NYSAFP APC/VBP points

Asks:

1. Processes that don't require a consultant or extra staff, especially for small practices where patient care and not administration are the primary function of every employee. Too many of the enhanced payment programs already implemented channel money through primary care physicians to consultants for small practices and additional professional management staff for larger ones.

2. Recognition of all the extra work beyond RBRVS face-to-face care, whose relative value for primary care is in any case no longer really appropriate, having been set based on a system of care that no longer applies. We need to be paid for the administrative tasks we and our paid office staff do (right now for free!) for the insurers--prior authorization, appeals, medication changes for formulary for non-medical reasons. We need to be paid for administration/paperwork and supervision of ancillary things like PT, school health, visiting nurses, DME, etc.--that is a key part of APC/Care coordination.

3. Default enhanced payment for chronic condition management for patients whose problem list essentially means they are getting it if the team is doing their job. As an example of a flawed precedent, right now the CMS process requires a written care plan that no one in my practice has found useful (since that information is always part of the visit and visit summary), and documentation by the minute. The payment is paltry if the real life useful concept of several 2-10 minute phone calls is what happens, especially if you go much over the 20 minute threshold for reimbursement. And contractors are gaming this right and left, taking a cut for doing a cookie cutter care plan for everyone with 2+ diagnoses and making a 20 minute phone call that does not serve the patient. I don't think we can fix CMS, but maybe other payers will see the value of getting this right.

4. Look at practice systems that produce good outcomes for a reasonable cost and with high patient satisfaction. Be sure that the processes that are in place support those systems. For example, there is some evidence that small private practices regularly perform very well based on these criteria, but struggle to meet metrics and may be paid less because of a lack of “bargaining power.” It is important that the systems that are put in place not be inadvertently designed to exterminate the very practices we would like to thrive.

The devil will be in fair, simple metrics that assure performance. Lazy, manipulative colleagues are not our friend in this.

Problems:

1. Largely alluded to above, but also more generally, removing piecemeal payment schemes. As an example, in our market for after-hours calls you can bill $19 for a 5 minute clinical phone encounter, but by the time you get consent from the patient because of the copay and endure their wrath, document and bill, it clearly leaves almost no pay for the actual work. This is especially since the whole fee will be copay for many, and they won't pay. This work needs to be paid as part of the global management fee.

2. Insurers, if they are truly to be our partners, need to take some of the heat for the need for any cost sharing for APC/VBP. They need to inform and educate members, since now it comes across as us asking for money for what has always been “free.” Patients have no notion of the behind the scenes work we have to do now compared with 10 years ago.

3. Do not require meeting flawed recognition criteria like PCMH as the sole avenue to VBP (I think this will be an issue with DSRIP, and some payers.)  As we all know, PCMH, for example, uses a lot of resources, has a lot of no-value-add work, distracts everyone from important things and often requires a paid consultant. However, I am not suggesting it cannot be one avenue for practices that have already made the effort.

4. Eliminate all the useless variability. Encourage payers to have a single approach/metric/standard to the extent they are willing. But do not necessarily have private payers mirror the public system if the public system, as usual, is overly bureaucratically complex.