

Proposed Chronic Care Alternate Payment Model

In reviewing all submissions, the working group outlined three main bipartisan goals that each policy under consideration should strive to meet:

1. The proposed policy increases care coordination among individual providers across care settings who are treating individuals living with chronic diseases;
2. The proposed policy streamlines Medicare's current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases; and
3. The proposed policy facilitates the delivery of high quality care, improves care transitions, produces stronger patient outcomes, increases program efficiency, and contributes to an overall effort that will reduce the growth in Medicare spending.

“Management is doing things right; leadership is doing the right things.”

– **Peter F. Drucker**

<https://hbr.org/1993/09/why-incentive-plans-cannot-work>

Fifty years of Medicare under Fee-For-Service (FFS) administered by commercial insurances has seen a remarkable rise in prices with quality that lags other countries. CMS is right in looking for Value not Volume in new Medicare arrangements. FFS wastes about \$100,000 /yr./MD in billing waste. This is money that could be spent on better care, not arguing about payment.

Most of the discussion on policies to promote Chronic Care have been about doing FFS ‘right’, not ‘doing the right things’- designing a system that gets people the services they need. We need a system that empowers clinicians to get people with chronic disease the care they need, when we don’t know beforehand what that care will be. Since we don’t know, instead of saying, “Medicare will pay X dollars for service Y, whether that’s what the person needs or not,” we should say, “Medicare will pay a certain amount for comprehensive primary care, based on how sick the person is, and make the primary care doctor responsible for providing that care.”

Proposal:

Create an optional primary care capitation system (Alternate Payment Method, APM) for Medicare enrollees with chronic disease, and allow doctors and patients to join it if they want. I would anticipate this being used for a provider’s entire Medicare patient population. It would be open to any Medicare enrollee.

Use CMS’s very successful [risk adjustment classification, CMS-HCC](#), to determine the expected global cost for people with multiple chronic illness. Pay 12% of that amount (the average cost of comprehensive primary care in OECD countries) as monthly capitation direct from CMS to the provider. Allow the provider to determine the mix of primary care services the patient needs.

Use a patient-centered method, [‘How’s Your Health’](#) (which tracks closely with CAHPS) to measure quality. Use CMS’s systems to track global costs, and report monthly to the physicians.

Allow patients to transfer out of this model immediately if they are not happy with their care. Allow physicians to change back to regular FFS Medicare with 30 days’ notice. Allow physicians who have ‘opted out’ of Medicare to participate in this program.

Providers with low quality scores after 18 months would be dropped from this program and return to regular FFS Medicare. Dual-eligibles would continue to be covered by Medicaid for non-primary care

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services. All patients would continue to be covered by standard Medicare for non-primary care services. Primary care providers would be at risk for providing comprehensive primary care in the short term, and for quality and cost as a condition of staying in the program for the long term.

A similar system included in the recent [APM Framework White Paper](#) was able to [reduce readmissions by >90%](#) for Medicare Advantage patients.