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The New Value-Based Approach to Primary Care, Part 2

Announcer:
Welcome to Reach MD. The following segment is the second part of a live meeting hosted by the American Medical Association focusing on the New Value-Based Approach to Primary Care. On the podium, is Adam Boehler, Director of the CMS Innovation Center who will present the detail of the models followed by Dr. Russell Kohl with the American Academy of Family Physicians and Dr. Kavita Patel, member of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), And, now here is Mr. Adam Boehler.

Adam Boehler: I want to thank the AMA for hosting this event and for your partnership. The Innovation Center has two primary goals; improving quality and lowering health care costs. We know that the AMA, AAFP, PTAC, and others inside and outside this room share those goals. The primary care's initiative leverages the redesign of primary care to drive delivery system reform. This is an important and significant step toward achieving better health at a lower cost. You may ask, why focus on primary care? A strong primary care foundation is essential to an effective health care system broadly. Despite only being 2 to 3% of spend, primary care providers have an enormous influence over downstream costs. Our current payment systems do not recognize the essential role that primary care providers play. We're going to change that today. The Primary Care Initiative is made up of two paths. The first is Primary Care First, which creates an opportunity for providers to leave behind fee-for-service and be paid for keeping their patients healthy and at home. The second is Direct Contracting. This allows sophisticated organizations to take full accountability for their patients at a local level. Both paths are voluntary and they emphasize a focus on complex, high need patients. Let's talk a bit about how each will work and the timeline for each as well.

Primary Care First is made up of two model options. Both options allow practices to move away from fee-for-service and to eliminate their revenue cycle operations. CMS will make monthly population-based payments along with a simple, flat primary care visit each time a provider sees a patient. Providers will be eligible for significant payments if their patients stay healthy and at home. There is downside risk of 10%, which is about equivalent to the revenue cycle cost today. There is an asymmetrically high upside potential of 50%. The performance will be measured on risk-adjusted hospitalizations or, said differently, the ability to keep patients healthy and at home. For example, doctors that earn $200,000 today could earn up to $300,000 if their patients stay healthy and at home. This model is scheduled to begin in January of 2020 and we expect to release the request for applications in the next month or so.

The second initiative, Direct Contracting, creates three payment options for providers to take risk and earn rewards based on quality outcomes. This model improves on prior efforts, including the Next Generation, ACL, and they're tailored for larger organizations that have experience at taking accountability. We're allowing providers in Direct Contracting to prospectively enroll patients, to encourage new entrance to compete all for the benefit of the patient. First, the professional option. This offers providers the opportunity to share in 50% of the savings and the losses on risk adjusted total cost of care. Providers in this option will receive predictable monthly payments for enhanced primary care services. The second option is the global option. This will provide providers the opportunity to take full, 100%, accountability for savings and losses. Providers will also receive predictable, monthly payments for primary care services or monthly payments for all health care services if they choose to pay claims. Finally, we are seeking input on a third option, the geographic option. This option is designed similarly to the global option, but participants will be able to assume responsibility for total cost of care for all Medicare beneficiaries in a targeted geographic region. We are seeking public input to further refine the design of this model and we hope that many in this room will provide us with that feedback. This model is very important to our focus on empowering local communities to take care of patients. Both the global and professional components are expected to begin in January of 2020 with the request for applications in June of this year. We expect to launch the geographic option in mid 2020 with your comments helping to finalize the design. Both Primary Care First and Direct Contracting encourage a focus on complex, chronic and seriously ill patients. These support approaches such as home-based models that are dedicated to serving this patient set. Our efforts

in this area draw from hot-spotting models and from proposals from the PTAC as well as American Academy of Hospice and Palliative Medicine, the CTAC or Coalition to Transform Advanced Care, and the American Academy of Family Physicians. If you remember one thing today, it should be this, Primary Cares is a clear sign that we are changing the status quo. These are sweeping models that will shift one-quarter of this country to outcomes-based payment. It's time to dismantle the old, broken fee-for-service system that we have today and replace it with one that pays for outcomes and quality. It's time that we empower providers so that they can focus on patients. This is why providers went to medical school in the first place. It's time that we put patients in the driver's seat so that providers can compete for their loyalty through a combination of service, price, and overall experience. When you pay for quality outcomes instead of volume, you transform a health care system that caters to special interest into a market-based system in which providers compete for the right to take care of each patient. The patient is the empowered consumer. We're not alone in this, but we're together with all of you and so many others. As the administrator said, we are grateful for all of the input that we've received from so many organizations that helped shape this work. This includes the PTAC, it includes responses to our OFI's, it includes countless stakeholder meetings, and meetings with Congress. I'm also grateful to the team at CMMI, to CMS, to HHS, and the White House for all of their work and support on these models. These models are also consistent with the policy direction in the MedPAC meeting just this month. These partnerships will now continue together as we move forward. We've designed the models to move in lockstep with other commercial plans, with states, and with others so that we can implement our shared vision to eliminate fee-for-service and move to an outcomes-based system. I am please now, to introduce Dr. Russell Kohl with the American Academy of Family Physicians. AAFP has been a critical partner through their PTAC submission and through their ongoing engagement.

Dr. Russell Kohl: It certainly is a privilege to be here today representing the American Academy of Family Physicians, our more than 131,000 members across the nation and the hundreds of millions of patients that we care for each year as family physicians. On behalf of the AAFP and our members, I would like to thank Secretary Azar, Administrator Verma and Director Boehler for the opportunity to join you at this event but, more importantly, to thank you for your efforts to reform our nation's health care system and for the emphasis that you're placing on making primary care actually a foundational element in our health care system of the future. Several years ago, Dr. Barbara Starfield first described the four Cs of primary care. First, contact, comprehensiveness, coordinated care, and continuity of care. In the time since Dr. Starfield published her research, we've spoken about the value of primary care to both individuals and our health care system as a whole, yet, the United States has largely failed to capitalize on that value in the past. In fact, our health care system has historically systematically undervalued primary care. As I prepared to be here today, I couldn't help but think about a couple of recent articles in JAMA Internal Medicine that demonstrate exactly what the value of primary care is. The first, a study published showing the extreme impact and value of primary care on both health and life expectancy in the United States, and a second study showing the historically low investment that Medicare has made in primary care. Today though, we believe we're taking an important step towards changing this dynamic by placing a greater emphasis on the investments we make in family medicine and other primary care providers. The names of these new programs, Primary Cares and Primary Care First, are reflective, we think, of a new commitment to greater investments in primary care. Over the past 20 years, the AAFP and our primary care colleagues have embarked on a quest to create a delivery system that reflects the core values of primary care and actually facilitates innovation in primary care delivery to reward comprehensive and continuous patient-centered care and not simply episodes of payment or episodes of care. For too long, we've approached delivery system reform as trying to identify systems that conform to our already established payment system, primarily fee-for-service. The AAFP, like so many others though, has grown to understand that fee-for-service is largely incongruent with the best practices of advanced patient-centered family medicine. And, to truly unleash the power of primary care, we must do two things, unhinge it from the episodic-based incentives of fee-of-service and eliminate the administrative complexity of practice that distracts family physicians from the actual care of patients. In short, it has become clear that we must create payment models that support our desired delivery models. This concept and vision for primary care is what actually brings us together today. As family physicians, we conduct almost 1 in 5 of the total medical office visits in the United States, far more than any other medical specialty. And, on behalf of our 131,000 members, I can say without reservation that the need for delivery system reform is acute. We applaud the introduction of the new primary care delivery and payment models and we look forward to working with CMS and CMMI on testing these new models as we continue our pursuit of a health care system that's built on a foundation of primary care. We also look forward to continuing our collaboration on other important programs such as the Patients Over Paperwork initiative. With that, I will invite Dr. Patel.

Dr. Kavita Patel: My name is Dr. Kavita Patel. I am a member of the PTAC,An 11-person committee created by Congress under almost unanimous bipartisan bicameral legislation and MACRA, so thank you very much Congress, whose mandate is reviewing new innovative value-based alternative physician-focused payment model proposals designed and submitted by frontline clinical providers to improve quality outcomes and/or make health care more affordable. So, having taken all of that, we've been working tirelessly to review over 20 proposals and more keep coming, and we've really been doing this in a transparent fashion with many of the people that are in the room and familiar faces, so we're very excited to see this culmination. Since our inception in 2016, we have kind of seen many

varieties of care models come from across the country and today we're hearing, along with all of you, how much of the fruits of that labor are coming to fruition. So, we look forward and I am encouraged to hear from the Secretary, Administrator, and Adam on their comments around how, not only has the PTAC's work been valuable, but, perhaps most importantly, that there is an avenue for a one-person practice, a frontline clinical person, to actually come forward with a good idea and see it being presented in this type of setting. With that, I thank you.

Announcer:
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