Comments/Suggestions in Response to the 'Roadmap for Strengthening and Sustaining Primary Care' Draft

1/14/22

Regarding the Core Functions and Overall Roadmap

A concern exists that the time needed, per patient, to provide the care outlined in the 11 core functions (pages 7-8) will not be possible without increasing the # of PCPs statewide (which is a goal as well though not a focus of this document). There will also be an inevitable need to increase adjunct staff. Will the State support salaries for recruiting additional nutritionists, behavioral health therapists, social workers, etc which would be "required" services as part of the "core functions" (specifically #4 and #5 on page 7)?

Core function #2 raises the questions of both the availability of such additional resources (non-clinicians and ancillary services) as well payment for these at the outset Will start-up funds be provided adequately to support these additions? Regarding core #4, will there be best practice recommendations of caseload size of these additional personnel designated to these practices? Core #6 refers to plans of care and likely a place for those staff mentioned in core #4 to play a role in enhanced care planning, visit preparation, and visit follow up. In some instances it is the PCP who currently bears the majority of the weight for these components of the visit. Perhaps clarification of how this may look operationally would be helpful. There will also need to be time allotted in the workday for increased partnership between practice staff and the PCPs in order to ensure care planning is optimized.

Page 8 suggests the presence of coaches to support these care delivery model improvements. There may be value in some form of competency to ensure all who are offering coaching/support are doing so in a similar manner to similar standards. Consider the structure of the Certified Content Expert (CCE) program that NCQA has for its PCMH coaches, and that something such as that may be a benefit in this process as well.

And in regards to the comparison of PCMH versus non-PCMH primary care practice requirements for OHS recognition, would there also be a payment differential for practices who maintain an active PCMH recognition. While there is some overlap between the NCQA PCMH standards and these proposed 11 core functions, there is a great deal of work that goes into obtaining and maintaining the PCMH designation, and would that (in this process) be rewarded in some way. Also, would OHS recognition renewal resemble that of a PCMH application, or rather attestations or something else? What would the oversight of granting the OHS recognition look like, such as audits or surveys, and what additional burden would be put on the practices and their administration to demonstrate compliance?

Regarding the Suggested Payment Models

Will practices and physicians/providers have input into the assessment of patient risk (i.e. p13, #6: "risk scores, and associated payment calculations") so that these predetermined values are mutually agreed upon rather than only, or predominantly, determined by payers (as seems to be the case, to date, with ACO models)?

How will patients (especially those with high-deductible plans) be affected with regard to bills they receive? In other words, will payers pass on the potential increased cost to patients (as is almost always the case)? Should there be regulations against this so that payers do not exponentially profit while patients, and practices, assume more financial risk in the process?

To date, most new payment models involve a "carrot and stick" model so to speak . . . i.e. initially physicians/practices/hospitals are rewarded and then with time (usually 1-3 years) those same entities are potentially financially penalized? What is the expectation with regard to the proposed payment models vis a vie their effect on payment to providers/practices in year 1 vs. year 5?

One point of concern is leaving the payment structures entirely up to the payers, so long as they are transparent. I believe it would be ideal to have some degree of enforced 'ground rules' and consistency among the payers while also allowing for some variation in payment design. There is little mention regarding how payers will be accountable to patients/providers/practices other than providing "transparency" with regard to data (as noted on pp 11-13). For this collaborative effort to succeed, I suggest adding language that more clearly delineates how payers, ideally in financial terms (since that would have the greatest impact and influence), will be held accountable to patients and physicians/providers/practices?

Related also is the need for improved patient attribution at the payer level. If a patient has not clearly identified to the payer who their PCP is, the patient is attributed based on frequency of a provider in claims data. For multi-specialty groups such as ours, this poses a significant challenge as so often our data is clouded by incorrectly attributed patients. To date the only way to fix this is to have the patients contact the payers themselves and let them know who is actually their PCP, and efforts to accomplish this are infrequently successful. Incentives would be maximized and more likely realized if we are able to focus on true primary care patients, have a clean denominator by payer for their panels and receive data in a timely (not claims-delayed) manner. The presence of wrongly attributed patients will and does impact how the data is reported and could prevent access to any exceptional performance payments.

And finally, what is the role of the primary care physician/provider with regard to specialist referrals? Page 12, #3 states one potential concern is to avoid "unnecessary utilization of specialist and emergency care" but at the same time we do not want to dis-incentivize PCPs to the point where they fear retribution by (appropriately) referring patients to specialists and/or the emergency department?

Thank you for allowing the opportunity to provide comment, feedback and questions regarding this proposed plan.