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Primary Care Payment Reform Workgroup Q&A February 16, 2021

Q: Referring to Arnie Milstein's American Idol in Medicine results, for the per capita reduction in cost, was there any truncation done to exclude high-cost claimants or specialty drugs from the total cost of care?

A: Adjustments were made to reflect the severity of illness of their patients. For each practice site, they calculated an observed-to-expected measure of total risk-adjusted spending per patient-year for attributed patients. The researchers also calculated spending by service category. Additional details on the study can be found here.

Q: How might the increased availability and utilization of telehealth impact this model?

A: Telehealth has expanded access and enabled some primary care practices to stay viable when patients were unable or unwilling to come in for visits. During COVID, primary care teams that had transformed themselves consistent with advanced practice or patient centered medical home models and had some portion of their payments being made on a capitated basis were much quicker to adapt to telehealth. As the pandemic has progressed, the portion of services provided by telehealth has receded significantly, but at still higher than pre-pandemic levels. It will be important to ensure that telehealth services are well coordinated to avoid redundant services and that data are effectively shared with practices so that primary care teams have access to patient information.

Q: One of the execution challenges of primary care payment reform is getting the carriers to adopt a common core measure set as opposed to carriers all building their own. How do we get all the carriers to agree on common measures of quality and patient experience?

A: Health plans continue to see payment models and measures as competitive differentiators, even though the lack of coordination creates significant burdens for practices that must collect and report multiple variations of measures. Recent estimates are that administrative costs in the U.S. are approximately $68,000 per physician per year due largely to variable health plan administrative requirements.[1] This is particularly burdensome for small primary care practices and does not improve quality or experience.

Q: Multi-payer alignment only happens when facilitated by neutral parties, such as state governments or employer/plan/provider coalitions. There have been numerous state efforts to push common core measure sets, including Washington Health Care Authority's primary care alignment effort, Integrated Healthcare Association's common ACO measure and several other state initiatives. There have also been numerous national efforts led by the National Academy of Medicine, National Quality Forum, CMS/CMMI and AHIP but no national effort has been led by private purchasers. The opportunity for this PBGH workgroup is to create a common set of measures across national private employers and public purchasers, and to direct our plan administrators to use them. It will require collective pressure from multiple purchasers to drive this change but the PBGH workgroup includes enough purchasing power to be successful.

A: There are opportunities in contracting to include measures we think best reflect quality, including patient experience and outcomes. Physicians and care teams have endorsed these measures as reflective of optimal primary care. Recently, a PBGH member moved to use these Advanced Primary Care measures, developed with California Quality Collaborative and other PBGH members, into their contracts. If other purchasers align around this common measure set and contracting practice, it will drive change.

Q: Aside from the payment model is there a transparency effort that works to exclude the "bad actors" both in terms of primary care and specialists based on a retrospective look at the composite quality scores or Medicare CG-CAHPS scores?

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[1] https://www.nytimes.com/2018/07/16/upshot/costs-health-care-us.html

A: New payment models must include robust quality and patient experience measures to ensure that patients are receiving the best care. Transparent reporting of these results to patients and purchasers is essential and should be a condition for participation. In addition to CG-CAHPs scores, these measures should include patient reported outcomes. Employers can always work with administrators to develop limited or preferred network products.

Q: What lessons learned from the Federally Qualified Health Centers (FQHC) model can be applied and useful in this discussion?
A: FQHC's have a common measure set dictated by the government to account for payment. Our work starts there. An example is in Alameda county where the FQHCs came together, formed an IPA and implemented a shared savings program to better support quality. They used the IPA to reinforce growth of their teams and expand what services they could bill for (e.g., a LCSW). Programs like these can be leveraged particularly around behavioral health integration.

More generally, FQHC's have been leaders in attending to the importance of social determinants of health, team-based care and behavioral health integration. Their maternal and child health clinical outcomes tend to be like those for private practices, although they work with populations with higher social needs.

Q: Does the focus on primary care reimbursement models only to reduce overall per capita costs only work now because the relative value unites (RVUs) for primary care doctors is lower than for specialists? Is there sensitivity analysis for when the RVUs for primary care providers rise where the model is not feasible?

A: Increased reimbursement is only one of the changes that should be considered. Primary care teams require additional resources to hire new team members, such as mental health providers. But increased payment should be connected to accountability for better outcomes and reduced total cost of care through reduced hospitalizations and low-value procedures and research has shown that this is achievable.

The result - transformed, team-based primary care - works because it delivers more coordinated care, particularly for people with chronic

conditions. The effect is to give the patient more control of his or her condition, better health outcomes and reduced use of other services.