Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

Primary Care Payment Model (PCPM) Recommendations

Welcome

<u>Bill Golden, MD, MACP</u>

Work Group co-chair PCPM work group

Medical Director, *Arkansas Medicaid*

Professor of Medicine and Public Health, *University of Arkansas*

PCPM Panelists

Stacy Sanders

Federal Policy Director

Medicare Rights Center

Martin Serota, MD

Chief Medical Officer and Senior Vice President

AltaMed Health Services, Inc.

Kevin Grumbach, MD

Hellman Endowed Professor of Family and Community Medicine Chair, *University of California, San Francisco*

Vice President for Population Health, *UCSF Health*

Chip Howard

Market Vice President and Payment Innovations Leader

Humana

PCPM Multi-Stakeholder Work Group

The LAN received over 130 nominations from highly qualified experts to serve on this work group

Work Group members:

- Drawn from across the nation
- Represent diverse clinical backgrounds and a wide range of experiences
- Serve many populations
- Work in a variety of settings (i.e., size, location & structure)

Our Goal

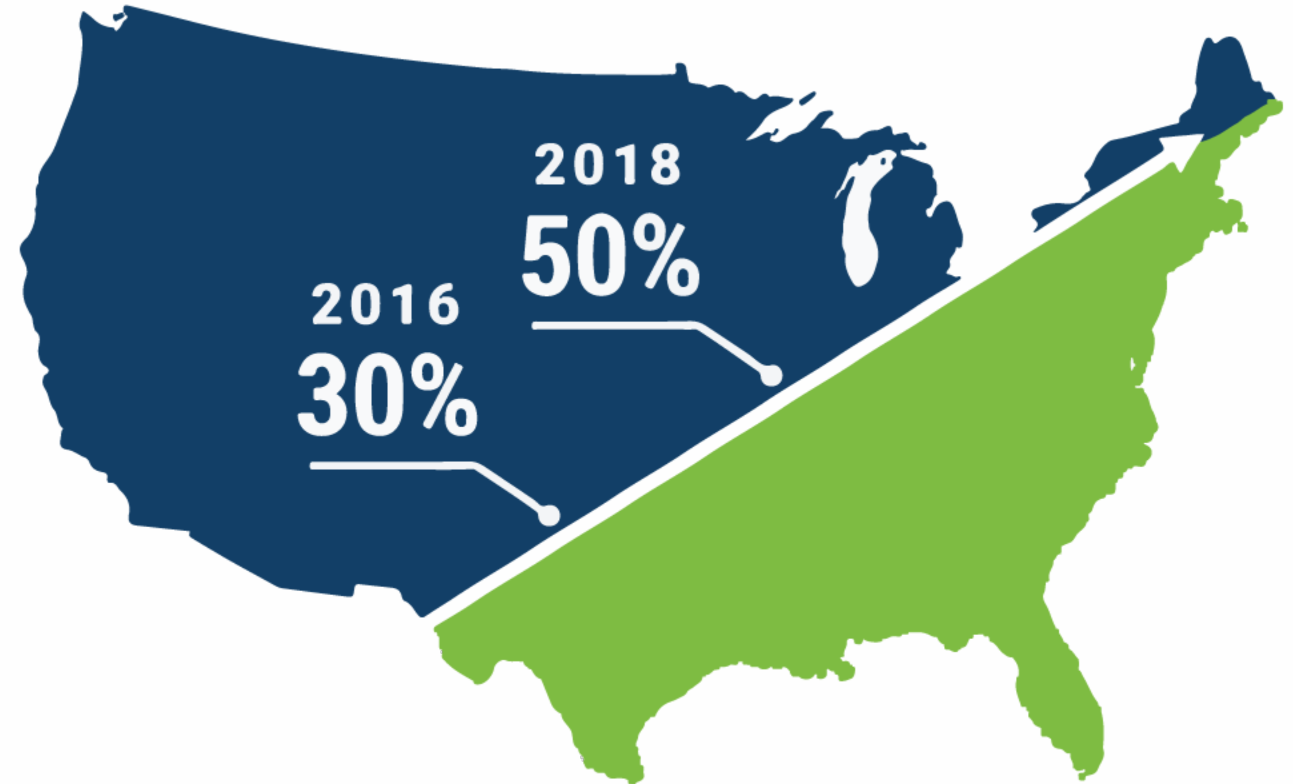
Goals for U.S. Health Care

2016 30% In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

2018 50% In 2018, at least 50% of U.S. health care payments are so linked.

These payment reforms are expected to demonstrate *better outcomes* and *smarter spending* for patients.

Adoption of Alternative Payment Models (APMs)



Better Care, Smarter Spending, Healthier People

PCPM Work Group Charge

In support of achieving the LAN's goal of 50% adoption of APMs across the U.S. by 2018, the Work Group will:

- Drive consensus on the best way to pay for primary care services using category 3 or 4 APMs
- Make practical recommendations for accelerating primary care APM adoption
- Encourage implementation of primary care payment models

Principle 1: PCPMs will support the effective delivery of high-value primary care for all patients.
Recommendation 1: PCPMs will be team-based, population-focused, and patient-centered.
Recommendation 2: PCPMs will take into account patient case mix.
Principle 2: PCPMs will enable primary care to focus on work that benefits patients.
Recommendation 3: Prospective population-based payment (PBP) that is risk-adjusted will constitute the dominant payment in PCPMs.
Recommendation 4: PCPMs will be multi-payer and participating practices should mainly serve patients in PCPMs.
Recommendation 5: PBP will be in excess of historical primary care payments to support additional expectations.
Recommendation 6: PBP will incentivize infrastructure investments.
Recommendation 7: Fee-for-service will continue to play a limited role in PCPMs.

Principle 3: PCPMs will encourage collaboration with other health care professionals.
Recommendation 8: Continued participation in PCPMs will be contingent on the ability of care teams to coordinate care.
Recommendation 9: Financial incentives in PCPMs will be transparent to all health care stakeholders.
Principle 4: Performance measurement in PCPMs will promote excellent clinical and patient experience outcomes that reflect patient goals and support partnership with health care professionals.
Recommendation 10: Performance measurement in PCPMs will be designed to eliminate unintended consequences.
Recommendation 11: Performance measurement in PCPMs will use aligned sets of comprehensive measures.

Principle 5: PCPMs will support integration with behavioral health and linkages to community services.
Recommendation 12: PCPMs will hold care teams responsible for behavioral health management.
Recommendation 13: PCPMs will allow flexibility for establishing linkages to community services.
Principle 6: PCPMs will support efforts to make caregivers and patients partners in health care delivery.
Recommendation 14: PCPMs will ensure that patient goals are reflected in care plans.
Recommendation 15: PCPMs will ensure that patient input is reflected in payment and delivery system planning and oversight.

Principle 7: Payers and primary care teams will collaborate to ensure the success of PCPMs.
Recommendation 16: Continued participation in PCPMs will be contingent on adequate performance.
Recommendation 17: PCPMs will foster data sharing and interpretation.
Recommendation 18: Primary care teams will receive the technical assistance they need to succeed in PCPMs.
Recommendation 19: PCPMs will not be expected to deliver a return on investment in the short term.

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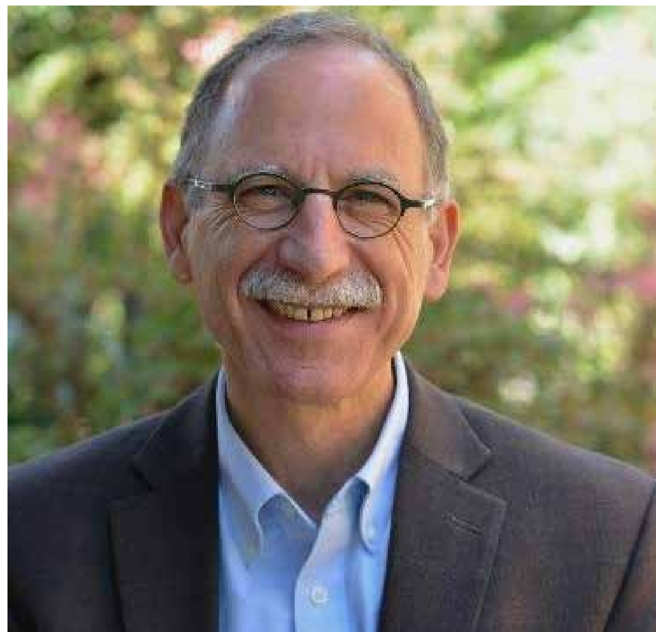

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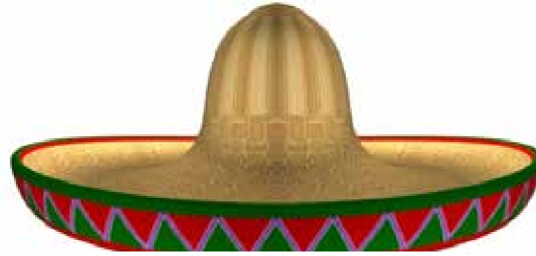
4 Hats

Patient

Primary Care



FQHC

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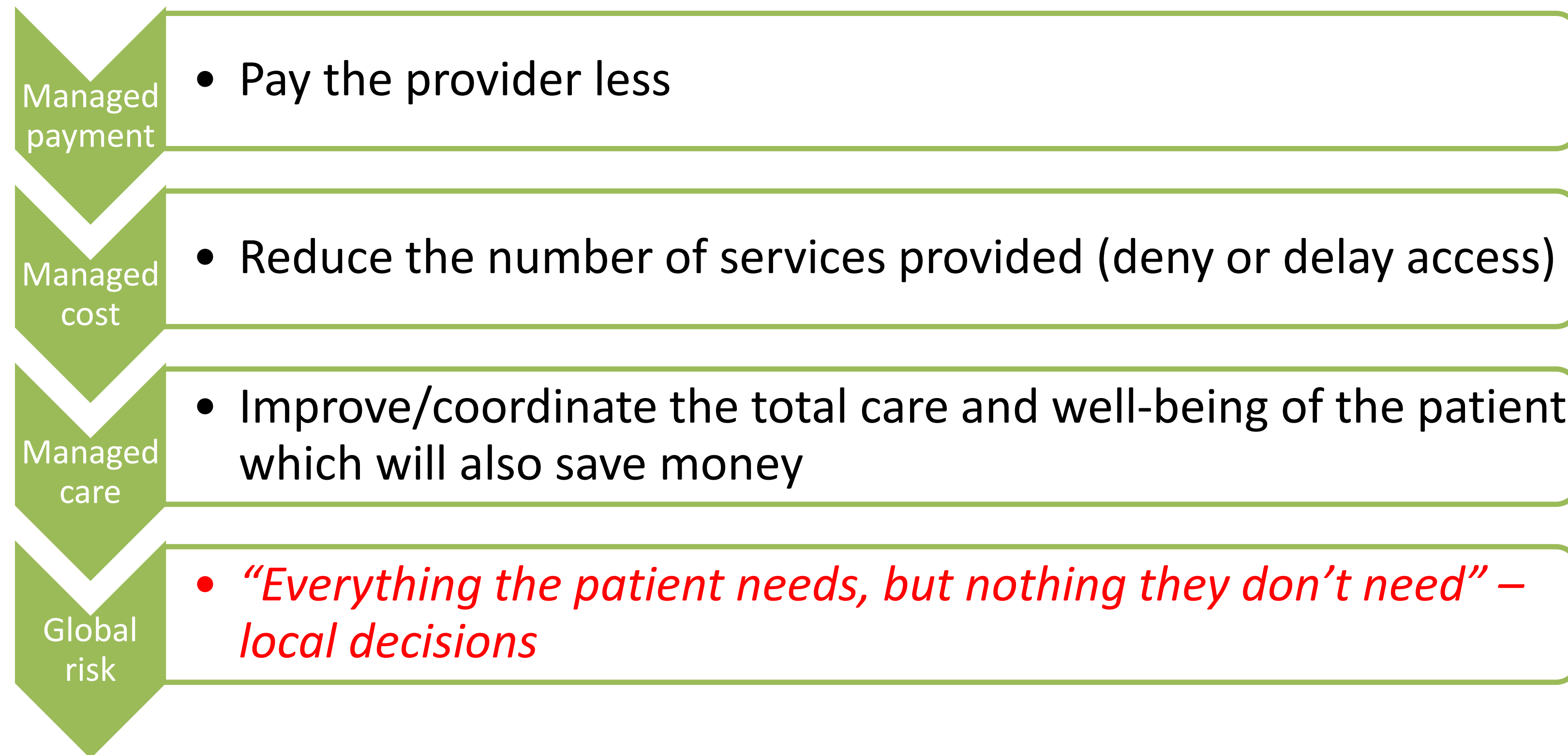
EVOLUTION OF MANAGED CARE



RISK CONTINUUM

Fee for service

Partial Capitation

- Professional risk
- Institutional risk
  - Shared risk
  - Dual risk

Full or Global risk

The more financial risk you take, the more your incentives are aligned with the patient

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ADVOCACY

Patient – global risk

Provider – must share in the fruits of innovation, efficiency

FQHC – Small groups and practices must be supported thru the transition because they are the source of innovation and competition

CAPG – IHA data shows that managed care delivers superior results at lower cost

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ALTAMED EXPERIENCE

Best results when:

- We take global risk (PACE)
- We provide comprehensive services (PACE, HIV)
- We manage the inpatients (dual risk vs no institutional risk)

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Example – Homeless Patients

WHO PAYS FOR HOUSING?

Fee for service – no one - $3,000 per day

Shared risk – no one - $3,000 per day

Dual risk – no one - $3,000 per day

Global risk – the “health plan” - $3,000 per month

Care is better for patient, at a fraction of the cost

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