

Transcript Details

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ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

The New Value-Based Approach to Primary Care, Part 1

Announcer:

Welcome to Reach MD. The following segment is the first part of a live meeting hosted by the American Medical Association focusing on the New Value-Based Approach to Primary Care. On the podium is Alex Azar, J.D., who is the 24th Secretary of the Department of Health and Human Services. Alex Azar is pursuing four primary objectives; lowering prescription drug prices, bringing an end to the opioid epidemic, changing the way Americans pay for health care, and making individual insurance more affordable and available. And now, here is Alex Azar.

Alex Azar: Thanks to everyone at the AMA for hosting us here today! It's appropriate to be at the headquarters of an organization with such a long history in American medicine. Because I believe that we will look back at what we are announcing today as a historic turning point in American health care. Today's announcement is the culmination of years of work by many at HHS and throughout American health care. When I announced last year that moving toward a value-based health care system would be one of my priorities as secretary, I was well aware that I was at least the fourth HHS secretary to take this issue seriously, dating back through Secretaries Burwell and Sebelius to Secretary Levitt who first laid out the idea of paying for value rather than procedures. It's only thanks to the efforts of my predecessors that we get to take this major step forward. Today could also not be possible without the enthusiastic support of so many physicians and other providers that includes members of HHS's advisory committee on physician-focused payment models (PTAC) a member of which we have here today, my friend, Dr. Kavita Patel. That committee has analyzed a huge number of payment model ideas from physicians who are excited about innovation, their work, including submissions from the American Academy of Family Physicians, the American Academy of Hospice and Palliative Medicine, and the Coalition to Transform Advanced Care, has inspired many significant aspects of the initiative we're announcing today. So, what are we announcing? We're launching CMS Primary Cares. An initiative with two sets of new payment models that are projected to enroll a quarter or more of traditional Medicare beneficiaries and a quarter of providers and arrangements that pay for keeping patients healthy rather than ordering procedures. The Primary Care First path will allow smaller primary care practices to be paid a simple, flat stream of revenue for each patient. When a patient stays healthy and out of the hospital, these practices will get paid a bonus. But, if the patient ends up sicker than expected, these practices will bear responsibility for the extra spending up to a certain share of their practices revenue. The other path, Direct Contracting, is more ambitious and it's aimed at larger practices. Just like in Primary Care First, when patients have a better experience and stay healthier, these practices will make more money. But, if patients end up sicker, Direct Contracting practices will bear the risk for the extra health spending not just at their own practice but throughout the system. Providers will have greater flexibility to spend these resources how they want, allowing them to come up with innovative ways to care for patients and receive significant savings if they keep patients healthier than expected. Within this initiative, we will also have options for providers who want to focus on particular populations and particular serious illnesses where there is a huge potential for better health outcomes and more savings. We're also seeking input on another Direct Contracting model to award a local entity, a contract for an entire geographic area, covering all patients and providers in the area who want to opt into this arrangement. This would provide an unprecedented ability for that local organization to negotiate better rates than Medicare does today, take responsibility for outcomes and provide benefits that work for the local community's needs. Primary care is a small slice of health care spending overall, but it has a significant impact on downstream costs and quality. This initiative will radically elevate the importance of primary care in American medicine, move toward a system where providers are paid for outcomes rather than procedures, and free up doctors to focus on the patients in front of them rather than the paperwork we send them. In just a minute, I am going to turn things over to Administrator Verma. I am sorry to say she is the one who sends the doctors the paperwork, but she has made sure there is a lot less of that paperwork every year. Moving in this direction toward value-based care has been largely just a vision for so long. Now, value-based care is a reality for a quarter of traditional Medicare beneficiaries in primary care and a significant and growing number of patients in other settings as well. This is the pivotal hockey stick

moment in paying for value in American health care. This initiative will lay the groundwork, not just for better care and lower costs in the 700 billion dollar Medicare Program and the 580 billion dollar Medicaid Program, but will also help drive innovation toward a new patient-centered approach in our entire 3.5 trillion dollar health care system. This initiative is specifically designed to encourage State Medicaid Programs and commercial payers to adopt similar approaches. I believe that true transformation is possible because of the experiences that we've gained, but also the bold leadership that we have today. President Trump understands that the American health care system too often takes advantage of the American patient rather than takes care of them and that the government policies have too often gotten in the way of delivering Americans better care at a lower cost. We're not going to fix this overnight. I do have to remind the President of that occasionally. Much more work still lies ahead, but we know where we're going. These models deliver on the vision that we've laid out for value-based care. Four Ps, patients in control as consumers, providers acting as accountable guides through the health care system, payments based on outcomes, and preventing disease before it occurs or progresses. These efforts, like our work on lowering prescription drug prices, promoting price transparency and so much else are not isolated initiatives. They are coordinated steps towards a much bigger vision even broader than value-based care. That vision is a health care system where every American patient feels she's treated like a person, not a number, where your doctor has one focus, not what procedures to order or how to bill you for them, but how to keep you healthy and well. That's the kind of system that can deliver American patients the options and control and that they want, the affordability they need, and the quality they deserve. That's what President Trump has promised American patients and we're delivering a major step toward it today.

Announcer:

You're listening to a live meeting hosted by the American Medical Association focusing on the New Value-Based Approach to Primary Care on Reach MD. You just heard from Dr. Alex Azar, J.D., the 24th Secretary of the Department of Health and Human Services. On the podium now is Administrator of the Centers for Medicare and Medicaid Services, Seema Verma.

Seema Verma: Supporting physicians has been a top priority for the Trump Administration. Over past many years, scores of regulations, CMS regulations, and new laws have created an incredible burden for providers from cumbersome reporting requirements to new mandates for the use of electronic health records designed for billing not patient care, and this has led to increasing clinician burnout and a reduction in the number of independent practices, and it has become more and more difficult to practice medicine. President Trump's commitment to improving quality of health care and lowering costs began with the Cutting the Red Tape Initiative, which was the genesis of the CMS's Patients Over Paperwork effort announced in 2017. This has led to our overall efforts to improve E/M codes, which we continue to work on, and deregulatory actions that have led to savings for providers across our health care system amounting to 5.7 billion dollars and 40 million hours saved through 2021. Patients Over Paperwork is an essential component to the charge that Secretary Azar has given us to remove barriers, to igniting a value-based transformation in the American health care system. The secretary has challenged us to pursue every lever to move our health care system towards one that incentivizes value by rewarding quality, lowering cost, and improving health. Those goals are critical because health care spending in America is on an unsustainable path. By 2027, Americans will spend almost 1 of every 5 dollars on health care and, earlier today, the Medicare Trustees reported that the Medicare Hospital Insurance Trust Fund is projected to be depleted by 2026. Today, our system creates perverse incentives to deliver more care as opposed to care that is focused on preventing disease and improving health outcomes. We need to change the trajectory of health care cost growth and make health care more affordable. Not only to make care more accessible, but to ensure the solvency of Medicare and Medicaid. And, while some have called for a complete government takeover of our health care system, I believe in solutions founded in choice, competition, and innovation. To that end, our innovation center is the testing ground for new payment and service delivery models that improve care and save taxpayer money. Today's announcement creates innovation in primary care that has the potential to entirely transform our fee-for-service system which is about 65% of the Medicare program into one that drives value. Primary care plays an essential role in moving us in a new direction. That's because primary care providers are at the center of our health care system. Gatekeepers that manage health care conditions, coordinate services across multiple systems and providers, responsibilities that have a direct and significant impact on the patient experience, health outcomes and the total cost of care. Most primary care reimbursement, however, continues to be based on the volume of patients they can churn through their office and they generally receive lower salaries than their specialist peers, and they often receive no financial reward for spending more time with complex patients or for preventing unnecessary hospitalizations. In fact, the opposite is true and we want to change that. CMS's primary care initiative is designed to offer clinicians an array of voluntary new payment options that are all designed to reward them for keeping people healthy, improving quality of life, and delivering positive health outcomes. These models are intended to allow clinicians to focus on patient care not billing, and to do what they've been trained to do. Through this initiative we are essentially offering five new payment model options for clinicians because we want to offer choices for providers, understanding that providers are in different places on the road to value. These models build on a number of CMS's primary care models, our work with Medicare ACO's and Next Generation ACO's and this is the next step on our road to value.

Today's models have two paths, Primary Care First and Direct Contracting. While Primary Care First is focused on individual primary

care practices, the DC model is aimed at organizations that have at least 5,000 Medicare fee-for-service beneficiaries. We believe that the road to value needs to have as many lanes as possible. The Primary Care First options will provide participating practices with a predictable payment stream, including a partial cap and some fee-for-service spend. Payments will ultimately be adjusted for performance and reducing hospitalizations and one model option includes an enhanced payment for practices that care for chronic needs of the seriously ill. Under the Direct Contracting options, we will expand our reach to a wider variety of organizations that have experience in taking on full financial risk and serving large patient populations, like ACOs and Medicare Advantage Plans. We have heard from many that there are providers who are ready and willing to take on more risk and we want to provide a venue to do so. These models include a range of options in how payments will be made and how much risk an organization wants to assume from complete responsibility for the total cost of care to a shared risk arrangement. Patients will continue to have access to an open network, but the new models will attract organizations to our Medicare fee-for-service program that have experience in managing primary and patient care, preventing disease, and keeping patients healthy. I want to thank the many providers and organizations who have helped provide input and expertise in the development of these models, in particular, PTAC-the palliative care groups, family physicians, TTAC, our Next Generation ACOs and many others.

Announcer:

You've been listening to Reach MD. The preceding program was the first part of a special live meeting hosted by American Medical Association focusing on the New Value-Based Approach to Primary Care. To download this podcast or to find more episodes in this series, visit ReachMD.com/AMA. This is Reach MD, be part of the knowledge.