**Primary Care Payment Reform Collaborative**

**Recommendations to the Oregon Health Policy Board**

**December 6, 2016**

**Recommendations (Excerpt)**

1. **Payment Model**

**Goal:** Develop a multi-payer (Medicare, Medicaid, commercial, publicly funded and self-insured) primary care payment framework that fosters alignment of both payment- and performance-incentive methodologies.

**Assumptions for payment model recommendation**

1. Per-capita investment in primary care in Oregon will increase in the aggregate given that primary care has benefits including – but not limited to – avoiding higher-cost care. This should be accomplished without passing increased costs on to the consumer or increasing the total cost of care by more than a set, sustainable rate. A return on investment from this strategy will take time. Budgetary tradeoffs may have to be made in the near-term to avoid a fiscal impact on purchasers.
2. Investments in primary care need to include resources to build and sustain infrastructure and capacity, including coordinated technical assistance and data aggregation at the system-level, and quality improvement activities and support for population-based initiatives at the practice level.
3. Payers and providers in Oregon will move away from a primarily fee-for-service system to a value-based payment approach that pays for advanced primary care[[1]](#footnote-1) services and the infrastructure to provide these services to reward high-quality, cost-effective care.
4. A variety of certification programs, including the PCPCH Program and National Committee for Quality Assurance Patient-Centered Medical Home Recognition (NCQA PCMH) can meet the requirements of advanced primary care.
5. Primary care is defined, per SB 231, as family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics, or general psychiatry. Specialty psychiatric and specialty obstetric services are not part of the calculation of primary care investment (payers will report on these costs, but they will be tracked separately).
6. Success for primary care payment reform innovation requires accountability, collaboration, alignment, and flexibility between all providers, payers and the state.
7. Payments for primary care services, including value-based incentive payments, should align with payments to care teams. Provider compensation models should support advanced primary care, include quality factors, and not depend solely on productivity (i.e., face-to-face visits).
8. Successful primary care payment reform must meet the medical, behavioral and social needs of diverse populations of patients and demonstrate financial sustainability across primary care practice settings.
9. Oregon’s multi-payer primary care payment framework must align with CMS’ CPC+ primary care payment framework while also supporting non-CPC+ populations and providers.
10. To support improved care and accurate measurement, we should aspire to a transparent and aligned member attribution methodology and support development of a proactive, patient-driven primary care provider selection process.

**Value-based payment definition**

For the purposes of this document, value-based payments (VBPs) are defined as strategies used by payers to promote quality and value of health care services. The goal of any VBP is to shift from pure volume-based payment—as exemplified by fee-for-service payments—to payments that reward providers for improvements in quality, utilization, and health outcomes.

Moving forward, the Collaborative will ensure that definitions are consistent with national efforts such as those used by the Health Care Payment Learning & Action Network.

**Potential payment model**

Over five years, align the payment models for all Oregon payers as defined in SB 231 (prominent commercial carriers, prominent Medicare Advantage carriers, Medicaid coordinated care organizations (CCOs), and health plans contracted with the Public Employees Benefit Board (PEBB) and the Oregon Educators Benefits Board (OEBB)), all products and insured populations covered by those payers, and all primary care practices recognized as providing advanced primary care: PCPCHs or clinics recognized as NCQA PCMHs. Specifically:

1. All payers will meet primary care spending percentage milestones to (a) achieve a percentage that, per the evidence-base[[2]](#footnote-2), is double the 2014 aggregate average commercial percentage spend for primary care reported in the 2016 report, *Primary Care Spending in Oregon: A Report to the Oregon State Legislature*; and (b) ensure that all prominent payers in Oregon are adequately investing in the primary care infrastructure.

* One key milestone is that, by the end of 2018, payers will align with CMS’s goal of 50% of Medicare’s total payments attributed to payment models that employ non-fee-for-service payments[[3]](#footnote-3) by encouraging 50% of all payers’ primary care payments be attributed to VBPs. In addition, strongly encourage an increased investment in primary care in the form of VBPs.
  + Mechanisms to meet this milestone would encourage that all new investment in primary care be in the form of VBPs. Primary care investments will result in an overall increase in the amount of total medical spending allocated to primary care—and would not include “withholds” or strategies that simply reallocate existing spending between fee-for-service payments and VBPs.

1. Payment models must ensure applicability to all populations and, using CPC+ as the guiding framework, include the following components:
   1. Up to 50% fee-for-service (face-to-face visits and other easily billable services).
   2. Risk-adjusted, population-based per-member, per-month (PMPM) payments that sustainably support a high-functioning primary care system including key elements such as risk-stratified care management, care coordination, behavioral health integration, integrated pharmacist, and non-visit-based care.[[4]](#footnote-4) PMPM payments may also include a component that is based on clinics’ demonstrated level of advanced primary care function, which could be measured using Oregon PCPCH or NCQA PCMH standards.
   3. Performance-based incentive payments (not a withhold) that align with agreed-upon metrics. It is recommended that incentives be worth ≥10% of total compensation – which is generally accepted best practice[[5]](#footnote-5) – to provide sufficient incentive to improve or achieve benchmarks.
   4. Payment models consistent and aligned with the CMS Track 2 CPC+ model, where current rates of fee-for-service are gradually converted to non-fee-for-service payments.

1. Advanced primary care is based on principles of programs such as OHA’s PCPCH program and builds on the care delivery models employed in CMS model tests such as the Comprehensive Primary Care Initiative. Next generation models for advanced primary care (such as CPC+) will seek to improve further the delivery of patient-centered care and population health. [↑](#footnote-ref-1)
2. Expert consensus is that primary care spending has to double from current levels. The average national primary care spend is 5-7% across all payers (including Medicare). Rhode Island’s model doubled the primary care spend over five years. Academic literature indicates the primary care spend goal should be 10-12%, which is double the current national average (See *Effective Payment for Primary Care*, Starfield et. al., pg. 8). Note that because Oregon chose to include specialty psychiatric and OB in our primary care spend calculation, we have an artificially high (7.2%) commercial primary care spend (not including Payer #3), for the vast majority (>90%) of the insured population. Doubling that equals 14.4%. However, if Oregon chose to leave out specialty psychiatric and OB spending, our true primary care spend would likely be between 5-7%, similar to the rest of the country, and doubling that would be 10-12%, which is consistent with the primary care spend goal identified in the academic literature. Oregon’s SB 231 Primary Care Spend report data analysis methodology is conducive to this approach. [↑](#footnote-ref-2)
3. Shatto, J. Center for Medicare and Medicaid Innovation’s Methodology and Calculations for the 2016 Estimate of Fee-for-Service Payments to Alternative Payment Models [Memorandum]. Washington, DC: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary. Retrieved from <https://innovation.cms.gov/Files/x/ffs-apm-goalmemo.pdf> [↑](#footnote-ref-3)
4. Oregon Health Authority Patient-Centered Primary Care Home Program: 2017 Recognition Criteria Technical Specifications and Reporting Guide. Retrieved from [http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf](https://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf) [↑](#footnote-ref-4)
5. Health Care Payment Learning and Action Network, *Alternative Payment Methodology Framework*, page 10. [↑](#footnote-ref-5)