

Advancing Primary Care

A Purchaser Playbook for Action



Equipping plan sponsors to seek and support high-value primary care solutions

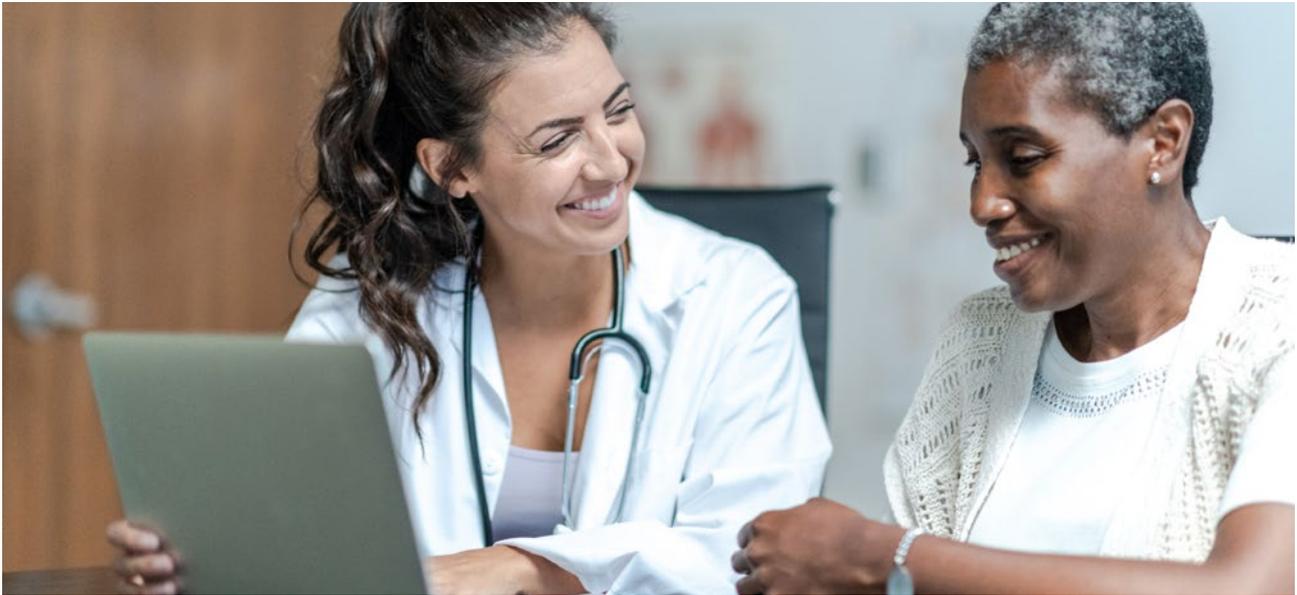


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Introduction

The Promise of Primary Care

While the pandemic has made the extensive shortcomings of our healthcare system impossible to ignore, it has also opened promising opportunities to make meaningful course corrections. Currently under-utilized, primary care has much to contribute to driving a more adaptable, streamlined, efficient system. And *advanced* primary care will improve even further the pathway to ongoing, coordinated, community-aligned, high-value care to better serve all Americans.

Due to early detection and treatment, coordinated care for chronic and complex conditions, and fewer unnecessary and costly visits to specialists and emergency departments, healthcare systems with a strong primary care foundation report:

-  **Better outcomes**
-  **Higher patient satisfaction**
-  **Lower costs**

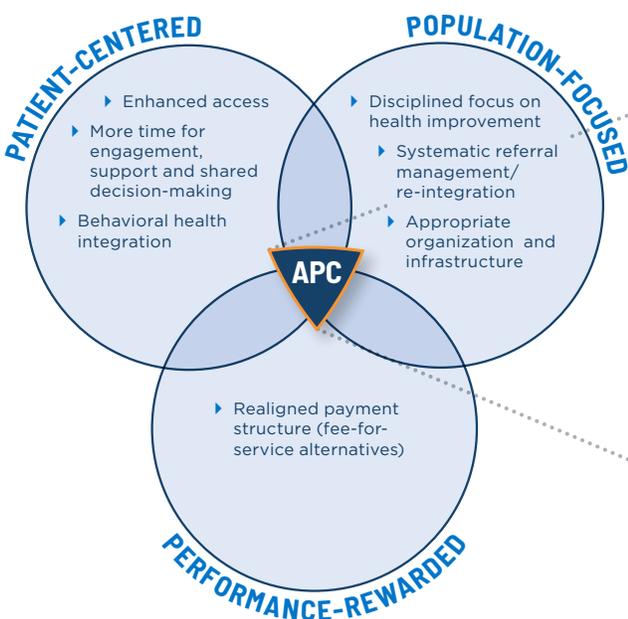
But primary care in the US has suffered due to under-investment and a fee-for-service reimbursement



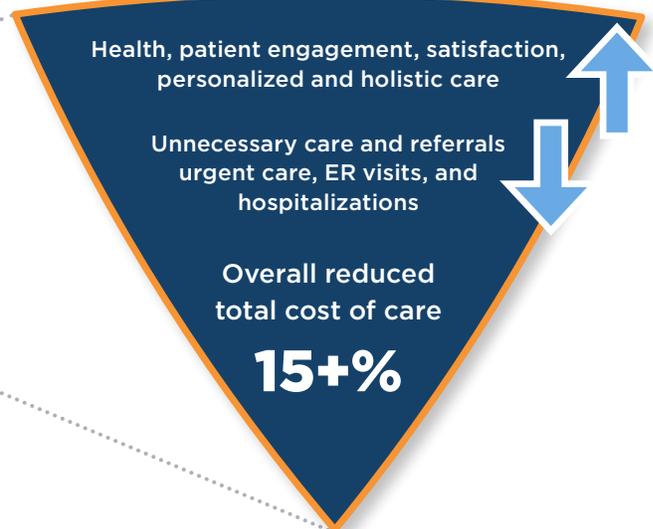
system that is misaligned with the most desirable aspects of primary care, namely:

- ▶ Total-person health (physical, mental, spiritual, financial, family/home, social/cultural)
- ▶ Team-based care
- ▶ Care coordination and integration
- ▶ Interoperable health IT infrastructure

This Playbook promotes the importance of employers and other healthcare purchasers working together to advocate for returning to the core values of primary care and building advanced primary care practices. Advanced primary care (APC) is defined as primary healthcare structured to deliver increased value for patients and purchasers.



THE PROMISE OF APC



Every Healthcare Purchaser Can Make a Difference

Even in the face of everyday healthcare benefits design and management complexities, healthcare purchasers can continue making progress toward improving employee health and wellbeing by reinforcing the importance of primary care/APC.



Communicate frequently. Communicate about the importance of primary care through direct messaging and benefit design, especially during open enrollment, when you can encourage plan participants to choose a primary care provider.



Encourage primary care adoption. Ensure participants have a regular source of primary care, steering them to advanced primary care sites available in your market.



Advocate for investment in primary care. Support increased investment in primary care using population-based approaches (not fee-for-service) and advocate for multi-payer approaches to primary care payment and measurement.



Set forth expectations in RFPs. Do existing RFPs send a signal to health plans that you are serious about improving access to high-value primary care? (See sample RFP questions in Appendix.)



Predictable, Fair Payment for Primary Care is Essential

The current healthcare system largely fails to pay appropriately for primary care. A more balanced payment approach tied to the objectives of APC will contribute to moving the market.

- ▶ Create a predictable and manageable revenue flow
- ▶ Allow for greater investment in the “7 Key Attributes of Advanced Primary Care” (see page 3 for details).

Emerging realigned payment models for APC include four pillars:

- ▶ Prospective payments
- ▶ Comprehensive primary care payment
- ▶ Risk-adjusted
- ▶ Evaluation of performance

Examples of APC payments include:

- ▶ Capitation (full and partial)
- ▶ Global primary care payment (evaluation and management, vaccinations, preventive care/screenings, mental health)
- ▶ Global primary care payment + chronic condition management

Mental Health Integration Matters

Integration of mental health care in primary care is an essential ingredient of APC. When contracting for APC services, the extent to which the organization or practice has systematically integrated appropriate tools and processes is critically important. Primary care clinicians traditionally provided most mental health care. Yet, studies show treatment of mental health conditions in primary care settings falls short of minimal best practice standards as much as 85% of the time. These shortfalls are largely related to the complexity of the fee-for-service billing and coding requirements to build capacity; a shortage of behavioral health practitioners; and the need for improved training for staff and physicians. Purchasers who want to support change can promote and support the use of proven approaches such as the Collaborative Care Model, defined on page 15.

Defining Advanced Primary Care

7 key attributes of APC identified by the National Alliance APC Advisory Committee

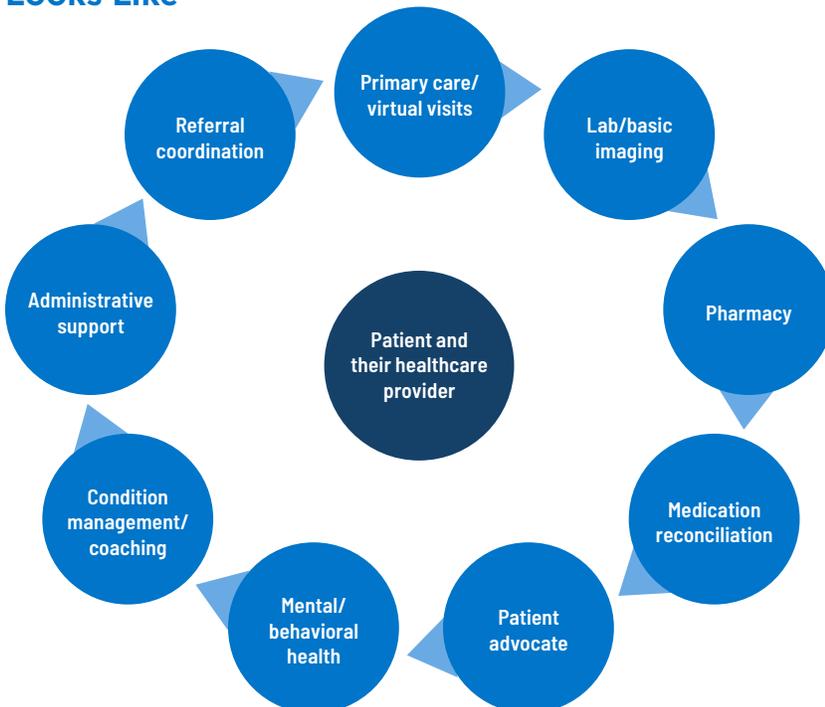
In the traditional fee-for-service primary care model, healthcare providers may be expected to see 25+ patients/day, leading to insufficient time for engagement, a tendency to refer, and high frustration levels for all.

APC is defined as primary healthcare structured to deliver increased value for patients and purchasers. This model can be explored further in a [recent report](https://bit.ly/3liH8NL) from the National Alliance (<https://bit.ly/3liH8NL>)

- 1 Enhanced access for patients**
Convenient access, same day appointments, walk-ins, virtual access, no financial barriers to primary care
- 4 Organizational & infrastructure backbone**
Relevant analytics, reporting and communication, continuous staff training
- 7 Referral Management**
More limited, appropriate and high-quality referral practices, coordination and reintegration of patient care
- 2 Optimize time with patients**
Enhanced patient engagement and support, shared decision-making, understanding preferences, social determinants of health
- 5 Disciplined focus on health improvement**
Risk stratification and population health management, systematic approach to gaps in care
- 3 Realigned payment methods**
Patient-centered experience and outcomes, quality and efficiency metrics, de-emphasize visit volume
- 6 Behavioral Health Integration**
Screening for BH concerns (e.g., depression, anxiety, substance use disorder), and coordination of care



What Integrated, Patient-centric, Primary Care Looks Like



Driving Toward Advanced Primary Care

MARKET
ASSESSMENT

INTERNAL
ASSESSMENT

CONTRACTING &
IMPLEMENTATION

MANAGEMENT,
METRICS & OVERSIGHT



- ▶ **Market assessment.** Understanding your local market(s) and how it aligns nationally is important in developing short- and long-term goals. Tap into health plans, consultants, and other advisors to understand the depth and breadth of primary care and APC options where your employees live and work.



- ▶ **Internal assessment.** Analyze what is in your immediate control—messaging/promotion, benefit design, and analytics. Is it feasible to offer onsite or near-site clinic access?



- ▶ **Contracting and implementation.** Determine the specific features of APC required in these payment/contracts with primary care providers, taking the “7 attributes” into consideration.



- ▶ **Management and metrics.** Taking the quality measures identified during the market assessment, plan sponsors can set forth plans for measuring quality and improvement. This could include utilization goals, financial targets, pay-for-performance measures, and opportunities for improvement, among other goals as appropriate for specific organizations.

Why Primary Care Matters

- ▶ If every American had a regular source of primary care, the US would save an estimated \$67B every year. <https://bit.ly/3iEBO5z>
- ▶ Every \$1 increase in spending on primary care results in \$13 in savings in overall spending. <https://bit.ly/2Yq8ylw>
- ▶ Adults with a primary care doctor have 19% lower odds of premature death than those who see only specialists. <https://bit.ly/3BtVQXy>
- ▶ US adults who have a primary care doctor save 33% on healthcare over their peers who see only specialists. <https://bit.ly/3adImDy>
- ▶ Access to primary care helps keep people of the emergency department ,where care costs at least four times as much as other outpatient care. <https://bit.ly/3Dfnp7v>

What's Happening in the Public Sector?

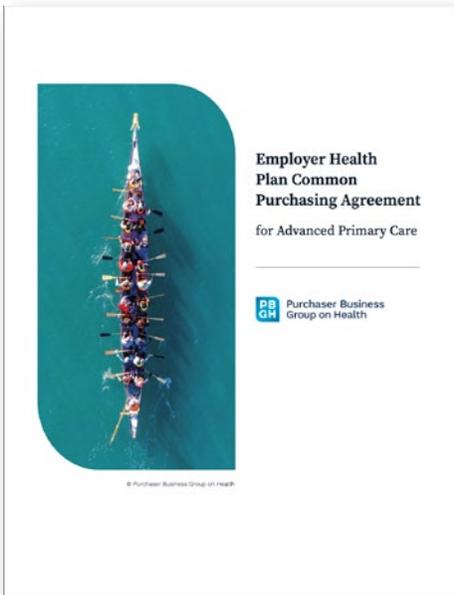
National Academies of Sciences, Engineering, and Medicine (NASEM)

Implementing high-quality primary care: Rebuilding the Foundation of Health Care (GET THE REPORT) <https://bit.ly/3afeOVY>

The collective action of employers and other purchasers will play a key role in advancing basic primary care and advanced primary care in the US in support of these objectives set forth by NASEM.

- ▶ Pay for primary care teams to care for people, not (only) doctors to deliver services.
- ▶ Ensure that high-quality primary care is available to every individual and family in every community.
- ▶ Train primary care teams where people live and work.
- ▶ Design information technology that serves the patient, family, and interprofessional care team
- ▶ Ensure that high-quality primary care is implemented in the US

Purchaser Business Group on Health on a Journey to Strengthen Primary Care



The Purchaser Business Group on Health (PBGH) Primary Care Payment Reform Summit brought together large private employers and public purchasers to advance common priorities for innovative primary care payment reform on September 30, 2021.

During this first-of-its kind Summit, healthcare purchasers engaged health plans and direct contracting partners with one voice about payment criteria developed by PBGH and its members to influence near-term change.

View the conference materials, including actionable tools and resources for purchasers, at pbgh.org/event/pbgh-primary-care-payment-reform-summit/. View the full library of PBGH APC resources at <https://www.pbgh.org/?s=advanced+primary+care>.

Appendix

Primary Care Policy Statement

There is a growing movement within the US to mandate through state legislation that a higher proportion of healthcare spending be allocated to primary care. While we generally agree that higher investment in primary care can lead to better clinical and financial outcomes over time, simply “spending more” on anything without direction or accountability can add costs without improvements in access, quality or patient experience. For this reason, we oppose any blanket healthcare spending mandates, including those on primary care.

However, we do agree that investing in the right infrastructure to support a more patient-centered and comprehensive primary care system can be associated with lower overall costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and improved health over time. The current high levels of healthcare spending in the US are disproportionately weighted against a comprehensive, coordinated primary care system. This lack of strategic investment in primary care gives rise to poor and, at times, wasteful patient access and a significant financial incentive for physicians and other clinicians to choose other areas of specialty, further undermining primary care.

We also need to recognize that our current fee-for-service payment system promotes higher volumes of care without accountability for the quality of care or patient experience. It is time for leaders to insist on the rapid adoption of value-based payment models for public and private payers, particularly for primary care, with a focus on transparent, population-based payment models with broad accountability for quality of care, patient experience, equity, and alignment to reduce the total cost of care.

Increased investments in primary care should be made using sustainable prospective payment designs that are tied to these areas of accountability:

- ▶ Consider other patient experience of care measures beyond CAHPS – see comments below.

- ▶ Enhanced access for patients (same-day and walk-in appointments; virtual care; longer patient appointment times as needed; a secure patient portal; access to a care team member after hours).
- ▶ Optimized time and partnership with patients (co-developed care plans and treatment goals; integration of patient preferences, including serious illness conversations, advanced directives, and end-of-life care; and addressing barriers due to social drivers of health).
- ▶ Disciplined focus on population health (risk stratifying and managing patients based on health risk; adopting a systematic approach to gaps in care; supporting patients in managing their own health through holistic lifestyle approaches).
- ▶ Behavioral health integration (systematic screening, treatment and/or referrals, and—with patient consent—information is shared with behavioral providers as part of a closed-loop feedback system to track outcomes over time).
- ▶ Effective referral and care management (practices make fewer, more-appropriate, data-informed, and higher-quality referrals. Patients can receive common procedures at the primary care office and closed-loop feedback systems for referrals, including those for social needs).

In addition, any investment should be tied to improving the primary care infrastructure that supports this broader vision of primary care, enabling practices to optimally use electronic health records and advanced analytics, reporting, and communication within and outside the organization, including knowing when a patient visits the emergency department or has been hospitalized, supporting longitudinal health management, and collecting and analyzing data related to demographic and socioeconomic factors. Primary care practices can use increased investment to better fund the infrastructure necessary for success. Health plans and purchasers (employers and union trusts) are essential partners in this endeavor and should consider

mechanisms to bolster practices' investments, including providing raw data, analyzed reports, and technical assistance ranging from educational webinars to peer-to-peer collaborative learning opportunities. While America's employers and purchasers remain committed to continuing to provide high-quality health coverage, they need help in the face of stubbornly high costs, and any policy mechanisms should be focused on improving total costs of care while sustaining and improving patient health outcomes, equity and patient experience.

The National Alliance of Healthcare Purchaser Coalitions has developed a detailed definition of a [comprehensive primary care model](#)—Advanced Primary Care (APC)—that includes seven key attributes. Private payers are willing to invest or support payment models aligned with APC but are not willing to pay more for the current primary care service model.



<https://bit.ly/3DwUHPZ>



The Person-Centered Primary Care Measure (PCPCM) is an 11-item patient-reported measure that assesses primary care aspects rarely captured, yet thought responsible for primary care effects on population health, equity, quality, and sustainable expenditures. Learn more at green-center-org/pcpcm.

Improving Healthcare Value with **ADVANCED** Primary Care (APC)

FAST FACT:
US adults who have a primary care physician have **33% LOWER** healthcare costs and **19% LOWER** odds of dying than those who see only a specialist. As a nation, we would **SAVE \$67 BILLION** each year if everybody used a primary care provider as their usual source of care.

*Contribution of Primary Care to Health Systems and Health, "NIBank Quarterly"

Over 80% of patients with common chronic conditions (diabetes, high blood pressure) access primary care, the most prevalent type of office visit. But misaligned incentives (i.e., fee-for-service), lack of behavioral health (BH) integration, and infrastructure and technology challenges can compromise healthcare quality and drive up costs.*

*NEPS (2018) reported by Robert Graham Center (2018)

1

Enhanced access for patients

Convenient access, same day appointments, walk-ins, virtual access, no financial barriers to primary care

2

More time with patients

Enhanced patient engagement and support, shared decision-making, understanding preferences, social determinants of health

3

Realigned payment methods

Patient-centered experience and outcomes, quality and efficiency metrics, deemphasize visit volume

4

Organizational & infrastructure backbone

Relevant analytics, reporting and communication, continuous staff training

5

Disciplined focus on health improvement

Risk stratification and population health management, systematic approach to gaps in care

6

BH Integration

Screening for BH concerns (e.g., depression, anxiety, substance use disorder) and coordination of care

7

Referral Management

More limited, appropriate and high-quality referral practices, coordination and reintegration of patient care

Most of these attributes are consistent with critical success factors identified by respondents to a National Alliance survey

PACIENT-CENTERED

- Enhanced access
- More time for engagement, support and SDM
- BH integration

POPULATION-FOCUSED

- Disciplined focus on health improvement
- Systematic referral management/re-integration
- Appropriate organization and infrastructure

PERFORMANCE-REWARDED

- Realigned payment

THE PROMISE OF APC

↑

Health, patient engagement, satisfaction, personalized and holistic care

↓

Unnecessary care and referrals
Urgent care, ER visits, and hospitalizations

Overall reduced total cost of care
15+%

Catalyst HEALTH NETWORK

OPTUM

Premise Health.

R Health
Care & Wellness

WeCare tlc
Healthcare At Work

National Alliance of Healthcare Purchaser Coalitions
Driving Innovation. Health and Value

<https://bit.ly/3oEIIg8>

Case Studies

Rosen Hotels & Resorts Associate Healthcare Program

Since 1991, Rosen Hotels & Resorts has offered an innovative in-house healthcare program that has saved the company approximately \$340 million (as of April 2018), affording the opportunity to provide associates incredibly low premiums and innovative programs. The plan features on-the-clock visits to primary care doctors and a variety of specialists at the onsite clinic though company-owned and operated [Rosen Medical Center](https://www.rosencare.com) (rosencare.com); minimal co-pays for office visits and prescriptions; and a focus on prevention and wellness/exercise programs. Although Rosen has not measured the soft cost savings such as increased productivity, reduced absenteeism, and improved presenteeism, no doubt the savings are significant. These cost savings are truly astounding considering the diversity of the Rosen workforce and the large number of hourly associates who have emigrated from other countries, many of whom have never received regular healthcare, and some who have never seen a doctor.

Read the full case study:

https://www.rosencare.com/wp-content/uploads/ROSEN_MedicalCenterFactSheet_6-12-18.pdf

JAMA Network: Utilization and Cost of an Employer-Sponsored Primary Care Delivery Model

KEY POINTS:

- ▶ **Question:** What are the utilization rates and costs of service of a comprehensive primary care model that incorporates employer-sponsored on-site, near-site, and virtual primary care?
- ▶ **Findings:** In this cohort study of 23,518 commercially insured employees, the employer-sponsored services cost a mean (SD) of \$87 (\$32) per member per month after accounting for infrastructure and service costs, with members using the model clinics for most of their primary care having higher primary care costs but lower

total health care costs in a matched cohort analysis controlling for demographics, diagnoses and risk.

- ▶ **Meaning:** The findings suggest that lower total person health care costs per person and higher primary care costs may be associated with preferential use by lower-risk persons and/or with the use of comprehensive primary care.

Read the full case study:

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2765201>

Annals of Family Medicine: Higher Primary Care Physician Continuity is Associated with Lower Costs and Hospitalizations

Purpose: Continuity of care is a defining characteristic of primary care associated with lower costs and improved health equity and care quality. However, there is a lack of provider-level measures of primary care continuity amenable to value-based payment, including the Medicare Quality Payment Program (QPP). This study created four physician-level, claims-based continuity measures and tested their associations with health care expenditures and hospitalizations.

Methods: The study used Medicare claims data for 1,448,952 beneficiaries obtaining care from a nationally representative sample of 6,551 primary care physicians to calculate continuity scores by four established methods. Patient-level continuity scores attributed to a single physician were averaged to create physician-level scores. Beneficiary multilevel models, including beneficiary controls, physician characteristics, and practice rurality to estimate associations with total Medicare Part A & B expenditures (allowed charges, logged), and any hospitalization were used.

Results: Continuity measures were highly correlated (correlation coefficients ranged from 0.86 to 0.99), with greater continuity associated with similar outcomes for each. Adjusted expenditures for beneficiaries cared for by physicians in the highest Bice-Boxerman continuity score quintile were 14.1% lower than for those in the

lowest quintile (\$8,092 vs \$6,958; $\beta = -0.151$; 95% CI, -0.186 to -0.116), and the odds of hospitalization were 16.1% lower between the highest and lowest continuity quintiles (OR = 0.839; 95% CI, 0.787 to 0.893).

Conclusions: All four continuity scores tested were significantly associated with lower total expenditures and hospitalization rates. Such indices are potentially useful as QPP measures and may also serve as proxy resource-use measures, given the strength of association with lower costs and utilization.

Read the full case study:

<https://pubmed.ncbi.nlm.nih.gov/30420363/>

General Motors & Henry Ford Health System Case Study: Direct-to-Employer

Under ConnectedCare, Henry Ford's costs must stay below mutually agreed upon annual limits and Henry Ford must meet 19 quality, cost and utilization metrics.

If Henry Ford achieves these objectives, it will share in any savings realized by GM. If it is unsuccessful, Henry Ford will be responsible for some amount of the losses incurred. GM and Henry Ford have agreed on prices for medical services provided to beneficiaries. Both organizations have partnered with Blue Cross Blue Shield of Michigan to manage claims-processing and otherwise administer the program.

Among its features, ConnectedCare covers hospital, outpatient, behavioral health, pharmacy, and physician services in a seven-county area. It offers same-day appointments with primary care physicians, appointments with specialists within 10 days, extensive telehealth options, and an exclusive phone line for GM beneficiaries to schedule appointments and get answers to questions.

ConnectedCare is GM's lowest-cost plan option and is projected to save employees hundreds of dollars per year in payroll contributions. Functioning like a PPO, ConnectedCare has a \$1,500 deductible and has a larger cost sharing differential between in-network and out-of-network providers than GM's other plan options.

For ConnectedCare to succeed, beneficiaries need to obtain services from Henry Ford providers, and avoid out-of-network providers as much as possible. Henry Ford is financially responsible for all costs of care, including costs incurred by non-Henry Ford providers.

Read the full case study:

<https://www.ama-assn.org/practice-management/payment-delivery-models/general-motors-henry-ford-health-system-case-study>

The Commonwealth Fund: Care Management Plus: Strengthening Primary Care for Patients with Multiple Chronic Conditions

Persona: Maria Viera, age 75, takes a dozen medications to treat her diabetes, high blood pressure, mild congestive heart failure, and arthritis. After she begins to have trouble remembering to take her pills, she and her husband visit her primary care physician to discuss this and a list of other worrisome developments, including hip and knee pain, dizziness, low blood sugar, and a recent fall. Maria's primary care doctor spends as much time with her as he dares, knowing that every extra minute will put him further behind schedule. Yet despite his efforts, there is not enough time to address her myriad ailments. She sees several specialists, but no one talks to all her providers about her care, which means she may now be dealing with conflicting recommendations for treatment, or medications that could interact harmfully. As a result, Maria is at high risk for avoidable complications and potentially preventable emergency department visits and hospital stays.

Approach: "Maria" illustrates the type of patient who might benefit from Care Management Plus, a health care delivery model designed for older adults with multiple chronic conditions. Intermountain Healthcare, an integrated care delivery system serving patients in Utah and Idaho, rolled out the program some 15 years ago not only to improve the quality and coordination of care but also to reduce health care costs and support primary care providers who treat these high-need, high-cost patients. Care Management Plus is built on the pillars of the Chronic Care Model, which identifies six essential components for high-quality chronic

disease care: The community, the health system, self-management support, delivery system design, decision support, and clinical information systems.

Results: Care Management Plus has roots stretching to 1995, when Intermountain extended its hospital-based care-management program to 10 primary care clinics within its Medical Group, which employs primary care physicians and specialists to provide care to Intermountain patients in clinic settings. The clinics hired “continuum care managers,” with an initial focus on improving diabetes management and thereby reducing avoidable hospitalizations, unnecessary primary care use, and costs. In 2001, the John A. Hartford Foundation’s Geriatric Interdisciplinary Teams in Practice initiative provided support for Intermountain to expand the focus of this work by adding training and specially designed information technology tools. The continuum care managers helped develop these tools, aiming to better address the medical, mental health, and social needs of older patients with multiple chronic conditions.

Between 2002 and 2005, the program was tested in seven primary care clinics within Intermountain, where physicians were given the option to refer chronically ill patients age 65 and older to an on-site nurse care manager. At the end of two years, patients enrolled in Care Management Plus, especially those with diabetes, had fewer hospitalizations and lower mortality compared with matched controls. The program had a positive effect on physicians as well. Doctors in the intervention clinics who were “high users” of the program—meaning they referred more than 2% of their patient population to a care manager—increased their productivity and were more satisfied.

Read the full case study:

<https://www.commonwealthfund.org/publications/case-study/2016/dec/care-management-plus-strengthening-primary-care-patients-multiple>

UnitedHealth Group: Physicians Provide Higher Quality Care Under Set Monthly Payments Instead of Being Paid Per Service

Primary care physicians paid under global capitation, which pays a set amount per month, per patient, achieve key quality metrics at higher rates than those paid under fee-for-service, according to research by UnitedHealth Group. The findings indicate that capitation provides the right incentives for value-based care, including delivery of the right care, at the right time, and in the right setting.

By identifying meaningful quality differences using metrics from the National Committee for Quality Assurance’s Healthcare Effectiveness Data and Information Set (HEDIS) related to preventive care and chronic conditions, the study showed patients treated under global capitation compare to FFS:

- ▶ Were screened at higher rates for breast cancer (80% vs. 74%) and colorectal cancer (82% vs. 74%)
- ▶ Demonstrated higher controlled blood sugar levels (89% vs. 80%) and were given more eye exams (84% vs. 74%)
- ▶ Received higher rates of functional status assessment (96% vs. 86%) and medication review (97% vs. 92%)

Read the full case study:

<https://www.unitedhealthgroup.com/newsroom/2020/uhg-study-shows-higher-quality-care-under-set-monthly-payments-403552.html>

Tools and Resources

Overcoming Financial Barriers:

- ▶ [BizMed Solutions APC ROI Model \(approved by the Validation Institute\)](#)
- ▶ [Investing in Primary Care: A State-level Analysis](#)
- ▶ [Primary Care Spending: High Stakes, Low Investment](#)
- ▶ [Realizing the Vision of Advanced Primary Care: Confronting Financial Barriers to Expanding the Model Nationwide](#)
- ▶ [Is COVID-19 the End of Fee-for-service Payment?](#)
- ▶ [Health Costs and Financing: Challenges and Strategies for a New Administration](#)
- ▶ [Navigating Change: Implications of CMS's 2021 Physician Fee Schedule](#)
- ▶ [Patient-centered Payment for Primary Care](#)
- ▶ [Advanced Primary Care: A Foundational Alternative Payment Model](#)

Articles and Resources of Interest:

- ▶ [Purchaser Business Group on Health Library of Advanced Primary Care Resources](#)
- ▶ [Primary Care in the United States: A Chartbook of Facts and Statistics](#)

- ▶ [Whole-person Care: Our Foundation, Our Future](#)
- ▶ [Want to get more employees to use preventive care? Here's where to start](#)
- ▶ [Advanced Primary Care: Defining a Shared Standard](#)
- ▶ [Advanced Primary Care: A Key Contributor to Successful ACOs](#)
- ▶ [A Community-based Approach to Comprehensive Primary Care](#)
- ▶ [Providing Holistic Preventive Health with Advanced Primary Care](#)
- ▶ [For Better Population Health, Invest in Primary Care Providers](#)

Addressing the shortage of primary care physicians:

- ▶ [Preventing the Looming Primary Care Physician Shortage](#)
- ▶ [Shortage of Primary Care Doctors is Costing American Lives](#)
- ▶ [Primary Care Practitioners Workforce Projections](#)

Glossary of Terms and Acronyms*

- ▶ **ACO (Accountable Care Organization)** - Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to a population of patients they serve. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).
- ▶ **Alternative Payment Model (APM)** - A value-based payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a patient population (U.S. Centers for Medicare & Medicaid Services/QPP, 2019).
- ▶ **Advanced APM** - Advanced APMs (AAPMs) are alternative payment models that include both up- and down-sided risk. AAPMs are a track of the Quality Payment Program that offer a five percent incentive for achieving threshold levels of payments or patients through Advanced APMs (U.S. Centers for Medicare & Medicaid Services/QPP, 2019).
- ▶ **Attribution** - The process that commercial and government payers use to assign patients to the physicians who are held accountable for their care (Fiesinger, 2016).
- ▶ **Beneficiary** - The name for a person who has health care insurance through the Medicare or Medicaid program (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).
- ▶ **BPCI, Advanced (Bundled Payments for Care Improvement, Advanced)** - BPCI-Advanced is a voluntary episode payment model that aims to support healthcare providers who invest in practice innovation and care redesign to better coordinate care, improve quality of care, and reduce expenditures, while improving the quality of care for Medicare beneficiaries. The goals of BPCI-Advanced include care redesign, health care provider engagement, patient and caregiver engagement, data analysis/feedback, and financial accountability (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).
- ▶ **Bundled payment** - Models of care which link payments for the multiple services beneficiaries receive during an episode of care (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).
- ▶ **Capitation** - A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a patient's health care services for a certain length of time (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).
- ▶ **Collaborative Care Model** - An evidence-based approach for integrating physical and behavioral health services that can be implemented within a primary care-based setting. It includes care coordination and management; regular/proactive monitoring and treatment to target using validated clinical rating scales; and regular, systematic psychiatric caseload reviews and consultation for patients who do not show improvement. The Collaborative Care team is led by a primary care provider (PCP) and includes behavioral health care managers, psychiatrists, and other mental health professionals empowered to work at the top of their license.
- ▶ **Comprehensive Primary Care Plus (CPC+)** - A national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).

- ▶ **Co-Pay** - A fixed amount you pay for a covered health care service after you've paid your deductible (U.S. Centers for Medicare & Medicaid Services/HealthCare.gov, 2019).
- ▶ **CRM (Customer Relationship Management)** - A comprehensive strategy and process of acquiring, retaining, and collaborating with selected customers to create superior value for the organization and the customer. It involves the integration of customer service-related functions of the organization to achieve greater efficiencies and effectiveness in delivering customer value (Navimipour & Soltani, 2016).
- ▶ **CPT Code** - The Current Procedural Terminology (CPT®) codes offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency (American Medical Association, 2019).
- ▶ **Direct Contracting (DC)** - A set of three voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare Fee-For-Service. The payment model options available under DC create opportunities for a broad range of organizations to participate with CMS in testing the next evolution of risk-sharing arrangements to produce value and high-quality health care. The payment model options are anticipated to appeal to a broad range of physician practices and other organizations because they are expected to reduce burden, support a focus on beneficiaries with complex, chronic conditions, and encourage participation from organizations that have not typically participated in Medicare FFS or CMS Innovation Center models (U.S. Centers for Medicare & Medicaid Services, 2019).
- ▶ **Downside Risk** - Downside risk in healthcare refers to assuming risk for actual costs of care. If the cost of care falls below the targeted costs, the practice will share in savings. If the cost of care exceeds

the targeted or budgeted costs, the practice will be responsible for a portion of the difference between actual total costs and targeted or budgeted costs (American Academy of Pediatrics, 2019). Downside risk puts providers at financial risk in the event that added resources are needed to care for a patient (in situations where additional care could have been avoided). The most common examples apply to hospitals, such as non-payment for preventable hospital-acquired conditions or readmissions (Delbanco, 2014).

- ▶ **DRG (Diagnosis Related Group)** - A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).
- ▶ **Episode of Care (episode)** - The set of services provided to treat a clinical condition or procedure (U.S. Centers for Medicare & Medicaid Services, 2016).
- ▶ **Episode-Based Payment Initiatives** - Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event (such as a hospitalization or chemotherapy administration) and extends for a limited period of time thereafter (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).
- ▶ **Fee-For-Service (FFS)** - A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits (U.S. Centers for Medicare & Medicaid Services/HealthCare.gov, 2019).
- ▶ **Full Risk (also known as two-sided risk)** - In two-sided risk models, providers still share in the savings but are also responsible for some of the loss if spending is above the benchmark (Chernew

& Frakt, 2018). Participating in these models can generally earn larger shared savings payments if they are successful, but they also face “downside” risk because they are responsible for repaying a portion of any losses to the government (Mechanic, Perloff, Litton, Edwards, & Muhlestein, 2019).

- ▶ **Global Payment** - A fixed prepayment made to a group of providers or a health care system (as opposed to a health care plan), covering most or all of a patient’s care during a specified time period. Global payments are usually paid monthly per patient over a year, unlike fee-for service, which pays separately for each service (National Conference of State Legislatures , 2010).
- ▶ **Healthcare Disparities** - Differences and/or gaps in the quality of health and healthcare across racial, ethnic, and/or socio-economic groups. It can also be understood as population-specific differences in the presence of disease, health outcomes, or access to healthcare (Riley, 2012).
- ▶ **High-value Care** - The best care for the patient, with the optimal result for the circumstances, delivered at the right price (Smith, Saunders, & Stuckhardt, 2013).
- ▶ **HMO (Health Maintenance Organization)** - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan and coverage typically includes a broader range of preventive care (U.S. Centers for Medicare & Medicaid Services/ Glossary, 2006).
- ▶ **Medicaid** - A joint federal and state program that helps with medical costs for some people with low incomes, disabilities, and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).
- ▶ **Medicare** - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD) (U.S. Centers for Medicare & Medicaid Services/ Glossary, 2006).
- ▶ **Modifiable Risk Factors** - Risk factors are conditions that increase your risk of developing a disease. Modifiable risk factors mean you can take measures to change them (UCSF Health, 2019).
- ▶ **Network** - A group of doctors, hospitals, pharmacies, and/or other health care experts hired by a health plan to take care of its members (U.S. Centers for Medicare & Medicaid Services/ Glossary, 2006).
- ▶ **OCM (Oncology Care Model)** - A payment and delivery model designed to improve the effectiveness and efficiency of specialty care in oncology. Physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients (U.S. Centers for Medicare & Medicaid Services, 2019).
- ▶ **Outcome Measures** - Outcome measures reflect the impact of the health care service or intervention on the health status of patients. One example of a health-related outcome measure: the percentage of patients who died as a result of surgery (surgical mortality rates) (Agency for Healthcare Research and Quality, 2011).
- ▶ **P4P (Pay-for-Performance)** - An umbrella term for early initiatives aimed at improving the quality, efficiency, and overall value of health care by addressing how providers are paid for healthcare. These early efforts paved the way for value-based payment reform by focusing on patient outcomes and provider performance (CMS/ORDI/MDPG, 2005) PCF (Primary Care First) - Primary Care First is a set of voluntary five-year payment options that reward value and quality by offering an

innovative payment structure to support delivery of advanced primary care. In response to input from primary care clinician stakeholders, Primary Care First is based on the underlying principles of the existing CPC+ model design: prioritizing the doctor-patient relationship; enhancing care for patients with complex chronic needs and high need, seriously ill patients, reducing administrative burden, and focusing financial rewards on improved health outcomes. (U.S. Centers for Medicare & Medicaid Services, 2019).

- ▶ **PCMH (Patient Centered Medical Home)** - An approach to providing comprehensive primary care for children, youth and adults by transforming how care is organized and delivered. The PCMH re-designs primary care to provide comprehensive, person-centered care coordinated among patients, patient's families, specialty care, hospitals, home health, and/or community-based supports and services (American Academy of Family Physicians, 2007), (Agency for Healthcare Research and Quality, 2019).
- ▶ **PPO (Preferred Provider Organization)** - A managed care plan in which patients can use doctors, hospitals, and providers that belong to the network, but can use doctors, hospitals, and providers outside of the network for an additional cost (U.S. Centers for Medicare & Medicaid Services/ Glossary, 2006).
- ▶ **P-VBPM (Physician Value-Based Payment Modifier)** - Provides for differential payment under the Medicare Physician Fee Schedule (PFS) based on the quality of care furnished compared to the cost of care during a performance period. The Value Modifier is an adjustment made to Medicare payments for items and services under the Medicare PFS (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).
- ▶ **PQRS (Physician Quality Reporting System)** - PQRS, formerly known as the Physician Quality Reporting Initiative, is a healthcare quality improvement incentive program initiated by CMS.

PQRS measures were developed across a wide range of quality and health outcomes and providers are required to submit data on these measures annually. According to the Affordable Care Act (2010), providers who fail to submit PQRS data will receive financial penalties (U.S. Centers for Medicare & Medicaid Services, 2008).

- ▶ **Reimbursement** - An umbrella term for the policies and practices that define the terms of coverage and payment for health care and technology (Bruen, et al., 2016). Reimbursement mechanisms for healthcare have included salary, Fee-for-service (FFS), capitation, Pay-for-performance (P4P), and diagnosis-based payment (DRGs, diagnosis-related groups) (Britton, 2015).
- ▶ **Risk-Based Contracting** - Risk-based contracts come in a variety of shapes and sizes. The highest form is full capitation in which hospitals or physician groups receive a monthly payment to provide all care for a patient (Barkholz, 2016).
- ▶ **Risk-based Payment Model** - There are a variety of risk-based payment models being developed. Risk-based models are predicated on an estimate of what the expected costs to treat a particular condition or patient population should be (American Academy of Pediatrics, 2019).
- ▶ **RVU (Relative Value Unit)** - A national standard used for measuring productivity, budgeting, allocating expenses, and cost benchmarking. RVUs do not represent monetary values. Instead, they represent the relative amount of physician work, resources, and expertise needed to provide services to patients. The actual dollar amount of a payment for the physician's services results only when a conversion factor (CF), dollar per RVU, is applied to the Total- RVU (Quan, 2007).
- ▶ **SDoH (Social Determinants of Health)** - Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. These include conditions impacted by the distribution of wealth and resources (Centers for Disease Control and Prevention, 2018).

▶ **TD-ABC (Time Driven Activity-Based Costing)** -

A methodology that calculates the costs of healthcare resources consumed as a patient moves along a care process (Martin, et al., 2018).

- ▶ **Upside Risk (also known as one-sided risk)** - Upside risk includes value-based payment models where the provider only shares in savings and not the risk of loss. For example, if the actual total cost of care of patients assigned to a physician's practice are lower than projected budgeted costs, the practice receives a bonus payment (shared savings). If, however, the total cost of care of patients assigned

to a physician's practice are higher than projected budgeted costs, the practice would not be penalized financially in an upside-only risk payment model (American Academy of Pediatrics, 2019).

- ▶ **Value-based Healthcare (VBH)** - A healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. (NEJM Catalyst, 2017) Value-based programs reward healthcare providers with incentive payments for the quality of care they give to people with Medicare (U.S. Centers for Medicare & Medicaid Services, 2019).



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