

FMAHealth Comprehensive Primary Care Payment Calculator User's Guide

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Disclaimer: Information provided in connection with this calculator by FMAHealth and its contributors is not a suggestion, invitation, direction or recommendation with respect to what you should charge or what your reimbursement rates should be for your services. Those determinations must be made by each physician or practice based on your own costs, patient population, regional and/or practice-specific circumstances, business judgment, negotiations with payers, and other factors within your discretion. This information is intended to increase the quality and availability of care and services for patients and to enhance, not suppress, competition for such services.

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I. OVERVIEW

The Comprehensive Primary Care Payment (CPCP) model was developed from a research study by Family Medicine for America's Health (FMAHealth <http://fmahealth.org>) to examine the efficacy, challenges and successes of value-based primary care payment models currently in use in the U.S. The resulting recommendations provide a framework and justification for critical components of a CPCP model. This methodology applies these recommendations by calculating a payment rate that is driven by current fee-for-service payment history and then applying 4 modifiers. These modifiers adjust the base rate to account for patient risk and social determinants of health for the population in question. They also provide further adjustments for quality, efficiency, and infrastructure for the primary care provider in question. The model is built on the assumption that to achieve the goals of the Triple Aim, primary care practices must transform to a medical home team-based model, and that there must be a commensurate reimbursement model to support the practices.

The purpose of this model is to assist provider groups and payers in the evaluation of comprehensive payment models for primary care and to provide a framework for implementing this type of model. Entities using this model are encouraged to model many different scenarios in order to understand the drivers of the model outputs given the particulars of their business and their goals. Successful entities will use this model to drive conversations with their partners about how a mutually beneficial comprehensive payment model would be structured and fine-tuned.

Below is summary of the key components of the model. It is broken out into a base rate and 4 additive modifiers. Some input data types are based on exact measurements (such as claims costs), will others are based on categorical data with thresholds (such as the quality and efficiency metrics).

Figure 1. CPCP Model Overview



II. DATA REQUIREMENTS

In order to generate a CPCP model estimate, the data elements listed below are needed. If the user does not have access to all of the information needed, estimate the data elements from the best information available. The following section references the Excel line numbers for each entry in the Inputs and Results tab of the CPCP Calculator. Note that in the calculator, user-entered fields are highlighted in green.

Figure 2 on the following page provides a set of default values that the calculator is packaged with. These values can be used as a starting point for a CPCP simulation, and can be used as defaults in the absence of actual or estimated values.

Figure 2. Default Values

Area	Parameter	Default Value	Required
Patient Population	Commercial, Medicaid, Medicare Members	Total >= 5,000	Y
	Commercial, Medicaid, Medicare Growth Trends	3%	N
Practice Revenue	Commercial PMPM	\$35.00	Y
	Commercial Trend	5%	N
	Medicaid PMPM	\$42.00	Y
	Medicaid Trend	5%	N
	Medicare PMPM	\$45.00	Y
	Medicare Trend	5%	N
Population Risk	25 th Percentile	30%	Y
	25 th -75 th Percentile	50%	Y
	75 th -95 th Percentile	15%	Y
	>95 th Percentile	5%	Y
Quality Metrics	Number of Measures	10	N
	Number Compliant	7	N
ACSC Metrics	Number of Measures	7	N
	Number Compliant	5	N
Potentially Avoidable ED	Number of Measures	1	N
	Number Compliant	1	N
Physician Access/Practice Patterns	Number of Measures	3	N
	Number Compliant	2	N
Infrastructure Assessment	Number of Measures	4	N
	Number Compliant	3	N

III. QUICK START GUIDE

Below is a summarized version of the calculator user instructions. These instructions can be used as a quick start guide to operating the calculator and creating a CPCP simulation.

1. Enter the practice name on line 13.
 - a. Under Practice Name, enter the name of the practice or practice group to be modeled.
2. Use the drop down to enter the region on line 14.
 - a. Use the Practice Region drop downs to specify the major U.S. region in which the practice group is located.
3. Use the drop down to enter the State-County on line 15.
 - a. Further specify the State and County which best describes the geographical centralization of the population.
4. Enter the number of commercial patients/members for each payer on lines 21-23.
 - a. Under Patient Population, enter the current number of total patients paneled to or attributable to this practice or practice group which are being modeled for a CPCP payment program. If the precise numbers of Commercial, Medicare and Medicaid members are not known, the total population can be rolled up under Commercial.
5. Enter the number of Medicaid MCO or FFS patients/members on lines 25-26.
 - a. If unknown, just confirm total patients/members on the commercial line
6. Enter the number of Medicare MCO or FFS patients/members on lines 28-29.
 - a. If unknown, just confirm total patients/members on the commercial line
7. Enter the expected population growth trend for commercial, Medicaid and Medicare on lines 32-34.

- a. Under trend, enter the annualized historical growth rate for the population. This is used to estimate the population growth in the next annualized period under consideration. For example, we may use a total population for CY 2016, and calculate the annualized growth trend from 2015 to 2016. Lines 21-23 allow the user to specify commercial populations for up to 3 payers. Lines 25-26 can be used to specify MCO or FFS Medicaid populations, and similarly for Medicare on lines 28-29. Finally, lines 32-34 are used to specify the approximate growth trends for the commercial, Medicare and Medicaid segments. If no substantial growth has been observed or is expected, set them to 0%.
8. Enter the commercial primary care PMPM (commercial revenue divided by member months) on line 42, with trend on line 43.
 - a. Under Primary Care Revenue, enter the total paid amount PMPM for the most recent 12-month period, broken out for Medicaid members. Estimate the associated practice revenue PMPM by dividing the annualized FFS practice revenue associated with population of interest by the annualized number of member months (estimated by multiplying the average number of total patients by 12). Finally, enter the estimated medical expense trend experienced by the population of interest.
Similarly, lines 42-43 are used to enter the Primary Care PMPM received through FFS or other reimbursement. This can be approximated by dividing the total primary care revenue by the member months. The trend field captures the observed or expected growth in this rate.
Lines 45-46 are used to enter the same data for Medicaid, and lines 48-49 for Medicare, if applicable.
9. Enter the Medicaid primary care PMPM (Medicaid revenue divided by member months) on line 44, with trend on line 45.
10. Enter the Medicare primary care PMPM (Medicare revenue divided by member months) on line 48, with trend on line 49.
11. Enter the risk percentile proportions in lines 55-58.
 - a. In order to estimate the population risk profile, generate a percentile breakout using the following percentile cut-points: Tier 1: < 25th, Tier 2: 25th – 75th, Tier 3: 75th – 95th, Tier 4: > 95th.
 - b. In the model, under Population Risk Adjustment, enter the percentile of the population that falls into each risk strata based on the current age-sex-diagnosis model in use for risk adjustment purposes. In Year 2, enter the expected migration (if any) of these risk percentiles. If no migration is expected, in other words, if the risk profile of the population is not expected to change, enter the same percentiles used in the baseline.
12. Navigate to the Performance Measures tab and enter a “1” in the Include column next to each measure to be included in the domain. For measures either pre-evaluated or expected to be evaluated at or above the agreed-upon threshold, enter a “1” in the Compliant column.
 - a. For measures either pre-evaluated or expected to be evaluated at or above the agreed-upon threshold, enter a “1” in the Compliant column. Leave all other cells empty. The summary and gating methodology is applied automatically and updated in the Inputs and Results tab. You can view these summary results in lines 62-76 of the Inputs and Results tab.
13. Return to the Inputs and Results tab and view the results beginning on line 78.

IV. RESULTS AND INTERPRETATION

A. CPCP Calculation Example

Figure 3 below is an example of a report produced by the calculator. The results include a breakdown of the base rate and modifier adjustments on a PMPM basis, and a graphical comparison to the current reimbursement level. The practice revenue comparison chart provides a graphical comparison of the traditional model in the baseline and the CPCP model under evaluation.

Figure 3. CPCP Report Example



B. Interpretation

In the example above, the Estimated CPCP PMPM Payment represents the fully adjusted monthly rate for this practice. Research indicates that this type of global payment model, paid prospectively for comprehensive patient care drives improvements in efficiency of care, improves quality of care and reduces total cost of care. This model provides the ability to assess the revenue to a practice under a CPCP contract vs current FFS payment. A practice can use this estimated revenue to design staffing models to support a team based performance driven clinic.

The model is based on a Total Cost of Care (TCOC) target between 10-12%. If the user's result is lower, then either the base rate is set too low or the modifiers are under-estimated. If it is higher than this range, then the model is over-estimating the reimbursement rate and either the base rate or modifiers should be re-evaluated to bring the Percentage of TCOC to within this range.

The output of this model can be used between payers and providers as a starting point to move primary care reimbursement away from FFS and to a value and performance based model that supports total patient care as well as measurable quality and system efficiency. While the model calls for an increased investment in primary care, this investment is strategic and purposeful. For physicians, this model creates the opportunity to be reimbursed for practice patterns and care objectives that benefit the patient as well as the healthcare system. Physicians or practice groups participating in a CPCP contract should see their revenue and professional satisfaction improve in proportion to their commitment to the principles driving this model.

This alternative payment model is designed to support these goals by creating complementary incentives between payers and providers. The model itself is designed as a flexible framework and can be adjusted by both payers and providers for a wide variety of populations, geographies, and existing contracting arrangements. The goal is to stimulate conversation between stakeholders to develop CPCP payment contracts. Further, FMAHealth encourages payers and providers to expand, enhance and disseminate thoughts on CPCP payment methodologies.

V. DEFINITIONS

Accountable Care Organization (ACO). Groups of doctors, hospitals and other health care providers who come together voluntarily to give coordinated high-quality care to their patients under advanced practice facilitation and care coordination models. These practices typically accept some degree of financial risk associated with the effective management of its patient population and may receive global payments or FFS hybrid payments from payers with which they contract.

Ambulatory Care-Sensitive Conditions (ACSC). A measure set used to assess the age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital.

Area Deprivation Index (ADI). A geographic area-based measure of the socioeconomic deprivation experienced by a neighborhood. Higher index values represent higher levels of deprivation.

Efficiency. Measures and measure sets commonly used to calculate the ratio between the costs of resources used compared to the number of episodes of care rendered to individual patients or the total care provided to a specific population. Efficiency measures are often used to assess the cost-effectiveness of treatment patterns.

FMAHealth. Family Medicine for America's Health is a five-year collaboration sponsored by eight key family medicine organizations in the United States. Its mission is to demonstrate the value of primary care in achieving better health and better care at lower costs for people across the United States while improving the ability of primary care professionals to reach the full potential of professional and personal success that primary care offers. To accomplish its mission, FMAHealth has created seven Tactic Teams that focus on the following critical areas: Practice Transformation, Technology, Research, Payment, Workforce Education and Development, Engagement of Stakeholders, and a Cross-Tactic Team on Reducing Health Disparities. For more information, see <http://fmahealth.org>.

Patient Attribution. The process of empirically assigning patients to physicians by using medical claims to identify the providers that a patient routinely sees. This is done to determine accountability for the patient's conditions and health care expenditures. This approach is often used in PPO markets where patients are not paneled prescriptively.

Patient Centered Medical Home (PCMH). A care delivery model whereby patient treatment is coordinated through their primary care physician. PCMH models rely heavily on team-based care and technological support to streamline clinical operations.

Primary Care Activity Level (PCAL). A bundled payment approach used to estimate the cost of all services that primary care practitioners should provide based on total cost of care patterns. The model uses resources spent on other types of care to signal the need for primary care services.

Quality. Health care quality is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes. Quality measures and measure sets are used to quantify the level of value and safety provided by health care resources.

Risk Adjustment. A statistical process that quantifies the underlying health status and likely future experience of a patient or patient population. Risk models are used to calibrate payments and clinical resources among health plans and other stakeholders based on the relative health of the population.

Social Determinants of Health (SDH). A branch of health services research which seeks to quantify the effect of socioeconomic factors on the ability of a patient or patient population to access and afford services, as well as successfully participate in prescribed treatment plans.

Total Cost of Care (TCOC). All costs associated with treating individuals including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. This total may not include some patient out of pocket costs.