NATIONAL ACADEMIES Sciences Engineering Medicine

Pay PCPs and Advanced Primary Care Management (APCM) Session

Standing Committee Responses

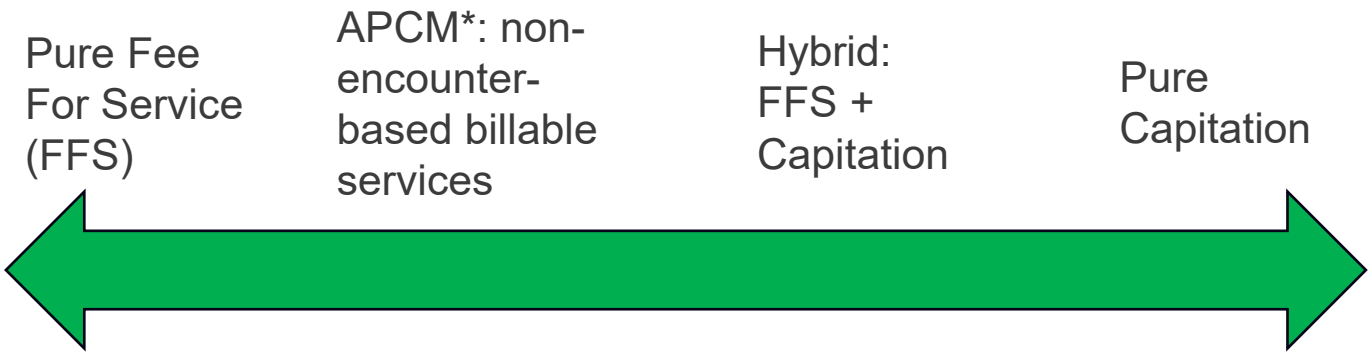
Primary Care Alternative Payment Models

- Broad recognition of limitations of fee-for-service payment method for advanced primary care
  - e.g., team care, services that are not visit-based

- Regulatory changes proposed by Center for Medicare and Medicaid Services (CMS) for Medicare payment
  - New Advanced Primary Care Management billing codes effective Jan 2025
  - Consideration of a hybrid payment model

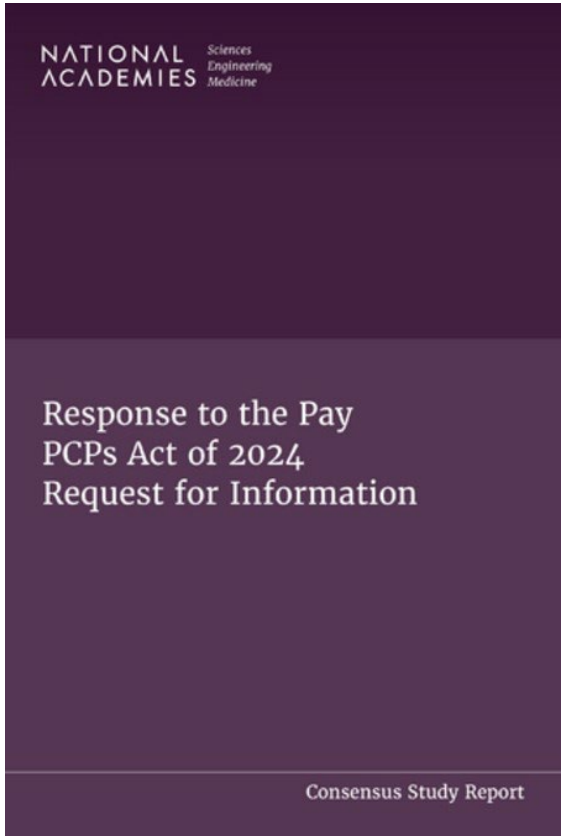
- Pay PCPs Act (S.4338 introduced by Senators Whitehouse and Cassidy)
  - Legislation to authorize hybrid primary care payment

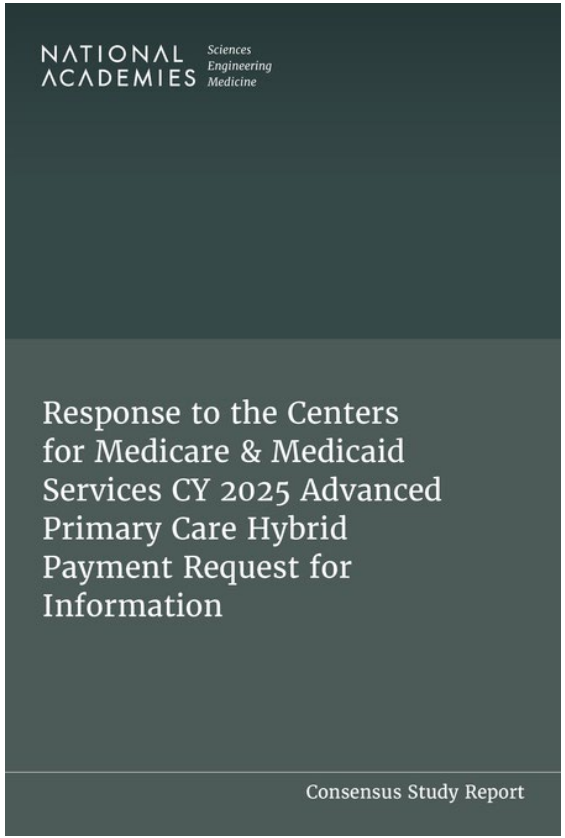
The Primary Care Payment Spectrum



*Advanced Primary Care Management CPT codes

Standing Committee Reports Responding to RFIs





Cross Cutting Themes for Both RFIs and Committee Reports

1. Consent and attribution process for non-encounter based payments
2. Beneficiary cost-sharing
3. Services to be included in alternative payment vs remaining as FFS
4. Ensuring accountability for advanced primary care without imposing undue administrative burden
5. Valuation of services under alternative models

CMS Proposed Advanced Primary Care Management (APCM)

"To strengthen the primary care infrastructure within FFS [fee-for-service] Medicare, we are exploring opportunities to create new sustainable pathways to support advanced primary care, equitable access to high-quality primary care, and continued transformation among a wide variety of practices… creation and ongoing refinement of specific billing and coding under the PFS [physician fee schedule] that better recognizes advanced primary care and incorporates the resources involved in furnishing longitudinal care and maintaining relationships with patients over time."

GPCM1, GPCM2, and GPCM3

- Payment for patients with traditional Medicare (not Medicare Advantage) who consent to receive APCM services
- May be billed as often as monthly if can document APCM capability; no encounter needed to bill in a given month
- Level 1 APCM: patients with ≤1 chronic conditions, 0.25 relative value units (RVUs) (~$15).
- Level 2 APCM: patients with ≥2 chronic conditions, 0.77 RVUs (~$50).
- Level 3 ACPM: qualified Medicare beneficiaries (e.g., dual Medicare/Medicaid) with ≥2 chronic conditions,1.67 RVUs (~$110).

10 Elements of APCM

1. Consent
2. Initiating visits for new patients
3. 24/7 access to care and care continuity
4. Comprehensive care management
5. Patient-centered comprehensive care plan
6. Management of care transitions
7. Practitioner, home-based, and community-based care coordination
8. Enhanced communication opportunities
9. Patient population-level management
10. Performance measurement

Committee Recommendation - ACPM

- Proposed APCM services aligns well with NASEM, 2021
  - Transitions to hybrid payment, increases PC payment, can improve high-quality primary care delivery
- Recommendation: CMS should use APCM payments and policies as a tool to expand the primary care workforce, increase access to advanced primary care for Medicare beneficiaries, and transform more primary care practices to advanced primary care practices.

Committee Recommendation - ACPM

- CMS should develop educational materials for beneficiaries and interprofessional team members to proactively teach the elements of advanced primary care and those services that should be included as part of APCM. This would help with consent which can establish attribution and create a social contract on services to be delivered.

Committee Recommendations: Expanding Hybrid Payment to Primary Care

- CMS could expand advanced primary care management services to create a future primary care hybrid payment model with greater prospective payment.
- Expanded hybrid payment could bundle monthly payment for: (1) APCM services; (2) an annual wellness visit or chronic care management visit to create personalized care plans and to establish attribution; (3) additional care management services, communications, and interprofessional team member services not currently reimbursed under fee-for-service; (4) a fixed number of behavioral health and social care visits; and (5) informatics for remote monitoring, telehealth, and advanced analytics services.

Committee Recommendations: Valuing and Billing

- CMS should rely on empirically collected data for time and practice expense calculations to help determine hybrid payment rates rather than information presented by the Relative Value Scale Update Committee (RUC) – including time spent in the electronic health record
- CMS should waive cost sharing for APCM and future hybrid payments that are critical for delivering high-value advanced primary care, which will require legislative action

Committee Recommendations: Risk and Quality

- Risk adjustment method for the proposed hybrid payment model should include a few basic demographic characteristics such as age and gender and heavily weight social factors predictive of high need for primary care services using place-based measures and geocoding of beneficiary residence to census block
- Quality measures should be about patient experience and key functional attributes of primary care (e.g., continuity, comprehensiveness, coordination, and access)

Response to the Pay PCPs Act Request for Information

- RFI included questions across 5 domains
  - Hybrid payments for Primary Care Physicians
  - Risk adjustment
  - Quality measurement
  - Included services under hybrid payments
  - Technical advisory committee to help CMS value services more accurately

Committee recommendations

- Hybrid payment
  - CMS prioritize voluntary attribution when possible, and using claims-based measures when voluntary attribution is not possible or feasible
  - Services from non-attributed providers remain FFS, while attributed providers should receive hybrid payments
- Risk-Adjustment
  - Risk adjustment for prospective payments should be based on select demographic measures and social factors predictive of high-need of primary care services. Social factors should only be considered if they lead to an upward adjustment

Committee recommendations

- Quality measurement
  - Use the Person-Centered Primary Care Measure (PC-PCM) to capture patient experience
  - Clinical measures should prioritize key PC functions: continuity, comprehensiveness, coordination, and access and not disease-specific measures
  - Referrals should not be a measure but equity should be;
  - Measures should parsimonious and use claims-based data when possible to minimize burden

Committee recommendations

- Included services in hybrid models
  - In addition to what the draft legislation proposed (behavioral health, care management, communications), the committee recommends specifying that services delivered by all members of the primary care interprofessional team be included in hybrid models.
- Technical advisory committee to help CMS more accurately determine fee schedule rates
  - Include specialties, interprofessional primary care team-members, health IT/AI experts, health economists, national and state-level policy researchers and methodologists
  - FACA-compliant, rely on empirically collected data where possible, have a clear process for revisiting and revising previous determinations

Common Themes for Discussion

1. Consent and attribution process for non-encounter based payments
2. Beneficiary cost-sharing
3. Services to be included in alternative payment vs remaining as FFS
4. Ensuring accountability for advanced primary care without imposing undue administrative burden
5. Valuation of services under alternative models
6. How to support practice transformation and advanced primary care for all patients in a practice when Medicare hybrid payments only apply to small share of patients

Panelists

- Carrie Colla, PhD, *Susan J. and Richard M. Levy Distinguished Professor, Dartmouth Institute for Health Policy and Practice*
- Sanjay Basu, MD, PhD, *Co-Founder and Head of Clinical, Waymark*
- Sophia Tripoli, MPH, *Senior Director of Health Policy, Families USA*