Comprehensive Primary Care Payment Calculator User’s Guide

Prepared by Health Data Decisions
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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, discussions 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.
# Table of Contents

I. **INTRODUCTION** ........................................................................................................... 3

II. **USER INSTRUCTIONS** ................................................................................................. 4
    A. **Practice Geography** .................................................................................................. 4
    B. **Patient Population and Trend** .................................................................................... 4
    C. **Primary Care Revenue** .............................................................................................. 4
    D. **CPCP Model Parameters** ........................................................................................... 4

III. **RESULTS** ...................................................................................................................... 4

IV. **GLOSSARY** .................................................................................................................... 5
I. INTRODUCTION

Family Medicine for America’s Health (FMAHealth) is developing a Comprehensive Primary Care Payment (CPCP) model to support the move from transactional payment to performance-based payment for value. FMAHealth 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: Engagement of Stakeholders, Health Equity, Payment Reform, Practice Transformation, Technology, Research, and Workforce Education and Development. For more information, see http://fmahealth.org.

The objective of this project is to research and develop a quantitative methodology to describe a comprehensive primary care payment model which supports it. This goal includes developing a prospective calculator which applies this methodology and models its expected impact. This study surveys the current state of value-based primary care payment models in use in the U.S. and draws key information about the efficacy, challenges, and successes of these programs. The resulting recommendations provide a framework and justification for critical components of a CPCP model.

This methodology applies these recommendations by calculating a base 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 following components of the CPCP model provide the necessary details to calculate a prospective reimbursement schedule using the base rate and modifiers.

- **Base Rate**
  - Primary Care Activity Level (PCAL) calculation
  - CPCP base rate calculation

- **Modifier 1: Population Adjustment**
  - Risk adjustment based on age, sex, and diagnoses
  - Risk adjustment based on social determinants of health
  - Risk adjustment based on complexity
  - Payment adjustment, up to 5%

- **Modifier 2: Quality Adjustment**
  - Quality metrics
  - Composite scoring method
  - Payment adjustment, up to 5%

- **Modifier 3: Efficiency Adjustment**
  - Quality metrics
  - Composite scoring method
  - Payment adjustment, up to 10%

- **Modifier 4: Infrastructure Adjustment**
  - Infrastructure metrics
  - Composite scoring method
  - Payment Adjustment, up to 7.5%

- **Final Rate Calculation**
  - Composite calculation

This base rate and modifier schema is intended to serve as a framework. It is understood that each population, payer, or provider will likely have idiosyncrasies that must be accommodated for contracting or other pragmatic purposes. This reimbursement framework provides a starting point for further tuning and discussion of a mutually beneficial CPCP model.
II. User Instructions

The following instructions can be used to create a model of an existing FFS primary care contract under a transformation to CPCP using the CPCP Calculator Excel workbook which is available for download at www.placholderURL.com. This workbook can be run on any version of Excel for Windows or Mac without additional plug-ins. The green shaded fields in the calculator represent user inputs. The results based on these user inputs are adjusted in the Excel workbook in real time as input parameters are entered. Simply overwrite the default values in the downloadable version of the workbook in order to execute the model.

A. Practice Geography

Under Practice Name, enter the name of the practice or practice group to be modeled. Use the Practice Region drop downs to specify the major U.S. region in which the practice group is located. Further specify the State and County which best describes the geographical centralization of the population. This information is used in several ways, including estimating the degree to which social determinants of health are likely to create barriers to care in this population and ratios of primary care expenses to total medical expenses.

B. Patient Population and Growth Trends

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. 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.

C. Practice Revenue

Under Primary Care Revenue, enter the total paid amount PMPM (per member per month) for most recent 12-month period, broken out by Commercial, Medicare and Medicare lines of business. If the precise numbers of Commercial, Medicare and Medicaid members are not known, the total population can be rolled up under Commercial. The practice revenue PMPM can be estimated by dividing the annualized FFS practice revenue associated with population of interest by the annualized number of member months for this population. Finally, enter the estimated medical expense trend experienced by the population of interest.

D. Population Risk Adjustment

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.

E. Quality, Efficiency and Infrastructure

The quality, efficiency and infrastructure measure selector tool can be used to model actuals known from certified engine results, or represent estimates based on population health data. To create a performance measure model for consideration, navigate to the Performance Measure 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. Leave all other cells empty. The summary and gating methodology is applied automatically and updated in the Inputs and Results tab.

III. Results
The base rate and modifier rates are expressed as dollars PMPM as a function of the above inputs. The Final Prospective CPCP PMPM represents the fully adjusted rate generated by this model. The Revenue Comparison chart provides a graphic comparison of the Traditional model in the baseline and the CPCP model under evaluation.

IV. Glossary

**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.

**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.

**Chronic Illness and Disability Payment System (CDPS).** A diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid beneficiaries.

**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.

**Managed Care Organization (MCO).** A network which provides coordinated care, e.g. HMO and PPO delivery models.

**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 socio-economic 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.