primary care Advanced APM
- Transition primary care payments away from fee for service
- Reduce physician administrative burden
- Increase investments in primary care

APC-APM Payment Model

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

How does the APC-APM work?

The APC-APM is envisioned as:

- A multi-payer model that builds and improves upon concepts already tested in other models (e.g. Comprehensive Primary Care Plus)
- Adaptable for small, independent practice
- Would work well with other integrated APM models (e.g ACO, CINs)
- Open to almost 200,000 primary care physicians
- Potentially impacting more than 30 million Medicare patients
- Providing primary care physicians with another APM alternative to MIPS

Global Primary Care Payment Covers E/M Services to Support Small Practice Transformation

- **Global Primary Care Payment Definition**
  - Prospective, risk-adjusted, per patient per month (PPPM) primary care global payment for face-to-face E/M services
- **Components of Global Primary Care Payment PPPM**
  - Average Medicare E/M expenditures PPPM based on 2016 claims data
  - Average of 3 primary care visits per year
  - Annual Wellness Visit and Advanced Care Planning codes included
  - Overall 10% increase in payment for E/M services
  - Adjustment for Social Determinants of Health (SDoH)
  - Divided by 12 for monthly payment
- **Draft Formula for Global Primary Care Payment**
  - Global Payment={[(Avg E/M ∗ 3 ∗ HCC multiplier) + (AWV (175) +ACP(75))] ∗ 1.1 ÷ 12

CMS Primary Cares Initiative

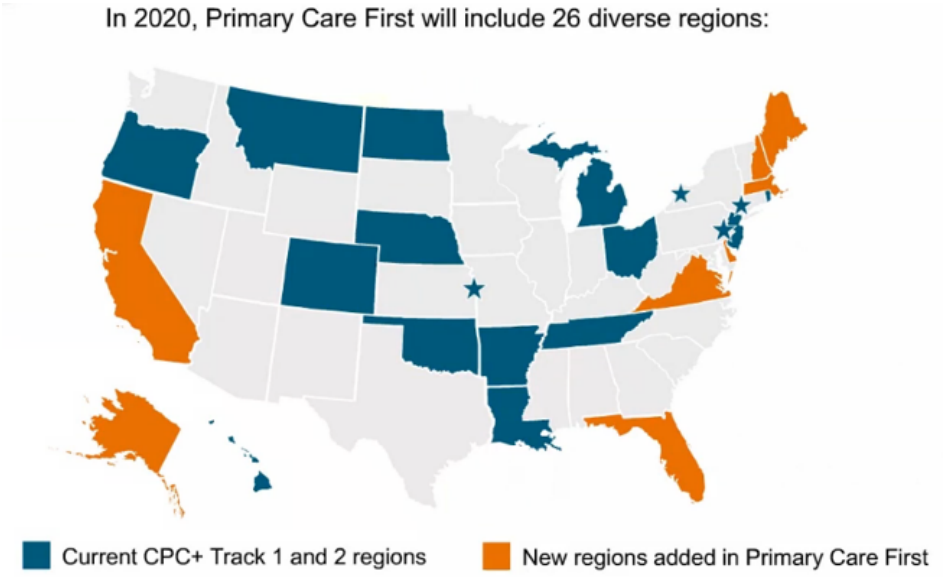
Primary Care First Models

FIGHTING FOR FAMILY MEDICINE

Primary Care First (PCF) Payment Model Options

Option 1	Option 2	Option 3
PCF Payment Model	**PCF High Need Populations Payment Model**	**Participation in both options 1 and 2**
Focuses on practices providing advanced primary care functions ready to assume financial risk in exchange for reduced burden and bonus opportunities based on performance.	Promotes care for high need, seriously ill population (SIP) beneficiaries who lack a primary care practitioner or effective care coordination.	Allows practices to participate in both the PCF Payment Model and the PCF High Need Populations Payment Model.

Primary Care First Regions



- CPC+ States & Regions
  - 26 regions including 18 CPC+ regions (CPC+ practices ineligible for first year of PCF model)
- Primary Care First Additional Regions
  - New regions include: AK, CA, DE, FL, MA, ME, NH, and VA
  - Regions selected based on where there are limited comparison group practices in the ongoing CPC+ evaluation

3 Key Questions

1. **Attribution Model**
2. **Payment Methodologies**
3. **Evaluation**

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Overview of AAFP

- The AAFP's mission is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity.
- The AAFP and its chapters proudly represent 131,400 family physician, resident, and medical student members. We believe and recognize that family physicians play a critical role in improving the health of patients, families, and communities across the United States.
- The AAFP is committed to helping family physicians improve the health of Americans by allowing them to spend more time doing what they do best: providing high quality and cost-effective patient care. The AAFP delivers value to its members through each of its strategic priorities.


AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

SUPPLEMENTAL SLIDES

PRIMARY CARES INITIATIVE

CMS Primary Cares Initiative – Primary Care First Models

American Academy of Family Physicians Summary

FIGHTING
FOR
FAMILY MEDICINE

CMS Primary Cares Initiative

- CMS announced five new payment models under two paths
  - Primary Care First (PCF)
    - Set of two payment model options testing if the delivery of advanced primary care can reduce total cost of care
    - Allows practices to assume financial risk in exchange for reduced administrative burden and prospective population-based payments
    - Also includes model for high need, seriously ill beneficiaries who lack primary care provider/coordinated care
  - Direct Contracting (DC):
    - Set of three payment model options aimed at reducing cost and improving quality of care for beneficiaries in Medicare fee-for-service
    - Built off NextGen ACO model, offers new forms of payments, enhanced cash flow options, a flexibilities to meet beneficiaries medical and social needs

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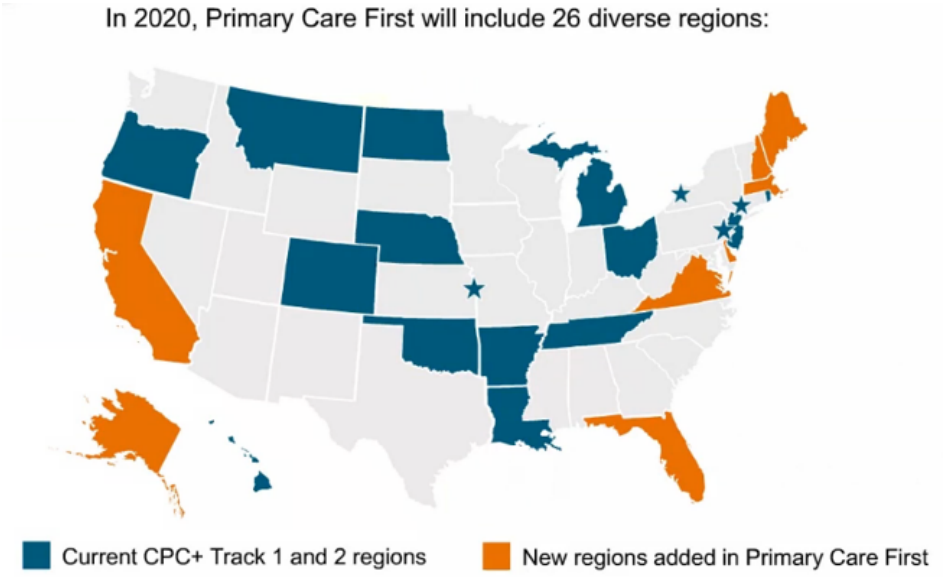

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Primary Care First Eligibility

- Include primary care practitioner (MD, DO, CNS, NP, PA) in primary care specialty (internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine)
- 125 attributed Medicare beneficiaries
- 70% of practice revenue coming from primary care services
- Experience with value-based payment arrangements/payments based on cost, quality, and/or utilization performance
- Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE) if available
- Attest on practice application to advanced primary care functions (24/7 access, empanelment, etc.)

Primary Care First Eligibility - SIP

- Include practitioners serving seriously ill populations (MD, DO, CNS, NP, PA)
- Meet basic competencies to successfully manage complex patients (e.g. interdisciplinary teams, comprehensive care, person-centered care, family and caregiver engagement, 24/7 access)
- For those participating in only SIP portion of the model – have network of providers in the community to meet patients' long-term care needs
- Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE) if available

PCF Comprehensive Primary Care Interventions

Comprehensive Primary Care Function	PCF Intervention
Access and Continuity	24/7 access to care team clinician with real-time EHR access
Care Management	Provide risk-stratified care management
Comprehensiveness and Coordination	Integrate behavioral health Assess/support patients' psychosocial needs
Patient and Caregiver Engagement	Implement regular process for patients/caregivers to advise practice improvement
Planned Care and Population Health	Set goals and continuously improve on outcome measures

PCF Payment Components

Total Primary Care Payment

- Professional population-based payment
- Flat primary care visit fee

+

Performance-based Adjustment

Opportunity for practices to increase revenue by up to 50% of their total primary care payment based on performance on acute hospital utilization. Downside risk is capped at 10%.

1. National adjustment
2. Cohort adjustment
3. Continuous improvement adjustment

PCF Total Primary Care Payments

Hybrid Total Primary Care Payments replace Medicare fee-for-service payments to support delivery of advanced primary care with predictable payments and reduced burden

Professional Population-Based Payment

Payment for services inside or outside the office. Risk-adjusted payment based on average risk of all attributed patients.

Practice Risk Group	Payment Per Beneficiary Per Month
Group 1	$24
Group 2	$28
Group 3	$45
Group 4	$100
Group 5	$175

+

Flat Primary Care Visit Fee

Flat payment for face-to-face primary care services. Intended to reduce billing and revenue cycle burden.

$50.52
per face-to-face encounter

PCF Performance-based Payment Adjustments

Exceed Quality Gateway (years 2-5)?

No → **-10%** adjustment to Total Primary Care Payment for next applicable year

Yes → 1 National adjustment

Exceed national benchmark (years 1-5)?

No → **-10%** adjustment *(still eligible for continuous improvement bonus)*

Yes → 2 Cohort adjustment

Bottom 50% of practices based on performance → **0%** adjustment

Top 50% of practices based on performance

Performance Level	Adjustment to Total Primary Care Payment
Top 20% of eligible practices	34%
Top 21-40% of eligible practices	27%
Top 41-60% of eligible practices	20%
Top 61-80% of eligible practices	13%
Top 81-100% of eligible practices	6.5%

PCF Performance-based Payment Adjustments

3 Continuous improvement adjustment

Practices are eligible for a **continuous improvement bonus of up to 1/3 of the total PBA amount** if they achieve their improvement target.

Performance Level	Potential Improvement Bonus
Top 20% of PBA-eligible practices	**16%** of Total Primary Care Payment
Top 21-40% of PBA-eligible practices	**13%** of Total Primary Care Payment
Top 41-60% of PBA-eligible practices	**10%** of Total Primary Care Payment
Top 61-80% of PBA-eligible practices	**7%** of Total Primary Care Payment
Top 81-100% of PBA-eligible practices	**3.5%** of Total Primary Care Payment
Practices performing above nationwide benchmark, but below top 50% of practices	**3.5%** of Total Primary Care Payment
Practices performing at or below nationwide minimum benchmark	**3.5%** of Total Primary Care Payment

PCF High Need Population Payment Model Option

Eligibility and Attribution

- Practices demonstrating relevant capabilities can opt in to be assigned SIP patients who lack a primary care practitioner or care coordination
- Medicare-enrolled clinicians who provide hospice or palliative care can also participate

Payments

Payments for practices serving SIP patients:

First 12 Months

- One-time payment for first visit with SIP patient: **$325**
- Monthly SIP payments for up to 12 months: **$275 PBPM**
- Flat visit fees: **$50**
- Quality payment: up to **$50**

PCF Quality Measures

Measure Type	Measure Title	Benchmark
Utilization Measure for Performance-based Adjustment (Years 1-5)	Acute Hospital Utilization (AHU – HEDIS measure)	Non-CPC+ reference population
Quality Gateway (Years 2-5)	CPC+ Patient Experience of Care Survey (modernized version of CAHPS)	MIPS
	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM)*	MIPS
	Controlling High Blood Pressure (eCQM)	MIPS
	Care Plan (registry measure)	MIPS
	Colorectal Cancer Screening (eCQM)*	MIPS
Quality Gateway for practices serving SIPS	TBD – could include 24/7 patient access and days at home	Non-CPC+ reference population

*Measure does not apply to practices in Practice Risk Groups 4 or 5 and for practices receiving SIP patients.

PCF Timeline

Activity	Timeline
Practice applications open	Spring 2019
Practice applications due; Payer solicitation	Summer 2019
Practices and Payers selected	Fall-Winter 2019
Model launch	January 2020
Payment changes begin	April 2020
2nd round applications	Mid 2020
2nd round begins	January 2021

CPC+ PCF Crosswalk

	CPC+	PCF
Care Delivery Requirements	Practices implement core and advanced primary care functions	Practices have capabilities to deliver advanced primary care functions at onset of the model
Payment	**Care Management Fee** for practice investment – Yes ($15 PBPM average for Track 1, $28 PBPM average for Track 2) **Performance-based Incentive Payment** – Yes (~10% of primary care revenue for Track 1, ~20% of primary care revenue for Track 2). Intended to motivate practices to reduce utilization and improve quality. **Underlying payments to practice** - FFS	**Care Management Fee** for practice investment – No **Performance-based Incentive Payment** – Yes (~50% of primary care revenue with capped downside risk of 10%). Intended to motivate practices to reduce acute hospital utilization to reduce total cost of care, while meeting quality and patient experience thresholds. **Underlying payments to practice** - risk-adjusted population-based payment with a flat primary care visit fee
Attribution	Voluntary patient alignment followed by claims based attribution	Voluntary patient alignment followed by claims based attribution; proactive identification and assignment of SIP patients
Participation	18 states/regions	26 states/regions, including 18 CPC+ regions

Links

Video of CMS Primary Care Initiative Launch

https://youtu.be/RTqXoqeTkH8

CMS Primary Cares Initiative press release

https://innovation.cms.gov/Files/x/primary-cares-initiative-onepager.pdf

Primary Care First press release

https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

AAFP CMS Primary Cares Website

https://www.aafp.org/practice-management/payment/medicare-payment/aapms/cms-primary-cares-initiative.html

SUPPLEMENTAL SLIDES

ADVANCED PRIMARY CARE ALTERNATIVE PAYMENT MODEL

APC-APM Payment Methodology

APC-APM Structure Provides Prospective, Stable Payment – Critical to Small, Independent Practices

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
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Fee-For-Service Payment

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Global Primary Care Payment Covers E/M Services to Support Small Practice Transformation

- **Global Primary Care Payment Definition**
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- **Components of Global Primary Care Payment PPPM**
  - Average Medicare E/M expenditures PPPM based on 2016 claims data
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  - Overall 10% increase in payment for E/M services
  - Adjustment for Social Determinants of Health (SDoH)
  - Divided by 12 for monthly payment
- **Draft Formula for Global Primary Care Payment**
  - Global Payment={[(Avg E/M ∗ 3 ∗ HCC multiplier) + (AWV (175) +ACP(75))] ∗ 1.1 ÷ 12

Population-Based Payment Supports Non-Face-to-Face Care

- **Population-Based Payment Definition**
  - Prospective, risk-adjusted, per patient per month (PPPM) population-based payment for non-face-to-face care

- **Components of Population-Based PPPM**
  - 3-tier risk-adjustment based on number of chronic conditions
  - Middle tier based on Medicare FFS CCM payment of $42
  - Upper tier based on CPC+ Track 2 Tier 5
  - Social Determinants of Health (SDoH) adjustment

- **Example Population-Based Payment Range**

# Chronic Conditions	PPPM Payment
0-1	$15.00
2-4	$42.00
≥5 or dementia diagnosis	$100.00

FFS Payments Support Range of Services Primary Care Physicians Deliver – Especially in Rural Areas

- **Fee-for-Service Payment**
  - Limited to services not included in primary care global or population-based payments
  - Ensures beneficiaries receive necessary services
  - Protects small, independent practices where primary care physicians provide broad range of services (e.g. OB/GYN care, wound repair, etc.)
- **Fee-for-Service Codes and Modeling**
  - 350+ HCPCS codes identified for possible inclusion in FFS payment bucket
  - Modeling range of FFS payments to inform APC-APM costs and possible ROI for Medicare

Performance-Based Incentive Payment Drives Accountability for Cost, Utilization, and Quality

- **Performance-Based Incentive Payment Structure**
  - −Performance pool could be structured as a “withhold”
  - −Participants report and are measured on the same quality and cost measures
    - 10 Quality measures (9 eCQMs, CAHPS or other patient satisfaction measure) meet/exceed thresholds to keep percentage of Quality component
    - 3 Cost measures (e.g. primary care ED, ambulatory sensitive inpatient, and readmission) meet/exceed thresholds to keep percentage of Cost component

- **Performance-Based Incentive Pool and Payment Calculations**
  1. Performance Pool = (Total Yearly Global Payment +Total Yearly PBP + FFS) ∗ 5% or 8% (depending on Advanced APM risk requirements)

  2. PBIB= Performance Pool ∗ % (Quality + Cost) Eligible to Keep

Beneficiary Attribution

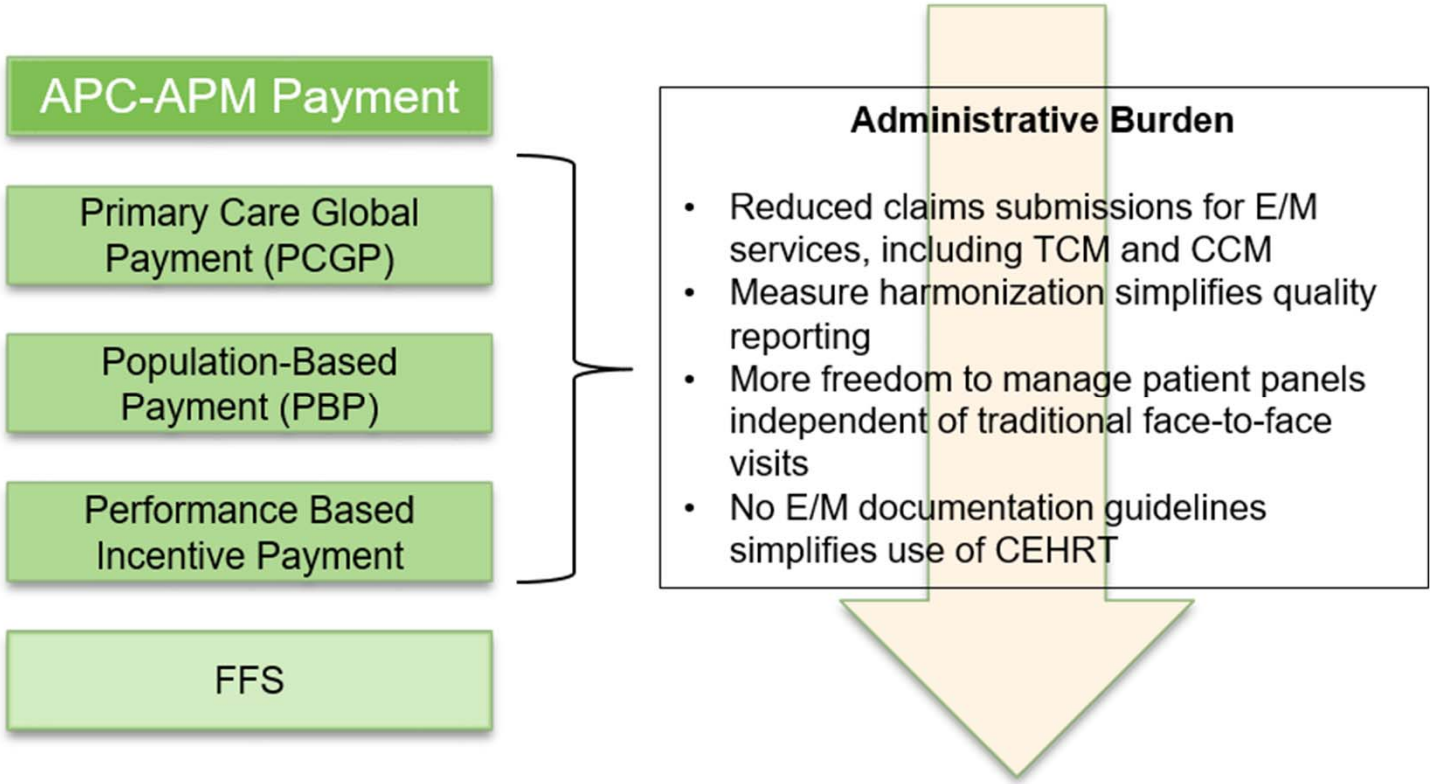
- Goal: Promote patient choice and engagement and test the "gold standard" for attribution in an APM, consistent with the HCPLAN's recommendations
- Patient-driven, prospective, four-step process with a 24-mo look-back period

Step in Process	Event Type	Eligible Procedure or Event	Look-Back Period	Assignment Criteria	Minimum Threshold for Assignment	In Event of a Tie
Step 1	Patient Selects PCP	N/A	N/A	N/A	N/A	N/A
Step 2	Primary Care Visits: Wellness visits	Well Visit E/M, Select G Codes Only	24 months	Plurality	1 visit	Most recent visit
Step 3	Primary Care Visits: All Other E/M visits	Any E/M Codes	24 months	Plurality	1 visit	Most recent visit
Step 4	Primary Care Prescriptions and Order Events	Any Rx code; claims related to medication prescriptions, DME, lab and referral orders	24 months	Plurality	3 events	Most recent event

Quality/Performance

- Select 6 measures from Core Quality Measures Collaborative's PCMH/ACO Primary Care Core Set
- Includes clinical quality, patient experience and utilization measures
- Like MIPS, benchmarks for performance measures will be based on performance of measures two years prior
- Failure to meet established benchmarks will result in practices repaying all or part of their performance-based incentive payment and may lead to practices being removed from the program

APC-APM's Potential Impacts on Administrative Burden



APC-APM Refinements Changes Since PTAC Deliberations Can Facilitate Implementation of New Primary Care Model

HHS Issues	Implementation Concerns	Current APC-APM Status
Accountability for Quality & Cost	• Increased payment w/out sufficient accountability • Self- selected quality measures not tied to accountability for total cost of care	• Incentive payments come from withhold based on cost-quality performance • Uniform set of quality measures; aligns with CPC+ and Core QM Collaborative measure set • Inclusion of additional utilization/ cost measures
Payment Methodology	• Complexity of payment; need for more specificity • Offsets for services provided outside of practices • Payments should focus on total cost of care • Ability of Medicare-only model to support transformation	• Modeling payment formulas, identifying service codes • Modified to single global primary payment • Includes increased payment for primary care services to support transformation
Participation Criteria	• Practice transformation w/out technical assistance • Sufficient CEHRT adoption • Clarity on APM entities and relationship to physicians and practices	• Designed for small, independent practice • Prospective, stable payments support transformation • AAFP outreach to practices can support participation, technical assistance
Model Evaluation	• Concerns related to comparison group • Impact of APC-APM on CPC+ evaluation	• Identifying non-CPC+ regions ripe for implementation • Engagement with experts on evaluation options

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