HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING

PRIMARY CARE PAYMENT MODELS

CONTENTS

Executive Summary

The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across and within the public and private sectors of the U.S. health care system. To advance this goal, the Primary Care Payment Model Work Group (the Work Group) was convened by the LAN Guiding Committee. It was charged with establishing consensus on the best way to pay for primary care using Category 3 or 4 population-based alternative payment models (APMs), and with making practical recommendations for accelerating adoption of these models. Composed of diverse health care stakeholders, the Work Group deliberated, incorporated input from LAN participants, and reached consensus on many critical issues related to primary care payment models (PCPMs), the subject of this White Paper.

Primary care is traditionally delivered by a wide variety of practitioners (including primary care physicians, nurse practitioners, and physician assistants). Primary care occupies a critically important position in the health care system because of its focus on wellness and prevention, because primary care teams are often patients' first point of contact with the health care system, and because decisions made by primary care teams, with patients and their families, have a major impact on quality of care and total health care spending. As a result of their unique position, primary care teams must establish foundational and health-promoting relationships, while at the same time serving as effective stewards for health care resources.

At present, primary care faces challenges fulfilling these obligations. Fragmented policies make it difficult to coordinate care with multiple providers, burdensome administrative requirements deprive primary care practitioners of time with patients, and fee-for-service (FFS) payments encourage primary care practices to adopt volume-based (as opposed to value-based) business models. These and other factors contribute to low job satisfaction and burnout among primary care physicians, and they are stifling the development of innovative approaches to primary care delivery.

The Work Group believes that PCPMs can serve as critical catalysts for implementing the types of delivery innovations that will enable primary care to perform its dual function of patient point of contact and

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To achieve the goal of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality, health outcomes, and value over volume. Such alignment requires a fundamental change in how health care is organized and delivered, and requires the participation of the entire health care ecosystem. The Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care ecosystem. By making a commitment to changing payment models, establishing a common framework, aligning approaches to payment innovation, sharing information about successful models, and encouraging use of best practices, the LAN can help reduce barriers and accelerate the adoption of APMs.

U.S. Health Care Payments in APMs

financial steward. This is because PCPMs can reduce administrative burden, encourage team-based approaches to primary care and care coordination, and allow the flexibility needed to innovate value-based delivery approaches, particularly with respect to establishing connections between primary care and behavioral health and community services.

The White Paper puts forth the following principles and recommendations; if adopted, the Work Group believes they will result in PCPMs that are capable of catalyzing improvements in primary care.

- Principle 1: New payment models will need to support high-value primary care that fosters health for all patients (including underserved, at-risk, vulnerable, and complex patients), expands access to innovative methods of delivering effective care, and minimizes disparities in care.
    - Recommendation 1: PCPMs should support population-focused, patient-centered, and team-based care.
    - Recommendation 2: PCPMs should adjust payments to account for underlying differences in the patient populations served by different primary care practices.
- Principle 2: PCPMs will need to allow primary care practices to focus on work that promotes the health of patient populations and minimize work that does not contribute to high-quality care.
    - Recommendation 3: The preferred form of payment for primary care employs risk-adjusted, comprehensive prospective payment, including some retrospective reconciliation, based on the patients empaneled or attributed to the primary care practice. This corresponds to payments in Category 4 APMs.
    - Recommendation 4: To effectively incentivize practice transformation, PCPMs should be multi-payer and cover the majority of a practice's patient population.
    - Recommendation 5: Prospective payments should be in excess of historic primary care payment amounts to support the infrastructure of the clinical team that will be held accountable for greater coordination of services and for bending the total health system cost curve.
    - Recommendation 6: PCPMs should use prospective payment to fund the necessary investments by primary care organizations in practice infrastructure to result in more efficient delivery of health care.
    - Recommendation 7: Fee-for-service payment should still play a limited role as part of a blended PCPM; it will be used to incentivize certain services that need to be performed in a face-to-face encounter and promote more efficient, comprehensive primary care.
- Principle 3: PCPMs will need to enhance collaboration with specialists, hospitals, emergency departments, and other health care professionals to deliver timely, appropriate, and efficient care.
    - Recommendation 8: Continued participation in PCPMs should be contingent upon primary care teams' adoption of technologies and processes that allow them to closely coordinate care with specialists and hospitals.
- Principle 4: Performance measurement in PCPMs will need to promote excellent clinical and patient experience outcomes that reflect patient goals and whole-person care, to enable health care professionals to partner with patients and families to achieve the outcomes they desire.

  - Recommendation 9: Financial incentives used in all models should be transparent to care teams and the public, be clearly communicated, and promote trust that these new payment models will promote better quality and appropriate costs.
  - Recommendation 10: Performance measurement systems should eliminate economic incentives to limit the provision of evidence-based care or deny costly or complex patients access to primary care practices and the care they need.
  - Recommendation 11: Incentive payments in primary care should be based on an aligned set of parsimonious set of aligned, high-impact measures of primary care, rather than rely exclusively on a rigid set of disease-specific metrics.

- Principle 5: PCPMs will need to encourage robust integration of primary care, behavioral health (including substance use treatment programs), and strong linkages with community resources to address social determinants of health.
  - Recommendation 12: PCPMs should hold primary care practices accountable for, and provide the resources to enable, the management of mental health and substance use services. This recognizes the critical role behavioral health plays in overall health, supports better integration between these services and primary care, and promotes shared accountability at the organizational and clinical levels.
  - Recommendation 13: PCPMs should maximize the flexibility primary care teams have to expend resources on coordination with community services, including direct support for community programs that demonstrably address social determinants of health to improve patient outcomes.
- Principle 6: PCPMs will need to promote multifaceted efforts to make caregivers and patients partners in the delivery of their care, as well as at all levels of PCPM design, implementation, governance, and evaluation.
  - Recommendation 14: PCPMs should ensure that primary care practices reflect patient goals, needs, and preferences in the care plans they develop collaboratively with the patient.
  - Recommendation 15: PCPMs should ensure primary care practices collect patient input, make patients meaningful partners on advisory councils, and encourage patients to provide input about the experience of their care.
- Principle 7: Payers and primary care teams will need to collaborate in partnerships to ensure the success of PCPMs.
  - Recommendation 16: Ongoing participation in PCPMs should be conditioned on a primary care practice's ability to demonstrate success on metrics of patient access, quality of care, comprehensive provision of services, responsiveness to patients, and effective stewardship of resources, as stipulated in the model design.
  - Recommendation 17: PCPMs should foster data sharing and analysis to facilitate care coordination, patient engagement, population health management, and performance assessment.
  - Recommendation 18: Primary care practices should receive external coaching support and technical assistance to help them transition to new payment and delivery models.
  - Recommendation 19: Although incremental progress should be made much more quickly, PCPMs can only be expected to deliver a return on investment over the long term.

Therefore, payers should develop business models that do not require investments in PCPMs to be recouped from reductions in total cost of care in the short term.

The paper concludes with some immediate action steps that stakeholders can take to address key implementation issues, which must be overcome to advance the Work Group's recommended approach to PCPMs.

Overview and Work Group Charge

The Health Care Payment Learning & Action Network (LAN) established its Guiding Committee in May 2015 as the collaborative body charged with advancing alignment of payment approaches across and within the private and public sectors. This alignment aims to accelerate the adoption of alternative payment models that reward quality and value in health care. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center operated by the MITRE Corporation, was asked to convene this large national initiative.

The LAN aims to have 50% of U.S. health care payments in alternative payment models (APMs) by 2018. Developing APMs for primary care constitutes a critical element in broader efforts to create and sustain a delivery system that values quality, cost effectiveness, and patient engagement.

In July 2016, CAMH convened the Primary Care Payment Model Work Group (the Work Group). The Guiding Committee charged the Work Group with developing practical recommendations on the best way to pay for primary care or services using alternative payment models. This White Paper represents the Work Group's response to the Guiding Committee's charge.

Introduction and Scope of the White Paper

According to the Institute of Medicine, primary care is defined as "integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Yordy & Vanselow, 1994, p. 15). Primary care physicians typically hold specialties in general internal and family medicine, as well as geriatrics and general pediatrics, but primary care teams comprise a much more varied set of health care professionals—including nurse practitioners, physician assistants, pharmacists, registered dietician nutritionists, behavioral therapists, social workers, community health workers, and administrative personnel. Roughly half of primary care physicians are in practices with five or fewer other physicians, and less than 15% are in practices with 50 or more. Although a majority of primary care physicians continue to work in small practices, the field has consolidated significantly over the past three decades. During that time, the share of physicians in solo or two-physician practices has fallen to roughly 20% (Muhlestein and Smith, 2016, p. 1639). Year to year, the number of active primary care physicians is declining, while numbers of nurse practitioners and physician assistants are increasing substantially (Bodenheimer and Bauer, 2016).

In addition to caring for urgent, acute, and chronic conditions, primary care teams focus on health promotion and maintenance; preventive services; engagement and education for patients and families; care planning; and care coordination across multiple care delivery settings (American Academy of Family Physicians, 2016a). Because primary care often provides the first point of contact for patients in need of treatment and diagnoses for common illnesses and conditions, it can serve as an entry point to the health care system, and it represents a promising venue for addressing social determinants of health. Primary care currently accounts for more than 55% of the 1 billion physician office visits each year in the United States, and decisions made by primary care professionals influence up to 90% of total health care

costs through referrals to other doctors, clinical testing and procedures, and patient hospitalizations (UnitedHealth Group Center for Health Reform & Modernization, 2014, p. 2). Nevertheless, primary care comprises only a tiny portion of national health care spending. Given its influential role as an entry point to the health care system and its close connection to patients, the ideal role of primary care from the perspective of the health care system is two-fold:

- Establish trusting partnerships with patients and caregivers that enable the delivery of high-quality, patient-centered care, wherever and from whomever it is needed; and
- Serve as effective stewards of health care resources through planned care, population health management and care coordination with specialty and other services (e.g., social services).

At present, primary care faces significant challenges fulfilling its dual role. These challenges are in part attributable to payment policies that encourage fragmented and uncoordinated care; other policies, or the absence thereof, introduce additional challenges by missing opportunities to support primary care (e.g., no requirement to notify primary care teams when a patient is hospitalized). Fee-for-service (FFS) payment, which remains the dominant method of primary care payment, also contributes to the challenges of delivering high-value primary care. Primary care teams face overwhelming administrative requirements, which consume approximately one-sixth of physicians' work hours and directly contribute to diminished satisfaction with providing medical care (Woolhandler & Himmelstein, 2014). Due to excessive administrative requirements and the incentives to operate high-volume practices in FFS payment models, primary care teams have trouble investing the time needed to develop effective partnerships with patients, families, and caregivers, which can lead to fragmented care and poor outcomes for patients. Primary care physicians report experiencing low satisfaction and burnout that contribute to the clinician shortage. Clinician shortages and burnout are correlated with unmet patient needs, in addition to costly utilization of unnecessary or easily preventable services in inappropriate (e.g., emergency room or specialist) settings (UnitedHealth Group Center for Health Reform & Modernization, 2014). Although nurse practitioners, physician assistants, and other health professionals are increasingly part of primary care teams built specifically to address population health needs, many payers are still grappling with scope of practice and payment issues for these clinicians.

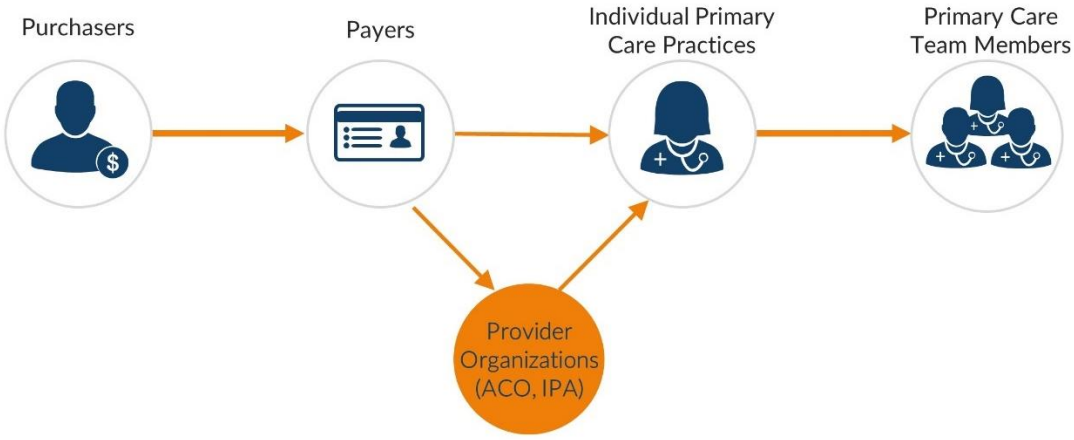
This White Paper advances a vision for primary care payment models (PCPMs) that can serve as a catalyst for transforming primary care to address these challenges and enable primary care teams to fulfill their ideal roles. Although value-based payment methods have been growing in recent years, survey data suggest that roughly 80% of family medicine physicians are not aware of what percentage of their practice's revenue comes from value-based payment, but that roughly half are either actively pursuing value-based payment opportunities, or are working on developing capabilities to do so in the future (Martin, 2016). Due to infrastructure and personnel constraints (particularly in rural locations), insufficient training around the complicated technical considerations involved, and cost-sharing arrangements that discourage patients from utilizing primary care services, there are considerable barriers to implementing PCPMs at present. Therefore, a critical goal of the White Paper is to inform health care stakeholders about how value-based arrangements in PCPMs can drive delivery system transformations that strengthen primary care's capacity to achieve better care, smarter spending, and healthier people, and to offer recommendations for structuring these types of arrangements.

Consistent with the overarching mission and vision of the LAN, the major goal of this paper is to put forward a payment model—established through the deliberations of a multi-stakeholder group—that public and private payers (i.e., Medicare, Medicaid, and commercial plans) can use to align payments to primary care practices. In addition to the other beneficial consequences of PCPMs discussed throughout

this White Paper, aligning payments from all payers will create a more stable and predictable environment for primary care practices. This, in turn, will allow them to make sounder investments in infrastructure and workflows that improve the delivery of primary care.

Payments may flow through multiple organizational levels (Figure 1) before they reach the members of primary care teams. Individual primary care practices may receive payments directly from a payer, or they may receive payments from a provider organization such as independent practice associations (IPAs), health systems, or accountable care organizations (ACOs). This White Paper primarily focuses on the transfer of payment from payers to provider organizations, as well as from payers to independent primary care practices that participate in a PCPM.

Figure 1: Payment Flow in PCPMs



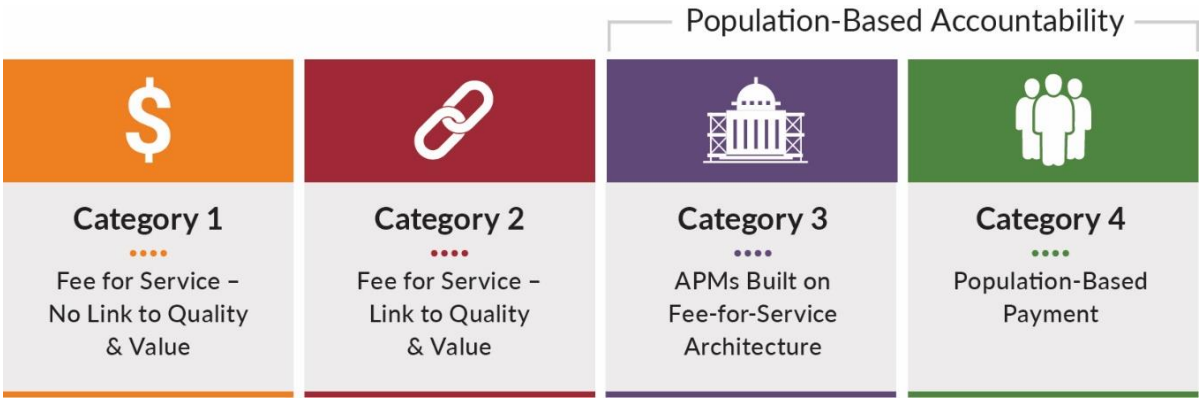
Whether payments for primary care exist independently of other payments for health care services (e.g., payments for hospitals and specialists), or whether these payments are combined with these or other types of payments, is not relevant to the principles and recommendations that appear below. In either case, the Work Group believes that payments for primary care should be structured the same. At present, it is not feasible to stipulate the way in which provider organizations, such as IPAs and ACOs, compensate individual practices within their purview. Nevertheless, in order for PCPMs to function effectively, it is essential for provider organizations to use the payment and incentive structures outlined in this paper when compensating individual primary care practices. In order to enable frontline practitioners to implement delivery reforms, and properly hold them accountable for managing costs and population health, these practitioners must receive payments that support the infrastructure needed for coordination and patient engagement.

Using traditional FFS payments to compensate practices within a provider organization or an independent practice is not consistent with these preconditions for delivery reform. The Work Group therefore strongly encourages provider organizations and independent practices to expeditiously modify their business and compensation models to implement the consensus positions that are outlined in this White Paper and needed to drive critical transformations in the delivery of primary care. This is consistent with Principle 3 in the LAN APM Framework White Paper, which states: “To the greatest

extent possible, value based incentives should reach providers across the care team that directly delivers care" (2016, p. 9).

This White Paper advances payment models that could meet the criteria of Categories 3 or 4 in the APM Framework (Figure 2).

Figure 2: APM Framework (At-a-Glance)



Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

Figure 3 illustrates how the main structural features of PCPMs advanced in this White Paper (infrastructure payments, targeted FFS carve out, and incentive payments) exist in relation to Categories 3 and 4 of the APM Framework.

Figure 3: Structural Components of PCPMs in Relation to the APM Framework

	Category 3 APMs Built on Fee-for-Service (FFS) Architecture	Category 4 Population-Based Payment (PBP)
Infrastructure Payment	Upside/Downside Risk on an FFS architecture for majority of services (including behavioral health) Care Management Fee (PMPM)	PBP for majority of services (including behavioral health)
Targeted FFS Carve Out		FFS for limited office-based services
Incentive Payments	Bonus for quality processes Bonus for quality outcomes Fee for Primary Care Medical Home (PCMH) outcomes	

Participation in any APM entails certain types of risk and accountability on the part of primary care practices, particularly when contrasted with FFS payments. Practices assume accountability when performance measurement is used to evaluate the quality (e.g., health outcomes) and effectiveness (e.g., reducing unnecessary utilization) of the care they provide. The scope of practices' accountability, quality, and effectiveness is defined by the scope of services and conditions included in the payment model. Because this accountability is accompanied by the potential for negative financial consequences, practices in APMs place themselves at risk for effective health management of the patients they care for. So long as a practice only assumes risk for conditions and services that it is able to provide, managing this clinical risk is fully within the practice's control. One of the key assumptions behind the drive to adopt APMs is that clinicians and other providers can deliver higher quality care if they are placed in the position of managing clinical risk that they can control.

However, primary care practices' accountability for costs is determined by the accountability and payment mechanisms in place, which place practices at financial risk for spending that they may or may not be able to control. Within a given patient population, there may be significant variation in the amount of spending per patient. Outliers in a patient population, such as patients with unusual and expensive conditions, account for most of the financial risk associated with these payment and accountability mechanisms, because they are rare and their health care needs are difficult to predict. As the patient pool expands, practices are better able to accommodate the financial risk associated with spending on outlier patients, because spending on these patients is offset by spending on a larger number of average cost or below-average cost patients. Therefore, practices' ability to take on additional accountability for costs, and to absorb financial risk associated with spending on outlier patients, is largely a function of the number of patients for which they are responsible.

Figure 4 illustrates these different types and degrees of risk. The top half of the diagram illustrates the spectrum of risk and accountability that practices assume for quality and effectiveness, such that risk/accountability increases as the scope of services increases. The lower half of the diagram illustrates the spectrum of risk and accountability that practices assume for costs. In this case, five examples of accountability and payment mechanisms illustrate increasing levels of risk, moving from left to right. The final example (i.e., fully capitated or "insurance" risk) is not appropriate for primary care practices to assume. Rather, insurance companies and large medical groups and delivery systems are the proper entities to assume this type of risk, because they serve patient populations that are large enough to absorb it, and because their principal role in the health care system is to buffer significant variations in spending per patient. Primary care practices nevertheless remain capable of assuming lesser levels of risk and accountability for costs—associated with the remaining three examples—but their ability to do so depends on the number of patients for which they are responsible, for the reasons discussed above.[1] Accordingly, practices interested in and willing to assume increasing levels of risk and accountability for cost will need to combine patient panels (as illustrated in Figure 2) to achieve patient populations that are large enough to overcome the effect of outlier patients. Additional details and nuances surrounding the appropriate levels of risk and accountability for costs are discussed in the principles and recommendations that follow.

[1] Estimates of how many patients are required for a primary care practice to assume accountability for capitated primary care payments (i.e., Category 4A in the LAN APM Framework) are associated with a significant amount of uncertainty, and are largely dependent on the patient population in question. Nevertheless, a threshold of 5,000 patients is typically regarded as the absolute minimum needed to safely operate with this payment mechanism, and somewhere between 20,000 and 25,000 are needed to reasonably assume this level of risk.

Figure 3: Types and Degrees of Accountability and Risk in APMs

Size of Population Under Care Increases from Left to Right

Principles and Recommendations for Accelerating and Aligning Primary Care Payment Models

This section considers principles and recommendations for PCPMs, based on the challenges primary care clinicians face and the goal of enabling primary care teams to take on the dual role discussed in the previous section. In this context, "principles" outline general characteristics of transformative primary care delivery and payment that PCPMs will need to promote to achieve significant improvements in health care delivery; "recommendations" identify specific payment mechanisms that drive delivery changes in a way that advances the principles. All the principles and recommendations aspire to meet the aims of patient-centered and equitable care, healthier people, smarter spending, and professional growth and satisfaction.

Principle 1: New payment models will need to support high-value primary care that fosters health for all patients (including underserved, at-risk, vulnerable, and complex patients), expands access to innovative methods of delivering effective care, and minimizes disparities in care.

The current health care environment does not sufficiently support or reward primary care teams to focus on many tasks that add value. PCPMs should therefore recognize and reward accessible, comprehensive, high-value care, which strengthens patient-centered relationships with the primary care

team and optimizes the health and well-being of a patient population. In order to accomplish this, primary care payments should be structured to encourage the types of innovative delivery approaches that provide the greatest value to patients and society at large. For example, PCPMs should be structured to pay for teams that engage patients in multiple ways and deliver care via modalities that accord with patient needs (e.g., telemedicine, non-face-to-face visits, hospital visits, home visits, and email). Payment models may continue to impede primary care teams' ability to improve health outcomes and reduce disparities if they reinforce itemized, volume-oriented, low-value approaches to care delivery, and discourage non-traditional approaches.

Recommendation 1: PCPMs should support population-focused, patient-centered, and team-based care.

Certain elements of PCPMs can be used to advance primary care clinicians' dual role of delivering care in the context of a trusted relationship that is cultivated over time, and of serving as stewards of health care resources. In particular, primary care teams should be the direct recipients of primary care payments that support a multidisciplinary, team-based, and comprehensive approach to care delivery. The composition of primary care teams, and the disciplines and specialties that individual team members represent, will depend on the characteristics of the patient population, and may include new and emerging professions, such as community health workers and health coaches. Because of the prevalence of behavioral health issues in the primary care setting, behavioral health integration (though not necessarily co-location) is a critical feature of PCPMs. Additionally, PCPMs will reward primary care teams for successfully affecting patient outcomes and self-reported goals, as opposed to rewarding teams that provide services that do not add value. These elements of PCPMs will enable primary care teams to work together to innovate new approaches to care delivery, which are capable of improving individual and population health and reducing disparities.

Definitions

Behavioral Health: The full range of mental health and substance use disorder conditions, services, clinicians.

Mental Health: Conditions, services, clinicians specifically related to the mental health field (e.g., anxiety, depression, and schizophrenia).

Substance Use Disorders: Conditions, services, clinicians specifically related to the substance use disorder field (e.g., substance dependence and abuse).

Additionally, primary care physicians also provide primary care in specialty settings, such as inpatient psychiatric facilities, dialysis facilities, and specialty cancer centers, as part of multidisciplinary teams. In these cases, primary care physicians who provide comprehensive primary care will need to be able to participate in PCPMs. These PCPMs will need to ensure that patients can access comprehensive primary care services, and to ensure there is coordination between specialty and primary care by establishing shared accountability between specialists and primary care physicians. Such arrangements, for example, would hold primary care physicians and behavioral health teams jointly accountable for achieving positive schizophrenia and preventative care outcomes; these arrangements are desirable because they promote high levels of coordination between primary and specialty care. Although this type of accountability arrangement may present challenges for rural practices where specialists are not always

available, e-consultations and other virtual relationships would promote integration and joint accountability between specialists and primary care teams. At present, there are evidence-based delivery models for creating the needed integration between primary care clinicians and specialists, but further work will need to be accomplished to demonstrate evidence-based payment models (Pincus et al., 2015).

Recommendation 2: PCPMs should adjust payments to account for underlying differences in the patient populations served by different primary care practices.

It is crucial to risk-adjust payments in PCPMs to account for the disparate resources that different patients require. These adjustments should be made based on measures of disease-based medical complexity, as well as on social complexity and other factors affecting the intensity of care. Much more work must be done to collect the data needed for risk-adjustment in a manner that does not place expensive or labor-intensive requirements on primary care practices, and to develop risk-adjustment methodologies that accurately capture the full dimensions of complexity and are less influenced by variation in clinician coding practices than variation in patients' actual complexity. Nevertheless, risk adjustment should ideally account for the complexity of comorbid conditions, including mental health conditions and substance use disorders. Payment rates should be higher for more socially complex patients, because these patients require more attention from primary care teams and more coordination with community services. When risk-adjusting payments for pregnant women and pediatric patients, adjustments should be based not only on current levels of risk, but also on the value of delivering prevention and wellness care now, to maximize patients' functional capacity and minimize future costs to the health care delivery system and society at large. Although geriatric patients will not accrue the benefits of prevention and wellness care over such long time frames, services such as fall risk assessments should be encouraged because they still bring considerable benefits over the patient's lifetime.

Principle 2: PCPMs will need to allow primary care practices to focus on work that promotes the health of patient populations and minimize work that does not contribute to high-quality care.

It is widely recognized that primary care practitioners, irrespective of their discipline or specialty, are dissatisfied with their work environment. Along with other factors (e.g., inadequate income, high administrative burden, and poor work/life balance), FFS contributes to this dissatisfaction by emphasizing transactional interactions with patients that inhibit the building of healing relationships and full collaboration. Volume-oriented FFS payment systems require primary care practitioners to perform tasks that do not create value for patients (e.g., excessive reporting and documentation of care). Removing these impediments could simultaneously improve patient care and practitioner and staff morale. It is imperative for PCPMs to minimize the need for primary care teams to do work that does not directly improve healing relationships and patients' health. Freed from excessive administrative burden, onerous record-keeping mandates, and requirements to perform unproductive tasks (but not the record-keeping needed for quality improvement and accountability efforts), primary care teams could dedicate themselves to redesigning processes of care that demonstrably improve patient outcomes, population health, and the quality of work life for the care team while simultaneously

reducing costs. This would enable all team members to contribute and collaborate at the top of their professional capacity, and it would help cultivate an inclusive and positive work environment. PCPMs should not require primary care teams to do tasks that interfere with their ability to optimize partnerships with patients, nor should they introduce new administrative requirements without removing existing ones that do not improve the value of primary care.

Recommendation 3: The preferred form of payment for primary care employs risk-adjusted, comprehensive prospective payment, including some retrospective reconciliation, based on the patients empaneled or attributed to the primary care practice. This corresponds to payments in Category 4 APMs.

Population-based payment (PBP), defined by the scope of services provided, must constitute the core mode of payment in PCPMs. Nevertheless, as discussed above in the context of Figure 4, the ability of primary care practices to absorb risk for costs is largely a function of the number of patients for which they are responsible. Therefore, the relative size of practices and provider organizations constitutes a critical consideration in designing the payment mechanisms associated with the PBP component of the PCPM.

Ideally, but only for practices and provider organizations that are large enough to assume this level of risk for costs, PBP should be made on a prospective, per-member-per-month basis, entirely independent of evaluation and management (E&M) codes. Arranging the PBP in this manner, and delivering the majority of payments via the PBP, would make PCPMs Category 4 APMs, discussed below in Principle 4. There are many advantages to using Category 4 PCPMs. Specifically, this type of payment model:

- Is relatively administratively simple, especially in comparison with administrative requirements for FFS payments;
- Gives primary care teams the flexibility they need to develop creative and innovative approaches to care delivery customized to individual patients;
- Promotes a whole-person orientation to care delivery, through whole-person payment; and
- Strengthens continuity of care and clinician accountability, because it encourages a strong patient link with community services and a medical home that covers a wide variety of clinical activities for a defined population.

For these reasons, Category 4 PBP is ideally suited for PCPMs, because it frees primary care teams to focus more on tasks that create value for their patient populations.

First, several specific characteristics of prospective PBP will enhance its positive impact in PCPMs and diminish the risk of unintended consequences. First, PBP will cover a significant percentage of costs associated with services provided by the primary care practice, with FFS payment reserved for a few exceptions (see Recommendation 4 below). Consistent with Recommendation 1 in Accelerating and Aligning Population-Based Payment Models: Financial Benchmarking, "Approaches to financial benchmarking should encourage participation in the early years of the model's progression, while driving convergence across providers at different starting points toward efficiency in the latter years" (2016, p. 10). These gained efficiencies, in combination with new and improved delivery systems made possible by PCPMs, will allow primary care to retain and increase its value to the health care system over time.

Second, because it is cumbersome, complicated, and potentially not possible in the case of unlicensed staff for payers to individually compensate each member of the primary care team, payments (whether from payers or provider organizations) should be made to the teams that comprise primary care practices. Team-based payments are important because they can help promote a team atmosphere where no individual assumes that they will fully succeed on their own, and they can help each member of the practice understand their roles and responsibilities in delivering care that is covered by the prospective PBP.

Third, although patients will always retain the option to choose primary care practices and clinicians, Category 4 PBP will require formal, prospective empanelment of patients. Consistent with the LAN White Paper Accelerating and Aligning Population-Based Payment Models: Patient Attribution, patient choice is the preferred method for empaneling patients to primary care practices; methods that consider previous treatment history (e.g., based on reviews of a patient's utilization patterns) are an acceptable alternative approach.

For the purposes of this paper, *surrogate markers of TCOC* include some mechanisms of comparing the total cost of caring for a practice's patients to the expected cost of caring for its patients, and evaluating practices on the result.

Fourth, the use of prospective payments can dramatically reduce the number of claims that need to be submitted for reimbursement. Nevertheless, primary care practices will still need to report data that are used to determine whether appropriate care was provided and to evaluate practices' success in managing population health. Close collaboration between payers, primary care practices, and commercial vendors will therefore be needed to ensure that available electronic health records (EHRs), registries, and other health information technology collect required data for process and outcome measures (including patient-reported outcomes) efficiently and affordably.

As discussed above, some practices and provider organizations may not be sufficiently prepared or large enough to manage the accountability required for a Category 4 PBP. Additionally, reimbursement for federally qualified health centers (FQHCs) may need to be modified to enable them to fully participate in this type of payment arrangement. In these cases, alternative PBP payment mechanisms can provide practical steps toward the full implementation of the Category 4 PBPs, or Category 3 PBPs can serve as end points in their own right. The following examples illustrate payment mechanisms that constitute an improvement over current FFS arrangements but still carry limitations that are not present in Category 4 PCPMs.

- PCPMs could adopt Category 3A or 3B payments for services that would otherwise be covered under the PBP, along with an attribution model that does not involve formal, prospective empanelment. Such models would entail accountability for surrogate markers of total cost of care (TCOC). Primary care teams would still need to manage the administrative complexity of FFS billing.
- PCPMs could maintain the existing FFS payment structure as the predominant form of primary care payment but also include prospective, population-based care management fees that represent a small portion of the physicians' revenue and are paid on the basis of the number of patients attributed to the practice. This payment model is consistent with a Category 2A PCPM, and is currently used by many payers under patient-centered medical home programs. This arrangement still retains the administrative complexity of FFS billing, and would therefore perpetuate the need for primary care practices to adopt volume-oriented business models. However, primary care teams would be able to devote more of their efforts to non-billable—but

nonetheless value-generating—services if care management fees constituted a significant source of income.

Table 1 provides additional details about the benefits and drawbacks associated with PBP mechanisms in different categories of the LAN APM Framework:

Table 1: Comparative Characteristics of Payment Methods in PCPMs[2]

	Category 1: FFS Payments	Category 2: FFS Payment with Management Fee and Link to Value	Category 3: PBP Built on FFS Architecture	Category 4: Prospective PBP for Primary Care Services
Basic characteristic	Payment for itemized services.	Most of payment remains based on itemized services, with additional adjustment based on performance metrics. Smaller care management component paid prospectively based on number of patients attributed to practice (may be limited to only complex patients).	FFS with additional adjustment based on performance metrics, as well as surrogate markers for TCOC (based on case-mix adjusted regional or historical FFS payments for attributed population). May also include a care management fee.	PBP payment based on number of patients formally empaneled with primary care practice. FFS, if used at all, relegated to small component for certain specified services (e.g., infusions).
Intrinsic financial incentive of payment type	Incentivizes greater volume of services, particularly those with higher payment.	Volume incentive remains, though may be mitigated to a degree if PMPM management fee sufficiently large.	Less incentives for volume if incentives are sufficiently large.	Least incentive for volume of itemized services. Incentivizes enrollment of more patients.

[2] The LAN is in the process of revisiting the original APM Framework White Paper in order to add additional clarification and refinement. That forthcoming LAN product will provide a better venue for discussing the nuances associated with classifying Comprehensive Primary Care Plus (CPC+) and other Advanced APMs under the Medicare Access and CHIP Reauthorization Act (MACRA).

	Category 1: FFS Payments	Category 2: FFS Payment with Management Fee and Link to Value	Category 3: PBP Built on FFS Architecture	Category 4: Prospective PBP for Primary Care Services
How is payment administered?	Claims submitted to payer for each service.	Claims submitted to payer for each service, with additional incentive payments based on performance metrics. PMPM management fee based on number of patients in eligible risk groups attributed to practice.	Claims still submitted for FFS payment, with additional incentive payments based on performance metrics, and on spending for attributed population. May include additional PMPM for care management.	Predominantly prospective PBP (based on a registry that tracks patients formally empaneled with a PCP/practice) with additional incentive based on performance metrics, as well as residual claims submission for selected services.
Does payment method depend on patients formally empaneled with a PCP/practice?	No.	Not usually, though patients often encouraged to sign agreement making practice eligible for PMPM management fee.	Not usually, though patients often encouraged to sign agreement making practice eligible for PMPM management fee, and for the purposes of establishing financial benchmarks.	Yes.

	Category 1: FFS Payments	Category 2: FFS Payment with Management Fee and Link to Value	Category 3: PBP Built on FFS Architecture	Category 4: Prospective PBP for Primary Care Services
What is the administrative burden on practices of payment method?	Heavy administrative burden due to FFS documentation rules and detailed claims submission.	Heavy administrative burden due to FFS documentation rules and detailed claims submission.	Heavy administrative burden due to FFS documentation rules and detailed claims submission.	Lower documentation and billing burden. Administrative requirements related to maintaining empanelment registries; usually requires at least rudimentary "dummy" claims or other data collection methods, quality improvement, performance measurement, and financial benchmarking.
Does the method promote advanced primary care model elements of team-based care and enhanced access through "virtual" visits?	No. Usually only limited types of licensed providers allowed to bill for their direct services. Rarely allows billing for non-visit encounters, and when allowed, transactional costs of claims processing are high.	To a larger degree, depending on magnitude of management fee.	To an even larger degree, depending on magnitude of the care management fee and significance of the performance metrics/incentive payments.	Yes. Prospective payment not tied to specific practice personnel delivering services or in-person visits.

	Category 1: FFS Payments	Category 2: FFS Payment with Management Fee and Link to Value	Category 3: PBP Built on FFS Architecture	Category 4: Prospective PBP for Primary Care Services
Does the method promote a population-oriented model?	No.	More so, depending on the magnitude of the care management fee and the performance metrics in place.	Moves towards a population health model based on attribution methodology, though less precisely defined population than under a prospective PBP model.	Yes. Clearly defines the population of patients for whom the practice is accountable and provides a clear denominator for performance measurement. Policies must specify the scope of primary care services expected to be delivered by the practice under the PBP model.
Does the method require risk-adjusted payment?	No. Patients with greater health care needs tend to generate higher volume of billings (though serving some needs such as behavioral health typically not adequately compensated).	Not for FFS component. Care management fee can be limited to only patients at higher risk (e.g., those with chronic diseases) or is risk-adjusted if a spectrum of patients is eligible.	Less important when historical FFS expenditures are used to calculate PBPs; more important when regional spending is used.	Yes. Without higher payments for higher-need patients, there is an incentive to avoid serving them.

Recommendation 4: To effectively incentivize practice transformation, payers should adopt multi-payer PCPMs that cover the majority of a practice's patient population.

When primary care practices contract with multiple payers and plans that employ different sets of payment mechanisms and benefits, misaligned incentives can distract practices and stymie practice transformation. Therefore, it is paramount for public and private payers (i.e., Medicare, Medicaid, and commercial insurers) to adopt aligned payment policies, which will help create the financial conditions for practices to make sound investments in population health management. Misalignment between

payment mechanisms is particularly challenging when patients covered in FFS plans considerably outweigh patients covered by PCPMs. Although patients will ultimately decide whether or not they want to join a PCPM, it is important for the majority of a practice's patient population to be covered by a PCPM. This is because delivery approaches necessarily differ in patients in the two models, practices will have difficulty justifying investments in innovations that will impact less than half their patients. For these reasons, widespread adoption of multi-payer PCPMs will catalyze delivery reform and give primary care practices a stable financial foundation, upon which they can develop and implement practice transformation.

Recommendation 5: Prospective payments should be in excess of historic primary care payment amounts, and physicians should use these payments to support the infrastructure of the clinical team, which will be held accountable for greater coordination of services, and for bending the total health system cost curve.

Out of necessity, the size of the prospective PBP will be largely determined by the scope of services covered. Nevertheless, it is not sufficient to base prospective PBP rates on current spending levels for primary care in FFS payment systems. First, care management/coordination and other services have historically been undervalued or not included in FFS payment, which has stunted the development and dissemination of these services. Second, payment needs to reflect the care traditionally delivered in primary care practices, as well as the growing expectations of stewardship that requires an expanded team with functions that traditionally were not part of payment and overhead. For these reasons, prospective payments in PCPMs cannot be based on current spending rates in FFS systems.

Although it will take some time for primary care practices to adapt to PCPMs and begin to realize savings from improved clinical outcomes (see Recommendation 19 below), the Work Group does not anticipate that additional investments in primary care infrastructure will require purchasers to spend more on health care. Rather, the Work Group expects that payment mechanisms in PCPMs will unleash value in other parts of the health care system, and ultimately result in a return on investment. In other words, in return for accepting increased payment rates through the prospective PBP portion of a PCPM, primary care teams will create additional value for the health care system, consumers, and purchasers.

In order to ensure increased spending on prospective payments results in a value-generating enterprise for the health care system as a whole, additional spending on primary care must be recouped through savings from reductions in the utilization of unnecessary care outside the primary care setting, as opposed to savings from reductions in unit payments for non-primary care services. Additional mechanisms to ensure care teams act as effective stewards of collective health care resources are discussed in Recommendation 9. PCPMs with PBP in excess of historical levels will only be sustainable if primary care teams are able to demonstrate, in one way or another, that their patients receive appropriate care, are referred to efficient, high-quality specialists and ancillary services, and achieve positive outcomes on quality measures. In this respect, the ongoing success of PCPMs is contingent on primary care teams' ability to limit inappropriate care (e.g., preventable hospitalizations or inappropriate medications and imaging) and manage their patient population comprehensively, with a view to TCOC and longitudinal health outcomes.

Recommendation 6: PCPMs should use prospective payment to fund the necessary investments by primary care organizations in practice infrastructure to result in more efficient delivery of health care.

As a matter of course, primary care practices should use prospective PBP to cover the costs of maintaining the infrastructure needed to support a highly functional delivery system, for testing innovative approaches to care delivery, and for investing in additional capabilities that will improve the quality of care that patients receive (e.g., patient and family advisory councils and team-based care management to monitor patient compliance). Because initial PBP will be made, in part, to support delivery innovation that will improve the value of primary care, these payments are accompanied by the expectation of better health system efficiency and lower growth of the total cost of care. It is important that payers do not maintain support of inefficient practices that do not transform to a population-based practice style and effective resource stewardship. As this newer approach to team-based panel management matures, most payments will be made through a risk-adjusted prospective payment, and there will be a concomitant reduction of payments for office visits themselves. This shift to prospective payment will evolve over time to allow practices to develop business models that will succeed in a new payment environment.

Recommendation 7: Fee-for-service payment should still play a limited role as part of a blended PCPM; it will be used to incentivize certain services that need to be performed in a face-to-face encounter and promote more efficient, comprehensive primary care.

Although PCPMs should be predominantly comprised of prospective PBP, some degree of a blended payment model that retains an element of FFS payment may have merit. Certain services and procedures provide considerable value for patients and require face-to-face interactions between a patient and a clinician, either in a clinician's office or in a patient's home. In such cases, it may be desirable to employ FFS payments as a way to encourage the appropriate use of face-to-face encounters for a small subset of high-value services and procedures that can help avoid more expensive acute or emergency care, and to safeguard against possible disincentives to provide these services under PBP. For example, it would be appropriate to use FFS to cover costs associated with specific services that accompany primary care services, such as joint injections and infusions. Although it is unreasonable to expect PCPMs to completely abandon FFS in favor of prospective PBP, FFS payment rates should not be so high as to create incentives to increase the volume of FFS services, instead of focusing practices on care covered under the prospective PBP.

Principle 3: PCPMs will need to enhance collaboration with specialists, hospitals, emergency departments, and other health care professionals to deliver timely, appropriate, and efficient care.

In order to fulfill the key functions of primary care, it is crucial to break down silos between different types of clinicians, and to more fully integrate and coordinate care that is delivered in different settings. Accordingly, PCPMs should promote closer collaboration and broader data sharing between primary

care teams and other sectors of the delivery system. They can do this by supporting care compacts and other written collaborative care agreements, and by providing mechanisms to compensate specialists, hospitals, and other practitioners for helping coordinate chronic care and care transitions and for providing low intensity non-face-to-face consultations and other services (e.g., focused training) that primary care practices need to effectively deliver comprehensive primary care. In order for primary care practices in PCPMs to succeed, providers across the health care system will need to recognize their mutual dependency and collaborate with one another.

Recommendation 8: Continued participation in PCPMs should be contingent upon primary care teams' adoption of technologies and processes that allow them to closely coordinate care with specialists and hospitals.

Close connections with specialists and hospitals are especially essential to primary care teams' ability to coordinate care for their patients. Technological innovations and improved communication will be central to improving these efforts. Primary care teams (including behavioral health clinicians), hospitals, specialists, home health agencies, and long-term care facilities all need to be able to view the same, comprehensive patient record, which will also enable the respective parties to easily identify one another when they care for the same patient. In the case of specialists, technologies and communication plans will need to be developed to increase the use of "e-consultations," which will allow specialists and primary care teams to exchange detailed information, and render judgments on the course of care, without requiring patients to show up for an additional visit with the specialist. For example, Project ECHO, an initiative of the University of New Mexico, the Robert Wood Johnson Foundation, and a recipient of a Health Care Innovation Award from the Center for Medicare and Medicaid Innovation, has made good of e-consultations to support primary care practices that treat behavioral health issues, hepatitis C, and other conditions for which the practices lack access to requisite specialists.[3] Hospitals and primary care teams will need to develop similar mechanisms to notify and communicate with primary care teams when one of their patients is admitted to the emergency department.

Establishing these measures will improve medication reconciliation, avoid duplicative or unnecessary care, and place primary care teams in the position to accept accountability for improving care transitions and coordinating care across settings. PCPMs should therefore require participating primary care teams to demonstrate that they are taking significant steps to put the necessary technologies and processes into place. Consistent with Recommendation 17 below, payers will likely need to play an important role in facilitating the development of the infrastructure that will support information exchange and communication between primary care teams, hospitals, and specialists. These additional data infrastructure needs should therefore be taken into account in business models for PCPMs.

[3] These consultations with specialists will also require modifications to FFS-based payment models for specialists, which are beyond the scope of this White Paper.

Principle 4: Performance measurement in PCPMs will need to promote excellent clinical and patient experience outcomes that reflect patient goals and whole-person care, to enable health care professionals to partner with patients and families to achieve the outcomes they desire.

Primary care teams use performance measurement to improve patient care and demonstrate to payers their performance is sufficient to warrant financial rewards. In order to function optimally, performance measurement systems should therefore be reflective of the patient-centered care that primary care teams strive to provide. Accordingly, measure sets will span the continuum of care that falls under the scope of primary care practices, will only require the reporting of data that are available to primary care practices, will promote patients' goals for health, will meaningfully differentiate between practices at different levels of performance, and will not unintentionally incentivize inappropriate or unnecessary care or disincentivize care for complex, high-need populations. Similarly, payment structures that accompany measure sets should motivate improvement across practices at different places in the care spectrum. When performance measurement systems are constructed in this manner, they will align and reinforce the internal motivations of clinicians to provide high-value care.

Recommendation 9: Financial incentives used in all models should be transparent to care teams and the public, be clearly communicated, and promote trust that these new payment models will promote better quality and appropriate costs.

Payment principles for practices and patients should be fully disclosed to the care team and the public, so that all participants understand how new payment approaches differ from traditional FFS models, and how certain incentives may positively impact the care that clinicians recommend or provide. Financial incentives should be developed in consultation with patients and consumers in order to reflect how patients define value, and to ensure that patients are not steered to lower-cost care without regard for quality. Transparency is critical to ensuring patients have trust in their primary care teams, and avoiding situations where patients believe their primary care team is limiting access to care for the financial benefit of the practice.

Unlike prospective PBP, incentive payments, or bonuses for high scores on cost and quality measures, constitute financial rewards for effective performance. As a result, they should be made as frequently and as close as possible to the period of performance and relate as directly as possible to the work of the primary care practice. Therefore, it is reasonable to use incentive payments to support and recognize the exceptional work of individual team members who demonstrate a positive impact on patient outcomes, improved patient quality of life and patient experiences of care, or services that reduce unnecessary utilization or the total cost of care. It is not acceptable to use incentive payments that are measured at the practice level for operational expenses that are beyond the practice. Although payers rarely obligate practices in PCPMs to provide team members individual incentive payments for high performance, it is important because individual team members may not feel their efforts are recognized, or may feel other team members are hampering the team's overall performance, when incentive payments are not equitably distributed among the team.

Incentive payments, based on effective stewardship of health care resources and performance on quality measures, will be used in conjunction with the PBP and FFS components of PCPMs. As discussed

above, in the context of Figure 4, cost accountability depends in large measure on the size of the practice or provider organizations. Practices and provider organizations that are too small to assume risk for costs should still be evaluated on the basis of utilization measures, which assess their ability to limit ineffective care, such as unplanned hospital readmissions. Nevertheless, PCPMs will need to hold practices and provider organizations of sufficient size more accountable for costs. Different accountability mechanisms are available for practices and provider organizations of different sizes. For example, some practices and provider organizations may only be large enough to assume accountability for utilization measures (e.g., measures of 30-day readmissions). Others may be large enough to participate in models that provide bonuses if TCOC is lower than expected, and others still may be large enough to receive bonuses and penalties depending on how costs for their patients compare to established benchmarks. Practices and payers will need to make careful decisions about the level of risk and accountability practices are able to assume on a case-by-case basis. However, as discussed above in Recommendation 5, the long-term sustainability of PCPMs is contingent on the ability of primary care practices to generate savings through reductions in unnecessary care. It is therefore important for practices to assume as much cost accountability as their patient populations allow in order to maximize the value of primary care for the health care system as a whole.

Recommendation 10: Performance measurement systems should eliminate economic incentives to limit the provision of evidence-based care or deny costly or complex patients access to primary care practices and the care they need.

Because PCPMs will be predominantly composed of prospective PBP, there are inherent economic incentives to limit both necessary and unnecessary care. One of the primary functions of performance measurement must therefore be to eliminate incentives to limit evidence-based care. This can be accomplished in large part by selecting appropriate measure sets. Additional protections against these perverse economic incentives can be gained by tying performance measurement to meaningful financial incentives. As discussed above, it is critical to risk-adjust payments in PCPMs to account for the disparate amount of resources that different patients require to meet their health care needs.

Nevertheless, patient characteristics outside a practice's control may result in lower quality scores. Further research is necessary to determine whether there are causal links between such factors and performance scores and to assess if risk-adjustment of quality measures is warranted in some care settings. The risk that adjusting measures for sociodemographic characteristics (e.g., education, race, ethnicity, and income) may mask existing health care disparities must be considered before implementing any such practice. Further, alternative strategies such as stratification, whereby practices serving similar populations are similarly measured, or where practices serving complex patients are paid more for achieving the same outcomes, should also be explored.

Recommendation 11: Incentive payments in primary care should be based on a parsimonious set of aligned, high-impact measures of primary care, rather than rely exclusively on a rigid set of disease-specific metrics.

Consistent with the recommendations advanced in the PBP Work Group White Paper, Accelerating and Aligning Population-Based Payment Models: Performance Measurement, measure sets used to evaluate

primary care teams should align with the underlying payments these teams receive, as well as the scope of services covered in PCPMs. Because PCPMs will predominantly consist of prospective PBP, measure sets should be oriented toward the results the primary care teams are able to affect (e.g., behavioral health management, chronic disease management, preventive care, medication management, and patient experience measures), as opposed to the particular steps teams take to achieve these results. Accordingly, measurement systems used to evaluate performance in PCPMs should be primarily comprised of measures of outcomes (including patient-reported outcomes), patient experience, and high-level indicators of quality care delivery that transcend individual illnesses and diseases. In order to reduce confusion and practice burden, these measure sets should align across payers. This orientation is important because it reinforces the perspective that the patient as a whole is the recipient of primary care, and that person-centered care does not view the patient as a collection of discrete symptoms and diseases. Because measures are not readily available, it will be important to expedite the development of high-level outcome measures through greater coordination, resource allocation, and patient involvement, along the lines of the recommendations put forward by the LAN PBP Work Group.

Although PCPMs will employ high-level measures of the primary care team's comprehensive performance, more granular and disease-specific measures will continue to play a role in evaluating performance. This is particularly the case in the immediate future, because high-level measures on health and quality are often not available. Even when these types of measures are available, more granular measures will be needed because there can be a significant time delay between the delivery of effective care and the appearance of (or lack thereof) important clinical outcomes. Therefore, process and intermediate outcome measures for which there is a good proxy for future health outcomes (e.g., Hemoglobin A1c control for people with diabetes) will always be appropriate for PCPMs, particularly if corresponding outcome measures are not available. Additionally, more granular measures are appropriate for PCPMs when they are evaluating care paid for via FFS. For example, measures on rates of age-appropriate annual wellness visits or immunization rates are appropriate for PCPMs that pay for these services on a FFS basis. Finally, it is important to note more granular, process-oriented measures will always remain central for internal quality improvement purposes, even if they are not used to evaluate the performance of primary care teams participating in PCPMs.

Principle 5: PCPMs will need to encourage robust integration of primary care, behavioral health (including substance use treatment programs), and strong linkages with community resources to address social determinants of health.

Primary care teams provide comprehensive, whole-person care and serve as the patient's entry point to the health care system. The prevalence of mental health conditions and substance use disorders is quite high among the people who receive primary care; these conditions influence other medical conditions and vice versa. Similarly, the characteristics of environments in which patients live play a significant role in the development or successful management of chronic and acute diseases. Therefore, PCPMs must reward primary care teams that effectively integrate with behavioral health specialists, and they must encourage care teams to develop strong linkages with community resources and services, in order for teams to provide whole-person care.

Recommendation 12: PCPMs should hold primary care practices accountable for, and provide the resources to enable, the management of mental health and substance use services, because this recognizes the critical role behavioral health plays in overall health, supports better integration between these services and primary care, and promotes shared accountability at the organizational and clinical levels.

The integration of mental health and substance use disorder services into primary care is critical because patient outcomes improve when there is coordination between primary care and behavioral health. Successful integration will need to include clear procedures to enable data sharing between primary care teams and behavioral health specialists, such that each party is aware of, and can contribute suggestions for, care in each setting. Depending on where patients seek care (i.e., at a primary care practice or specialty behavioral health setting or both), there are two broad categories of behavioral health conditions for which there might be different strategies: 1) mild to moderate behavioral health conditions and 2) severe behavioral health conditions.

On the one hand, mild to moderate behavioral health conditions (e.g., generalized anxiety disorder and mild, recurrent depression) are common in primary care and are most often treated in the primary care setting. Evidence-based delivery models exist for effective integration of behavioral health and primary care to treat these conditions, often in concert with other chronic conditions that are commonly comorbid with these behavioral health conditions. Evidence-based delivery models, such as the Collaborative Care Model, rely heavily on case finding, ongoing care management, decision support tools, self-management support, linkages with community and social services, and other key delivery system principles. Typically, psychiatrists and other behavioral health specialists are members of an integrated team providing supervision of care managers as well as advice and consultation.

In this context, behavioral health care can be delivered by licensed professional behavioral health specialists, such as psychologists, psychiatrists, psychiatric nurses, and social workers. However, it can and should also include others (e.g., nurses and behavioral health coaches) who can be trained to provide many evidence-based behavioral health services. Although mild to moderate behavioral health conditions will continue to be treated in the primary care setting, when specialty behavioral health practitioners are participating in providing care for these patients, PCPMs will need to encourage effective integration between the two fields by establishing mutual accountability for primary care and behavioral health outcomes. This can be accomplished in several ways, and practices may use a combination of these strategies to address different behavioral health conditions in their patient population. For example, behavioral health specialists can be members of the primary care team, be co-located but separate from the care team, or maintain contracts to provide integrated behavioral health services from a different location. Co-location of behavioral health specialists is advantageous but not sufficient in and of itself and may not be feasible for many primary care practices. Irrespective of where these specialists are located, PCPMs should be equipped to support any arrangement that fits their local circumstances, encourages multidisciplinary approaches to care coordination, and provides care plans that integrate the patient's behavioral and medical conditions. Irrespective of the particular arrangement, primary care teams will need to manage mild to moderate behavioral health issues like other chronic conditions, and PCPMs will need to enable them to do so.

There are many ways in which PCPMs can help integrate primary and behavioral health care, and hold primary care teams accountable for behavioral health management. Strategies for enhancing practices' capacity to fully integrate behavioral health models have been described (Chung, Rostanski, Glassberg &

Pincus, 2015). In particular, the Collaborative Care Model is an evidence-based approach to behavioral health integration that has achieved significant results (Katon et al., 2010). For primary care practices and organizations of sufficient size, mental health and substance use spending is included in the prospective PBP component of PCPMs and covers behavioral health services the primary care team provides. The advantage of "carving in" mild to moderate behavioral health care is that it maximizes primary care teams' flexibility to properly steward the resources needed to coordinate with behavioral health specialists. It enables cross-functional teams to collaborate on innovative delivery models for patients with behavioral and medical comorbidities and effectively utilize care management strategies. Teams can take advantage of technologies that enable internet-based interventions, electronic communications between patients and care managers and among team members (e.g., consultations with behavioral health specialists), and other tools for improving and coordinating care. In addition, integrated strategies can increase utilization of screening and appropriate interventions and referrals for treatment, seamless transitions between primary care and behavioral services, and the full integration of behavioral management plans into primary care plans. More generally, this type of payment arrangement is most conducive with the evidence-based care integration delivery models mentioned above. It is essential, however, that payment mechanisms appropriately account for the costs of providing these services, are appropriately risk-adjusted, and assure accountability for the provision of high-quality behavioral health care through a limited set of structure, process, and outcomes measures.

In certain circumstances, primary care practices and provider organizations may not be large enough, or may not have access to a sufficient number or range of behavioral health specialists, to assume the cost accountability associated with including behavioral health payments in the PBP component of PCPMs. In such cases, the inability of practices to absorb outlier spending on behavioral health could have the effect of disincentivizing the delivery of behavioral health services. Accordingly, in these cases it is acceptable for primary care practices to receive payments for behavioral health in the FFS component of PCPMs, but shared accountability mechanisms should be implemented to encourage collaborative delivery innovations and encourage coordination in treating behavioral and medical comorbidities.

On the other hand, severe behavioral health conditions (e.g., schizophrenia and substance use dependence) are most commonly treated in a specialty setting. However, since individuals with these conditions are also at much greater risk for other comorbid medical conditions, and often have difficulty accessing primary care, coordination between primary and specialty care is especially important. While the care for severe behavioral health conditions would, in most cases, be centered in the behavioral health specialty setting and be paid for on an FFS basis, shared accountability mechanisms must be in place to assure these patients receive adequate primary care, and that there is coordination between the behavioral health specialty and primary care settings. PCPMs for primary care practices that enroll individuals with severe behavioral health conditions will ideally be appropriately risk-adjusted Category 4 PBP for the majority of primary care services (as discussed in Recommendation 3). Importantly, in the context of Principle 1, innovation models for integrating comprehensive primary care and behavioral health specialty care for these populations should be encouraged, and APMs designed for these models are urgently needed.

Recommendation 13: PCPMS should maximize the flexibility primary care teams have to expend resources on coordination with community services, including direct support for community programs that demonstrably address social determinants of health to improve patient outcomes.

As discussed, one of the benefits of moving away from FFS payments for primary care is that it gives care teams the financial flexibility they need to innovate novel approaches to care delivery. Environment conditions can exert a powerful effect on the health status of patients, and on their ability to receive needed care. For example, housing instability, malnutrition, and social isolation can create or exacerbate health issues and disparities. Similarly, lack of transportation or child care can limit patients' ability to seek needed care which could prevent more significant problems in the future. Much like accountability for behavioral health management, there are many ways to encourage strong linkages with community-based services that can address health-related unmet social needs. Payers and primary care teams should consider technical assistance, quality improvement, and practice coaching support that will be required for effective linkages between primary care and community-based social care. As permitted by law, PBP components of PCPMs could be used to collaborate with community-based organizations and service providers to innovate approaches to social and community conditions that interfere with care delivery and exacerbate health problems. The committee recommends that PCPMs should not hold primary care practices accountable for creating social service infrastructure, because this is clearly beyond the practice's purview, and that community-based organizations should be adequately resourced to develop partnerships, account for new referrals, and respond to new and growing needs. Alternatively, holding primary care teams accountable for resource use and health outcomes could encourage greater usage of community services. Either approach, or something in between, should be sufficient to establish stronger connections with community service providers, such that the administrative complexity of the former approach is counterbalanced by stronger incentives to connect in the latter.

Granting primary care teams this flexibility can result in the deployment of a number of innovative approaches. For example, Medicare's Second Generation Social/Health Maintenance Organization (S/HMO) Program allowed primary care teams to provide expanded care benefits for eligible patients. These expanded benefits included care coordination programs in which multidisciplinary ambulatory care teams conducted health-risk screenings, identified at-risk patients, developed care plans, and regularly contacted at-risk patients to identify potential emergent health issues. Where appropriate, the S/HMO Program reimbursed primary care teams (via prospective PBP) to provide transportation, respite care, house cleaning, emergency response, and adult day care benefits, at a nominal cost to patients (via copays). Evaluations of the S/HMO Program identified reductions in the utilization of intensive services (e.g., emergency department visits) and increases in the utilization of less intensive services (e.g., physical therapy) for high risk-patients, while at the same time improving functional status compared to a control group that did not receive expanded benefits (Newcomer, Harrington, & Kane, 2002; Thompson, 2002).

Other examples of coordination and contracting between primary care and community services include integration of social determinants screening in patient-care workflows; embedding community health workers or non-clinical specialists (e.g., peer services for housing support) in health care settings; data sharing and referral management as allowable with non-clinical community based organizations; contracting with community health workers and other non-medical professionals; educational and occupational support; in-home improvement/adaptation to accommodate physical disabilities; and

aging and disabilities resource centers. Many screening tools are available to assist in capturing data that can be used to help manage, and risk-adjust for, social determinants of health. Additionally, the Institute of Medicine has also provided detailed guidance on how to best capture data on social determinants of health in electronic health records (2014). Payers and practices should consult these resources when establishing and strengthening linkages to community services that address social determinants of health.

Principle 6: PCPMs will need to promote multifaceted efforts to make caregivers and patients partners in the delivery of their care, as well as at all levels of PCPM design, implementation, governance, and evaluation.

Consistent with the LAN's Principles for Patient- and Family-Centered Payment (Appendix C), and the notion of person-centered care advanced by the LAN APM Framework and Progress Tracking Work Group, PCPMs must attend to the needs and priorities of patients and create the conditions in which patients are active partners in all aspects of quality improvement activities and health care planning and delivery. This is particularly important in two contexts: 1) the creation, execution, and modification of patient care plans, and 2) input and oversight over the design of PCPMs and the primary care practices that participate in them.

Recommendation 14: PCPMs should ensure that primary care practices reflect patient goals, needs, and preferences in the care plans they develop collaboratively with the patient.

Active patient engagement in creating, implementing, and changing care plans is vital in all medical realms and is not unique to primary care. Nevertheless, active collaboration and shared decision-making between patients and primary care teams on care plans is acutely important for primary care because of primary care's unique role in coordinating other aspects of care. It is therefore essential for PCPMs to include mechanisms to ensure that primary care teams develop and execute care plans that reflect patients' goals, values, and preferences. Decision aids may prove useful in this context. In order to ensure patients and their families or other caregivers are able to be proactive partners in creating care plans and in clinical decision-making, and that care plans are regularly updated to reflect new developments, PCPMs should also ensure critical information for health management is culturally appropriate, accessible for the hearing impaired and blind, and made available in patients' primary languages at the general population's reading level. External organizations (e.g., patient advocacy groups) will need to help primary care teams develop health education materials that include input from multiple stakeholders, make use of health literacy experts, and include qualitative methods of testing, such as cognitive interviews and focus-group testing.

Recommendation 15: PCPMs should ensure primary care practices collect patient input, make patients meaningful partners on advisory councils, and encourage patients to provide input about the experience of their care.

Consumers, patients, families, and their advocates play a vital role in ensuring the transition to and operation of PCPMs do not impede the delivery of high-value care. Commensurate with this responsibility, patients, families, and patient advocates must have a voice in decisions about the design, implementation, and evaluation of PCPMs (including the selection and specification of quality measures). Where feasible, practices are encouraged to use advisory councils with patient representatives to obtain these types of input from patients. Whichever forum is used, payers will need to develop standard operating procedures for soliciting input from patients and communities to design educational tools that make transparent financial incentives, as well as how new payment models potentially impact how care is delivered. Correlatively, practices and payers should take steps to educate their communities about ways to minimize the challenges practices face in improving quality and patient experience.

As allowed by law, payers, primary care practices, and patients can reach consensual, transparent agreements on value-based benefits packages that promote the use of high-value, evidence-based primary care services through lower cost-sharing. Research demonstrates that high-cost sharing (e.g., deductibles, copayments, and coinsurance) can lead patients to forgo necessary care and may lead to the use of more expensive care, such as emergency room visits and hospital stays. Conversely, low-to-no cost-sharing for high-value care can facilitate increased access and may prevent the use of costlier care (University of Michigan Center for Value-Based Incentive Design, 2012; Swartz, 2010). Where possible, providers, practices, and patients should collaborate on value-based benefits packages to promote the use of high-value primary care services and eliminate financial barriers to accessing such care. Additionally, patient and family advisory councils have proven useful by ensuring patient portals are easy to use, accessible to a wide range of patients, and include functions that are important to patients and their families; by enhancing support for patient transitions to the home following an acute and/or post-acute care stay; and by identifying helpful community-based supports and resources, to name a few examples.

Principle 7: Payers and primary care teams will need to collaborate in partnerships to ensure the success of PCPMs.

Primary care teams and payers are better positioned than other health care stakeholders to put into place the payment and delivery reforms that will be required to make PCPMs successful for patients, the health care system, and society at large. It is therefore essential for payers and primary care teams to jointly accept accountability for designing and implementing PCPMs that have the potential to transform the practice of primary care. Payers, in particular, are obligated to be engaged stakeholders in the development, implementation, and dissemination of PCPMs that align payments across multiple public and private payers. Payers are also responsible for establishing organizational and functional frameworks for the delivery of high-value primary care, and for helping to educate members and beneficiaries about actions they can take to enhance the effectiveness of primary care services. Payers will also need to develop tools to track and monitor the value added by primary care, and they should make similar tools available to primary care teams. The availability of these tools will enable payers and

primary care teams to identify emergent risks and make adjustments to model elements and delivery systems, which will improve the long-term financial sustainability of PCPMs.

Recommendation 16: Ongoing participation in PCPMs should be conditioned on a primary care practice's ability to demonstrate success on metrics of patient access, quality of care, comprehensive provision of services, responsiveness to patients, and effective stewardship of resources, as stipulated in the model design.

Establishing rigid preconditions for primary care practices' participation in PCPMs is counterproductive because it stifles delivery system innovation and the dissemination of APMs. Nevertheless, care quality, access, and patient health are jeopardized if primary care teams participate in PCPMs but are unable to undergo the practice transformation required to be successful. Therefore, payers should allow all eligible primary care practices to participate in PCPMs, but demonstrable success should be a condition for continued participation. In other words, primary care practices should only be allowed to remain in PCPMs if they accomplish (or are on track to accomplish) the work of the model as it is set forth.

The metrics and criteria used to grant ongoing participation in PCPMs should include a variety of indicators of access, care quality, patient engagement, care comprehensiveness, and financial accountability. For example, the Arkansas Medicaid Program evaluates various levels of participation in primary care APMs on the basis of several conditions, such as:

- The presence of dedicated staff for care coordination and practice transformation;
- The existence of a formal strategy for care coordination and practice transformation;
- Documented efforts to implement same-day appointments;
- The successful integration of EHRs into practice workflows that enhance data sharing with affiliated providers;
- The identification of high-risk patients; and
- A documented approach to contacting patients that do not receive preventative care.

Other conditions for participation, and other aspects of clinical performance that could result in enhanced compensation, could include demonstrated success on metrics of:

- Avoidance of wasteful or unnecessary medical tests, treatments, and procedures;
- Appropriate use of low-cost therapeutic alternatives when prescribing medications;
- Ability to educate patients about ways to avoid wasteful and potentially harmful care; and
- Reductions in disparities in care for the practice population.

Additional oversight of PCPMs and the primary care practices that participate in them can be accomplished through monitoring both activities and utilization, soliciting stakeholder input throughout implementation, and through ombudsman programs, audits, and formal evaluation studies. Nevertheless, it is essential to design these programs in a way that captures essential information about practice performance, while at the same time minimizing administrative burden on primary care teams.

Recommendation 17: PCPMs should foster data sharing and analysis to facilitate care coordination, patient engagement, population health management, and performance assessment.

Consistent with the core recommendations of the LAN PBP Work Group, PCPMs should treat aggregated, de-identified data as a public good, and they should establish the infrastructure needed to allow patient-level data to follow the patient. Although a variety of architectures can be used to accomplish these goals, payers will likely need to play a critical role in furnishing the data that primary care teams need to successfully engage in population health management. Such data include aggregated data on cost and quality performance (including comparisons with similar practices), patient-level data from other practices and providers (e.g., unaffiliated hospitals and post-acute care facilities), real-time data on patient transitions, and data on patient empanelment and attribution. Data that primary care practices can use to identify and manage patients who account for abnormally high amounts of spending will be especially important for effective resource management.

In addition to catalyzing enhanced data sharing and data use among primary care practices, payers will likely also play a greater role in sharing aggregate, multi-payer data on plan and practice performance on cost and quality metrics. Providing this information is critical for establishing the value of primary care delivered in PCPMs and making informed decisions about plan and practice selection, and stakeholders should collaborate to establish common data sharing requirements and standards. Additionally, primary care teams will need to redouble their efforts to increase patients' and caregivers' access to their personal health data, so they can better manage their health and well-being and become more active participants in care plans and clinical decision-making. Through the OpenNotes initiative or a similar platform, patients and authorized caregivers have access to the same comprehensive patient record as primary care teams, hospitals, and specialists, and primary care teams should proactively and collaboratively develop communication plans for exchanging information with patients and caregivers. Enabling and welcoming patient-provided data is also critical for identifying errors or gaps in the patient's profile, improving care, and strengthening the clinician-patient relationship. To arrive at more accurate assessments of social determinants of health and promote linkages between community services and health care, data sharing with community service providers should also be strengthened in a manner that preserves patient privacy.

Recommendation 18: Primary care practices should receive external coaching support and technical assistance to help them transition to new payment and delivery models.

Transitioning primary care practices that have historically been designed to generate volume in FFS models into practices that are designed to deliver value in PCPMs is no simple matter. Business models that ensure uninterrupted revenue streams during the transition, and financial stability within the PCPM, will need to be developed carefully to minimize disruptions in services and access. Similarly, practice workflows will need to be completely redesigned to meet the care delivery expectations supported by the financial foundations that PCPMs provide. The experience and expertise needed to drive these types of transformations is not widespread among primary care practices. Therefore, primary care practices will require external coaching support and technical assistance in at least eight areas: 1) business and financial transformation; 2) practice infrastructure transformation, including

effective teamwork; 3) data collection and measurement; 4) incorporating data into work flow; 5) population health analytics; 6) leadership development, including methods to effectively partner with patients and families in care redesign; 7) identifying and recovering from burnout; and 8) interfacing with payers and other members of the health care system. Additional clinical education on patient communication skills (e.g., motivational interviewing) would likely enhance patient engagement efforts, as would additional education for patients to prepare them to be active participants in these new models of care. Payers and other outside organizations (e.g., regional collaboratives) will likely need to play a significant role in establishing and disseminating assistance plans in each area.

With respect to business transformation, primary care practices will require assistance with cost projections, staffing plans, and budgeting to ensure practices remain financially viable in PCPMs. With respect to practice transformation, primary care teams will need help structuring work flows that focus resources on high-need patients, enhancing coordination with other provider groups and community services organizations, and developing streamlined procedures that ensure accurate and comprehensive data collection. Primary care clinicians will also need enhanced training in methods to partner effectively with patients in care redesign efforts and in communication practices such as motivational interviewing. Because primary care in PCPMs is a data-driven endeavor, primary care practices will require considerable support with the creation and interpretation of meaningful analyses that enable team members to identify high-need patients, monitor and design comprehensive care plans, and make informed decisions at the point of care. Payers and other outside organizations (e.g., professional associations) will likely play a prominent role in providing coaching support and technical assistance that focuses in these three areas.

Recommendation 19: Although incremental progress should be made much more quickly, PCPMs can only be expected to deliver a return on investment over the long term. Therefore, payers should develop business models that do not require investments in PCPMs to be recouped from reductions in total cost of care in the short term.

Because primary care emphasizes a preventative approach and longitudinal care for the whole patient, improved patient outcomes often do not materialize immediately, and may take years (and in the case of some preventive measures, decades) to realize. Accordingly, and because primary care has traditionally been such a minor part of the total cost of care, it is unreasonable to expect PCPMs to significantly impact total cost of care in the short term. Nevertheless, taking into account the heterogeneity of practices within PCPMs, it is reasonable to expect to see other, incremental returns on investment in the short to medium term. For example, it is reasonable to expect practices to demonstrably reduce hospitalizations and readmissions, and duplicative or unnecessary imaging; implement better medication management; and better integrate care in the first five years of a PCPM.

These types of practice transformation can be used as surrogate indicators of future returns on investment in PCPMs. Practices and provider organizations that are further along should be able to demonstrate fairly quickly that they are able to generate cost savings from referrals and improved population health management. Over the long term, it is entirely reasonable to expect most investments in PCPMs will be recouped through reductions in total cost of care. Payers will need to develop business plans that take these incremental and long-term expectations into account, while at the same time incentivizing practices across the spectrum to deliver the highest-value care possible. Although this may be difficult for Medicaid plans in states that are required to balance their annual

budget, additional steps and budgetary tradeoffs will be necessary to enable PCPMs to achieve their promise of improving care and reducing costs.

Action Steps

Numerous public comments on the draft version of this White Paper requested additional guidance on how to overcome the difficult technical issues associated with designing and operationalizing PCPMs. In an effort to expedite the adoption of PCPMs, the Work Group encourages practices to work with others in their region, instead of in silos, and to engage with others in actual initiatives instead of merely dialogue on payment reform. In order to further these efforts, the Work Group has identified several key implementation issues that will need to be addressed. These issues are listed below, with the understanding that other consensus groups will need to tackle them in earnest, as they cannot be fully explored in the context of this White Paper.

1) As discussed in the context of Recommendation 4, it is quite burdensome for primary care practices to meet discrepant requirements for different payers that offer PCPMs, and misaligned incentives in different payers' PCPMs will diminish opportunities for practices to participate. It is therefore important to ensure payers collaborate to design PCPMs with aligned requirements, quality measures, incentives, and benefit designs. Further efforts will also need to establish a forum and process for achieving this consensus. Further implementation guidance will also need to identify practical steps to align PCPM incentives across payers in a reasonable time frame, given that payers and primary care practices already have in place contracts with different terms and durations.
2) As discussed throughout this White Paper, PCPMs will need to better identify and account for social determinants of health in order to properly risk-adjust the PBP component, improve population health management, and establish effective linkages with community-based services. It is therefore important to reach consensus on which assessment tools should be used to collect reliable data on social determinants of health, how these data should be factored into risk-adjustment methodologies for payment, and how to make these data actionable for practices engaged in population health management.
3) As discussed in the introduction, as well as in the context of Recommendation 9, it is critical for incentives in PCPMs to reach practitioners on the ground, especially when primary care practices receive payments from provider organizations that serve as intermediaries between payers and practices. In light of this, further implementation guidance will be needed on steps that payers and practices can take to ensure financial incentives in PCPMs (e.g., bonuses for cost savings) reach frontline providers. Specific guidance on the types of contractual arrangements that can be put into place to achieve these ends would be particularly helpful.
4) As discussed in the context of Recommendation 3, many practices will not be in a position to move quickly into PCPM arrangements that use Category 4 PBP. It is therefore important for payers and practices to collaborate on targeted gainsharing approaches to managing TCOC, which do not entail the same level of financial risk as broader surrogate markers of TCOC management. For example, targeted gainsharing of savings on pharmacy and hospitalization costs could provide a smoother "on-ramp" for practices that are at the early stages of transitioning to PCPMs.
5) As discussed in the context of Recommendation 15, benefit designs that impose high out-of-pocket costs on patients who seek primary care may diminish access to services that improve outcomes and reduce costs over the long term. Such benefit designs are contrary to the goal of prevention, and may result in higher spending if the design has the unintended consequence of driving increased hospital visits. Any benefit design that creates disincentives to seek high-value

primary care is not consistent with the principles for PCPMs that are captured in the White Paper. It is therefore important that payers, providers, purchasers, and patients collaborate on approaches to benefit design that do not create out-of-pocket expense barriers to primary care. We encourage payers to incorporate a benefit design that provides positive incentives to receive higher-value care.

Conclusion

The Work Group is committed to the concept of using PCPMs to transform the practice of primary care, as part of a broader effort to achieve better quality and outcomes and lower costs. The recommendations in this White Paper lay out an approach to PCPMs that can be used nationally by commercial and public payers. The Work Group believes that over time, alignment between public and private programs is highly desirable, and that the principles and recommendations set forth in this paper can be used to drive such alignment.

Appendix A: Roster

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Appendix B: LAN Related Content

The LAN has written a suite of papers to help align payment reform efforts. The first, the Alternative Payment Model Framework, describes four categories of alternative payment models. The papers referred to in this appendix include recommendations on the design of two payment reforms, population-based payments and clinical episode payments, from the two most comprehensive categories defined in that framework.

These recommendations are the result of input from a wide variety of persons and organizations with either direct experience with implementing one or the other payment reform or deep experience in the health care field.

CAMH convened two Work Groups, the Population-Based Payment (PBP) Work Group and the Clinical Episode Payment (CEP) Work Group, to develop recommendations for the implementation of population-based payment and clinical episode payment models. Their recommendations focus on specific design elements, many of which overlap and upon which there was much common agreement even as the Work Groups deliberated separately. Each of the four PBP White Papers described below focuses on a separate design element (financial benchmarking, patient attribution, performance measurement, and data sharing) in a PBP context. In a PBP arrangement, an accountable entity takes responsibility for the care for a defined population over a specified period of time (typically a year) for the full continuum of care.

These design elements should be considered as a whole for effective PBP implementation as they interact considerably. For example, to determine the financial benchmark, it is critical to know precisely which patients are being attributed to the PBP model. Further, most PBP initiatives will require performance on certain measures to be one factor in considering whether the accountable entity has met the benchmark. Data sharing is critical for the providers to effectively target their efforts, for payers and purchasers to monitor performance, and for patients to be empowered to be active in their care.

The CEP Work Group also divided their recommendations into design elements, but included several operational considerations along with 10 design elements. The recommendations were organized in chapters in the comprehensive White Paper and applied to three clinical areas where clinical episode payment models would be most effective: elective joint replacement, maternity care, and coronary artery disease (CAD). While the clinical focus is more targeted here, the underlying concepts for setting the episode price (including the level and type of risk), defining the population and services included in the episode, patient engagement and quality metrics, and the data infrastructure are similar to those of the four PBP White Papers.

The following provides links and a brief overview of each of the papers written by the LAN Work Groups. By reading the full suite of products, readers of this paper will be better able to make decisions about the most effective payment model(s) to implement and the key issues to consider when designing those models. Visit our website (https://www.hcp-lan.org) for an up-to-date list of LAN work products and for a glossary of terms. *(Last updated 6/27/2016)*

Population-Based Payment (PBP) Models:

Accelerating and Aligning Population-Based Payment (PBP): Patient Attribution

The Patient Attribution White Paper describes the method by which patient populations are assigned to providers who are accountable for total cost of care and quality outcomes for their designated populations in a PBP model. The paper recommends that active, intentional identification, or self-reporting by patients, should be considered first. The paper also outlines nine additional recommendations that payers and providers can use when making decisions on attribution in their PBP models.

Accelerating and Aligning Population-Based Payment (PBP): Financial Benchmarking

The Financial Benchmarking White Paper describes approaches for setting an initial benchmark and updates over time, as well as addresses risk-adjustment considerations. The White Paper discusses the need to balance voluntary participation with the movement toward convergence in a market with providers at different starting points.

Accelerating and Aligning Population-Based Payment (PBP): Data Sharing

The Data Sharing White Paper offers several guiding principles and recommendations that highlight the future development of data sharing arrangements in PBP models. The paper also outlines use cases for data sharing which describe particular types of data sharing arrangements, in both their current and aspirational states. The goal is to create an environment where data follows the patient and is available to stakeholders (patients, providers, purchasers, and payers) in a timely manner.

Accelerating and Aligning Population-Based Payment (PBP): Performance Measurement

The Performance Measurement White Paper offers both short-term action recommendations and a long-term vision for accelerating alignment around APMs. The paper offers a way forward that could lead to radical change in how performance is measured across the board in order to enable the implementation of effective population-based payments. The White Paper describes how to evolve from granular measurement systems of the full continuum of care, which focus on narrow and specific care processes, to more macro-level measurement systems oriented on outcomes. The paper also makes strong recommendations for immediate action steps by describing four key performance measurement principles and seven recommendations for building and sustaining a performance measurement system that supports and encourages collaboration among stakeholders.

Clinical Episode Payment (CEP) Models:

Accelerating and Aligning Selected Clinical Episode Payment (CEP) Models

This paper provides high-level recommendations for designing clinical episode payment models. A clinical episode payment is a bundled payment for a set of services that occur over time and across settings. The paper outlines design elements and operational considerations for three selected clinical areas: elective joint replacement, maternity care, and coronary artery disease. Recommendations are organized according to design elements and operational considerations. Design elements address questions stakeholders must consider when designing an episode payment model, including the definition, the duration of the episode, what services are to be included, and others. Operational

considerations relate to implementing an episode payment model, including the roles and perspectives of stakeholders, data infrastructure issues, and the regulatory environment in which APMs must operate.

Several key principles drove the development of the recommendations across all three episodes: 1) incentivizing person-centered care; 2) improving patient outcomes through effective care coordination; 3) rewarding high value care by incentivizing providers and patients, together with their family caregivers, to discuss the appropriateness of procedures; and 4) reducing unnecessary costs to the patient and the health care system.

The recommendations are designed to speak to a multi-stakeholder audience with the goal of supporting broad clinical episode payment adoption.

Elective Joint Replacement

The elective joint replacement recommendations emphasize using functional status assessments (both pre- and post-procedure) and shared decision-making tools to determine whether a joint replacement is the appropriate treatment for a given patient.

Maternity Care

The maternity care recommendations emphasize the need for patient engagement, education, and parenting support services (in addition to clinical maternity care), to achieve a number of critical goals. These include increasing the percentage of full-term births and the percentage of vaginal births, while decreasing the percentage of pre-term and early elective births, complications, and mortality.

Coronary Artery Disease

The coronary artery disease (CAD) recommendations are based on a CAD condition-level episode, which includes a "nested" bundle for procedures like percutaneous coronary intervention (PCI) and coronary artery bypass graft (CABG). The recommendations emphasize overall condition management designed to reduce the need for procedures, and strong coordination and communication between the surgeons who perform cardiac procedures and the providers who deliver follow-up and long-term cardiac care.

Appendix C: Principles for Patient- and Family-Centered Payment

The following principles, produced by the LAN's Consumer and Patient Affinity Group, are intended to help guide the development of new payment strategies. They provide guidance and aspirational direction to ensure that we address the needs and priorities of patients and families as we transition to value-based payment. The principles rest on the conviction that consumers, patients, and families are essential partners in every aspect of transforming health care and improving health.

Consumers, patients, families, and their advocates should be collaboratively engaged in all aspects of design, implementation, and evaluation of payment and care models, and they should be engaged as partners in their own care.

The collaboration in design of payment and care models should include oversight, governance, and interface with the communities where care is delivered. At the point of care, patients and families should be engaged in ways that match their needs, capacities, and preferences. Collaborative care should be aligned with patient goals, values, and preferences (including language), and should reflect shared care planning and decision-making throughout the care continuum.

Positive impact on patient care and health should be paramount.

The central consideration in all payment design should be improving patient health outcomes, experience of care, and health equity, while also ensuring the most effective use of health care resources.

Measures of performance and impact should be meaningful, actionable, and transparent to consumers, patients, and family caregivers.

New payment models should be assessed using measures that are meaningful to patients and families. They should prioritize the use of measures derived from patient-generated data that address both care experience and outcomes. Measures should also address the full spectrum of care, care continuity, and overall performance of specific models. Measures should be granular enough to enable patients to make informed decisions about providers and treatments.

Primary care services are foundational and must be effectively coordinated with all other aspects of care.

Payment models should foster this coordination, particularly between primary and specialty care, in order to promote: optimal coordination, communication, and continuity of care; trusted relationships between clinicians and patients/families; concordance with patient goals, values, and preferences; integration of non-clinical factors and community supports; and coordination of services delivered through non-traditional settings and modalities that meet patient needs. Effective delivery and coordination of primary care services should promote better care experience, optimal patient engagement, better health outcomes, and increased health equity.

Health equity and care for high-need populations must be improved.

New payment models should foster health equity, including access to innovative approaches to care and preventing any discrimination in care. They should collect data that allow for assessment of differential impacts and the identification and redress of disparities in health, health outcomes, care experience, access, and affordability.

Patient and family engagement and activation should be supported by technology.

New payment models should promote use of information technology that enables patients and their designated caregivers to easily access their health information in a meaningful format that enables them to use the information to better manage and coordinate their care. The technology should also enable patients to contribute information and communicate with their providers, and it should foster the patient-clinician partnership in ongoing monitoring and management of health and care.

Financial incentives used in all models should be transparent and promote better quality as well as lower costs.

Financial incentives for providers and patients should be fully disclosed so that patients and consumers understand how new payment approaches differ from traditional fee-for-service models, and how certain incentives may impact the care providers recommend or provide. Financial incentives should be developed in partnership with patients and consumers in order to reflect how patients define value, and to reduce financial barriers to needed care and ensure that patients are not steered to lower-cost care without regard for quality.

Appendix D: About the CMS Alliance to Modernize Healthcare

The Centers for Medicare & Medicaid Services (CMS) sponsors the CMS Alliance to Modernize Healthcare (CAMH), the first federally funded research and development center (FFRDC) dedicated to strengthening our nation's health care system. The CAMH FFRDC enables CMS, the Department of Health and Human Services (HHS), and other government entities to access unbiased research, advice, guidance, and analysis to solve complex business, policy, technology, and operational challenges in health mission areas. The FFRDC objectively analyzes long-term health system problems, addresses complex technical questions, and generates creative and cost-effective solutions in strategic areas such as quality of care, new payment models, and business transformation.

Formally established under Federal Acquisition Regulation (FAR) Part 35.017, FFRDCs meet special, long-term research and development needs integral to the mission of the sponsoring agency—work that existing in-house or commercial contractor resources cannot fulfill as effectively. FFRDCs operate in the public interest, free from conflicts of interest, and are managed and/or administered by not-for-profit organizations, universities, or industrial firms as separate operating units. The CAMH FFRDC applies a combination of large-scale enterprise systems engineering and specialized health subject matter expertise to achieve the strategic objectives of CMS, HHS, and other government organizations charged with health-related missions. As a trusted, not-for-profit adviser, the CAMH FFRDC has access (beyond what is allowed in normal contractual relationships) to government and supplier data, including sensitive and proprietary data, and to employees and government facilities and equipment that support health missions.

CMS conducted a competitive acquisition in 2012 and awarded the CAMH FFRDC contract to The MITRE Corporation (MITRE). MITRE operates the CAMH FFRDC in partnership with CMS and HHS, and maintains a collaborative alliance of partners from nonprofits, academia, and industry. This alliance provides specialized expertise, health capabilities, and innovative solutions to transform delivery of the nation's health care services. Government organizations and other entities have ready access to this network of partners, including RAND Health, the Brookings Institution, and other leading health care organizations. This includes select qualified small and disadvantaged businesses. The FFRDC is open to all CMS and HHS Operating Divisions and Staff Divisions. In addition, government entities outside of CMS and HHS can use the FFRDC with the permission of CMS, CAMH's primary sponsor.

Appendix E: References

Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. (2016). APM framework final white paper. Retrieved from https://hcp-lan.org/workproducts/apm-whitepaper.pdf

American Academy of Family Physicians. (2016a). Primary care. Retrieved from http://www.aafp.org/about/policies/all/primary-care.html

American Academy of Family Physicians. (2016b). Direct primary care. Retrieved from http://www.aafp.org/practice-management/payment/dpc.html

Bodenheimer, T. & Bauer, L. (2016). Rethinking the primary care workforce: An expanded role for nurses. *New England Journal of Medicine*, *375*(11), 1015-1017.

Centers for Medicare & Medicaid Services. (2016, September 9). Comprehensive primary care plus. Retrieved from https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Centers for Medicare & Medicaid Services. (n.d.). PACE. Retrieved from https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html

Chung, H., Rostanski, N., Glassberg, H., & Pincus, H. (2015). Advancing integration of behavioral health into primary care: A continuum-based framework. United Hospital Fund. Retrieved from https://www.uhfnyc.org/publications/881131

Institute of Medicine of the National Academies. (2014). Capturing social and behavioral domains and measures in electronic health records: Phase 2. Retrieved from https://www.nap.edu/catalog/18951/capturing-social-and-behavioral-domains-and-measures-in-electronic-health-records

Katon, W.J., Lin, E.H.B., Von Korff, M., Ciechanowski, P., Ludman, E.J., Young, B., McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *New England Journal of Medicine*, *363*(27), 2611-2620.

Martin, S.R. (2016). Presentation to the PCPM Work Group on behalf of the American Academy of Family Physicians.

Muhlestein, D. & Smith, N. (2016). Physician consolidation: Rapid movement from small to large group practices, 2013–15. *Health Affairs*, *35*(9), 1638-1642.

National Business Group on Health. (2016, March). The primary care imperative: New evidence shows importance of investing in patient-centered medical homes. Retrieved from http://www.businessgrouphealth.org/resources/topics/primary_care_imperative_file2.cfm

Newcomer, R., Harrington, C., & Kane, R. (2002). Challenges and accomplishments of the second-generation social health maintenance organization. *The Gerontologist*, *42*(6), 843-852.

Pincus, H., Jun, M., Franx, G., van der Feltz-Cornelis, C., Ito, H., & Mossialos, E. (2015). How can we link general medical and behavioral health care? International models for practice and policy. *Psychiatric Services, 66*(8), 775-777.

Primary Care Patient-Centered Collaborative. (2015). Defining the medical home. Retrieved from https://www.pcpcc.org/about/medical-home

Robert Wood Johnson Foundation. (2016). What is OpenNotes? Retrieved from http://www.opennotes.org/about-opennotes/

Swartz, K. (2010). Cost-sharing: Effects on spending and outcomes. Robert Wood Johnson Foundation. Retrieved from http://www.rwjf.org/en/library/research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html

Thompson, T. (2002). Evaluation results for the social/health maintenance organization II demonstration. Retrieved from https://innovation.cms.gov/Files/Migrated-Medicare-Demonstration-x/SHMO_Report.pdf

UnitedHealth Group Center for Health Reform and Modernization. (2014). Advancing primary care delivery: Practical, proven, and scalable approaches. Retrieved from http://www.unitedhealthgroup.com/~/media/UHG/PDF/2014/UNH-Primary-Care-Report-Advancing-Primary-Care-Delivery.ashx

University of Michigan Center for Value-Based Insurance Design. (2012). The evidence for V-BID: Validating an intuitive concept. Retrieved from http://vbidcenter.org/the-evidence-for-v-bid-validating-an-intuitive-concept/

Woolhandler, S., & Himmelstein, D. U. (2014). Administrative work consumes one-sixth of US physicians' working hours and lowers their career satisfaction. Retrieved from http://org.salsalabs.com/o/307/images/Physician%20admin%20time_IJHS.pdf

Yordy, K. D., & Vanselow, N. A. (Eds.). (1994). *Defining primary care: An interim report*. National Academies Press.