VBP points.

Smart phone televisit for primary care consult on inpatients, but those who admit should get bonus over hospitalist, since performing both functions.

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.

2. Recognition of all the extra work beyone RBRVS work(whose relative value for primary care was set based on a system of care that is now ancient), not just non-face-to-face care. We need to be paid for the administrative tasks we do (right now for free!) for the insurers--prior auths, appeals, med changes for formulary not medical reasons. We need to be paid for admistration/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. Right now the CMS process requires a writtne 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 min threshhold. And contractors are gaming this right and left, taking a cut for doing a cookie cutter care plan for everyone with 2+ Dx's and making a 20 min phone call. I don't think we can fix CMS, but maybe other payers will see the value.

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

Problems: Largely alluded to above, but also more generally removing piecemeal payment schemes, like Excellus has 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. Especially since the whole fee will be copay for many, and they won't pay.

Also,the insurances need to take some of the heat for the need for any cost sharing for VBP--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 c/w 10 years ago.

Do not require meeting flawed recognition criteria like PCMH as the sole avenue to VBP (I think 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 can't be one avenue for practices that have already made the effort.

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.

Bob

