Primary Care Subgroup Meeting
August 24, 2021

OHS
CONNECTICUT
Office *of* Health Strategy

Roll Call

Public Comment (2 minutes/person)

Approval of July 27th Meeting Minutes

Agenda

Welcome and Roll Call	Office of Health Strategy	1:00 PM
Public Comment	Members of the Public	1:05 PM
Approval of July 27th Meeting Minutes—Vote	Members of the PCSG	1:15 PM
Continuation of Roadmap Development	Bailit Health	1:20 PM
Next Steps and Wrap-up	Bailit Health	2:55 PM
Meeting Adjournment	All	3:00 PM

Continuation of Roadmap Development

Today's focus: Revisit #2, #3, #4 and #5

Process Step	Description
1. Establish highest priority objectives for a strengthened primary care system	This should be a listing of only the highest priorities, such as those identified in the "Guiding Principles." It should not be all-inclusive.
2. Adopt an advanced primary care practice model	This should describe core, essential practice functionalities.
3. Decide how practices will be supported in adopting the practice model, and by whom	For example: learning collaborative, practice coaching, self-taught with learning aids, or a combination
4. Adopt a program for confirming practice model adoption	This is necessary for payers to support investment.
5. Adopt a payment model(s)	The payment model(s) should support the care model, sustain practices and align with objectives for high-value.
6. Adopt an implementation plan	The plan describes who will be responsible for doing what, and by when. Involved stakeholders should support the plan; commercial payers must commit to it.
7. Define a measurement and evaluation plan	To determine that the highest priority objectives were achieved, without any unintended adverse consequences.

Highlights from the July meeting (1 of 2)

1. Several members of the Subgroup felt strongly that adoption of a primary care definition was critical and that additional work would be necessary to come to agreement on a recommendation for OHS.
2. The Subgroup requested an additional review of core practice team functions.
3. Regarding the proposal presented for practice coaching:
   - Subgroup members suggested that not every practice team needs a practice coach to demonstrate mastery of the core practice team functions.
   - Subgroup members requested more flexibility for practices that want the option to use their own internal practice coaching resources.
   - Others agreed flexibility is important, as is uniformity in coaching curriculum.

Highlights from the July meeting (2 of 2)

4. There was no specific feedback on the proposal presented for practice team recognition.
5. Additional primary care payment models were suggested for consideration including:
   - episode-based payments for members with chronic conditions and
   - a hybrid payment model that combines new prospective payments with reduced fee-for-service payments.

Since July, OHS has continued to engage stakeholders to solicit feedback on draft primary care proposals

OHS received feedback from individual Primary Care Subgroup members and also from non-Subgroup members from these other stakeholders:

- Provider Organizations:
  - Community Health Center Inc.
  - Northeast Medical Group
- Medical Societies:
  - Connecticut Chapters of American College of Physicians
  - American Academy of Pediatrics
- Payers:
  - Aetna
  - ConnectiCare
  - UnitedHealthcare

Adopting a primary care definition

- Since the July meeting, some Subgroup members re-proposed adopting the National Academy of Sciences updated definition of high-quality primary care:
  - *High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.*[1]

Is there anyone who objects to adopting this primary care definition?

[1]National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

Modified core practice team functions based on OHS consideration of recent feedback (1 of 5)

1. Care delivery is centered around what matters to the patient*, developing **trusted relationships with patients**, making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow-up.
2. Care delivery is **team-based**, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.
3. Practice teams formally **designate a lead clinician** for each patient. That person fosters a continuous, longitudinal relationship.
   - *Lead clinician is defined as "designated medical professional within a practice team who holds lead responsibility for an individual patient relationship e.g., a physician or APRN."*

- ** All references to word "patient" include patient and/or family caregiver*

Modified core practice team functions based on OHS consideration of recent feedback (2 of 5)

4. The practice team coordinates care for its patients between visits and across the continuum of care. To support such work, the practice team includes a) **qualified embedded clinical care management personnel** to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) **embedded non-clinical care coordination personnel** to connect all patients with community supports to address social risk factors, and work with families and other caregivers.*

*Alternative approaches involving virtual care may be required for very small practices, including those in rural communities.

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Modified core practice team functions based on OHS consideration of recent feedback (3 of 5)

5. **Behavioral health** is integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment.*
   - *Alternative approaches for mental health are permitted for small independent practices and will be defined through subsequent OHS guidance.*
6. The practice team delivers "**planned care**" at every visit, including reviewing the patient's medical record prior to the visit and addressing all identified issues during the visit.

*Alternative approaches involving virtual care may be required for very small practices, including those in rural communities.

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Modified core practice team functions based on OHS consideration of recent feedback (4 of 5)

7. Care is easily **accessible** and prompt, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is culturally competent.
8. Care delivery follows **evidence-based** guidelines for prevention, health promotion and chronic illness care, supported by EHR clinical decision support.
9. **Patients are engaged** and supported for healthy living and management of chronic conditions.

Modified core practice team functions based on OHS consideration of recent feedback (5 of 5)

10. The practice team **utilizes** patient information in conjunction with **data** from an EHR (when utilized by the practice), HIE, pharmacies, and payers to identify patient care needs, monitor change over time, and inform targeted **quality and equity improvement** activity, including design and implementation of quality improvement plans.

11. The practice team demonstrates an awareness of health and social issues in the community it serves and delivers **community-oriented care** to address health and social needs.
    - *OHS received feedback from one member that #11 should not be required, as the "delivers" part of the statement is not feasible for practices to implement.*
    - *What is the Subgroup's reaction to this feedback? Overall recommendation?*

For discussion

- Does the group agree with the changes made to the core practice team functions?
- Are there other suggested modifications?
- OHS anticipates finalizing the core practice team functions after this meeting. Does the group have final feedback it would like OHS to consider?

Modified practice coaching proposal based on OHS consideration of recent feedback (1 of 2)

1. Practice teams seeking enhanced payments are required to demonstrate mastery of all 11 core functions.
2. Practice coaching is offered to practices to support mastery achievement and primarily provided by an OHS-contracted third party, with shared funding provided on a pro rata basis by the state's largest commercial insurers
   - Practice teams undergo an initial and then a periodic assessment to evaluate practice team functionality relative to the 11 core functions.
3. Some practice teams may alternatively elect to instead receive practice coaching from the following alternative sources if the source demonstrates a commitment to and plan for addressing the 11 core practice team functions in its coaching
   - commercial insurer
   - internal organization or external resources

Modified practice coaching proposal based on OHS consideration of recent feedback (2 of 2)

4. Regardless of the coaching vehicle, practice teams must demonstrate mastery of the core functions to the satisfaction of the OHS-contracted third party.

Revisiting payment model options

- Today we will continue review of a proposal for a prospective primary care payment model to be utilized as a fee-for-service alternative, at the practice's option.
- In addition, we will review the following additional proposals:
  - Hybrid primary care payment models that combine varying levels of capitated and fee-for-service payments
  - Chronic condition episode-of-care bundles

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Potential benefits to primary care practices of a prospective payment model

1. Provides practice teams with greater flexibility to deliver primary care that better meets the needs and preferences of patients, e.g., traditionally uncompensated time to coordinate care for medical and social needs outside of the practice, use of community health workers, etc.
2. Allows practice teams to provide team-based services using care modalities that aren't often compensated under traditional FFS models, and reduces the financial imperative to generate office visits
3. Provides a predictable monthly cash flow; COVID-19 revealed how important this can be
4. Because the payment only includes those services the practice team delivers, the model does not transfer significant financial risk to the practice

Proposed primary care payment model for Subgroup consideration

- Make a value-based prospective primary care payment model available to interested practices, while permitting continued FFS payments to others
- Practices are eligible for enhanced payments under either approach, so long as they are seeking or have obtained OHS-recognition for mastery of the 11 core practice team functions.
  - Practices begin receiving enhanced payments upon indicating intent to become OHS-recognized.

1. Primary care practices are prospectively paid a fixed PMPM fee for most primary care payments in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel
2. Insurers can elect to enhance payments to practices however they like in order to hit the primary care spend target; the mode is not specified in OHS' recommendations

Common parameters for prospective payment

- The proposed prospective payment model includes common parameters to protect practices and insurers from challenges and risks associated with such a model and to maximize its overall success.
- Some parameters are widely accepted in value-based payment contracting; others are proving successful in national and state primary care initiatives.
- Recommendations were derived from those established by a stakeholder work group commissioned by the Rhode Island Office of the Health Insurance Commissioner to facilitate stakeholder discussions towards adoption of a primary care capitation payment method.

Primary care payment model proposal (1 of 2)

1. Primary care practices are prospectively paid a fixed PMPM fee for most primary care payments in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel. The model calls for:
    - Risk-adjusted payments based on clinical complexity or by age and gender
    - Prospective patient attribution
    - Measures and monitoring practices to protect against stinting of care and undesired adverse risks
    - Multi-payer alignment on contractual primary care quality measures
    - Practice eligibility for substantial incentive payments based on quality performance
    - Data sharing and education

Primary care payment model proposal (2 of 2)

2. Practices can otherwise choose to continue receiving FFS payments and still receive enhanced payment. The FFS model includes:
   - Multi-payer alignment on contractual primary care quality measures
   - Practice eligibility for substantial incentive payments based on quality performance
   - Data sharing and education

Risk-adjusted payments based on clinical complexity or by age and gender

- Risk adjustment is intended to reflect the relative risk of the patient panel in the prospective payment rate, reducing the incentive for a practice to seek out healthier patients and discourage sicker patients.

Recommendation:

- Insurers should risk adjust their payments to account for variation in the health care conditions of different patient panels, age, and gender, or solely for age and gender.
- Insurers may implement the risk adjustment tool of their choice, but should provide a high level of transparency to practices about how the software is applied, including underlying parameters, assumptions applied by the insurer, and the impact of risk adjustment on payments.

Prospective patient attribution

- A primary care practice that contracts on a prospective payment basis would be paid prospectively for those patients attributed to the practice.
- The practice would receive a FFS payment for the care of other patients and for services other than the prospectively paid services delivered to the attributed patients.

Recommendation:

- Insurers can utilize an attribution methodology of their choosing which may include attribution methodologies in current use, so long as they are transparent about the methodology with practices.
- Insurers should reattribute patients monthly, communicate these updates to practices in a timely manner, and use these updates when calculating capitation payments.

Measures and monitoring practices to protect against stinting of care and other undesired adverse risks

- As with any payment model, prospective models have some limitations, e.g.,
  - Practices could take on more patients than they can realistically care for, resulting in limited appointment availability
  - Practices could direct patients to unnecessary utilization of specialist and emergency care

Recommendation:

- Careful monitoring of practice behavior to identify cases where access is decreasing or there are other signs of stinting on care.
- Use of available data to monitor this problem to the extent possible, and take corrective action when performance measures indicate the need to do so.
- Identification and adoption of measures that incentivize practices to minimize inappropriate use of specialists and emergency departments.

Multi-payer alignment on contractual primary care quality measures

- Quality measurement and reporting are critical to improving patient care, outcomes, and experience.
- Quality reporting requirements are burdensome on practices, particularly for small practices that lack the support and infrastructure to effectively respond to the volume of requests for quality data. It consumes resources which would otherwise be directed to patient care.
- A quality measurement strategy for primary care aligned across insurers, with manageable reporting requirements, would help minimize the burden on practices.

Recommendation:

- OHS' Quality Council should define a subset of primary care measures, derived from OHS' Core Measure Set, that insurers use in all primary care practice contracts.

Practice eligibility for substantial incentive payments based on quality performance

- The primary care payment model should reward quality with an opportunity to earn substantial incentive payments based on practices' performance on certain measures.

Recommendation:

- OHS does not propose a specific incentive methodology at this time, but does recommend primary care quality measures from a new OHS primary care aligned measure set be employed in the methodology.

Data sharing and education

- High quality data exchange is necessary for insurers and practices to make the most of a prospective arrangement.
- Some practices will benefit from education and coaching about how to deliver patient care in a financially sustainable way in the context of a capitated payment methodology.

Recommendation:

- Insurers should supply providers with timely, high-quality data to allow more effective management of their patient panel and their revenue under a capitated arrangement. This includes data about a practice's panel, risk scores, and associated payment calculations. This also requires practices to provide accurate accounting of services rendered.
- Insurers should provide appropriate technical assistance and educational support to facilitate the transition to capitated payments.

Other primary care payment models for consideration (1 of 2)

Payment Model	Description
1. Capitate common E&M code services only and pay FFS for remaining services	▪ A hybrid payment that combines a prospective payment for the most common evaluation and management codes for mid-level outpatient office visits for established patients and FFS for a small number of specific services that are proven to improve quality, access, and costs ▪ Capitation is linked to substantial incentives to improve value by restraining costs and improving quality
2. Pay reduced FFS and reduced capitation for all services (i.e., CMS Primary Care First)	▪ A hybrid payment that combines a population-based payment that is the same for all patients within a practice and a flat primary care visit fee for identified procedure codes ▪ Practices are eligible to receive performance-based incentives based on cost reduction and quality improvement

Other primary care payment models for consideration (2 of 2)

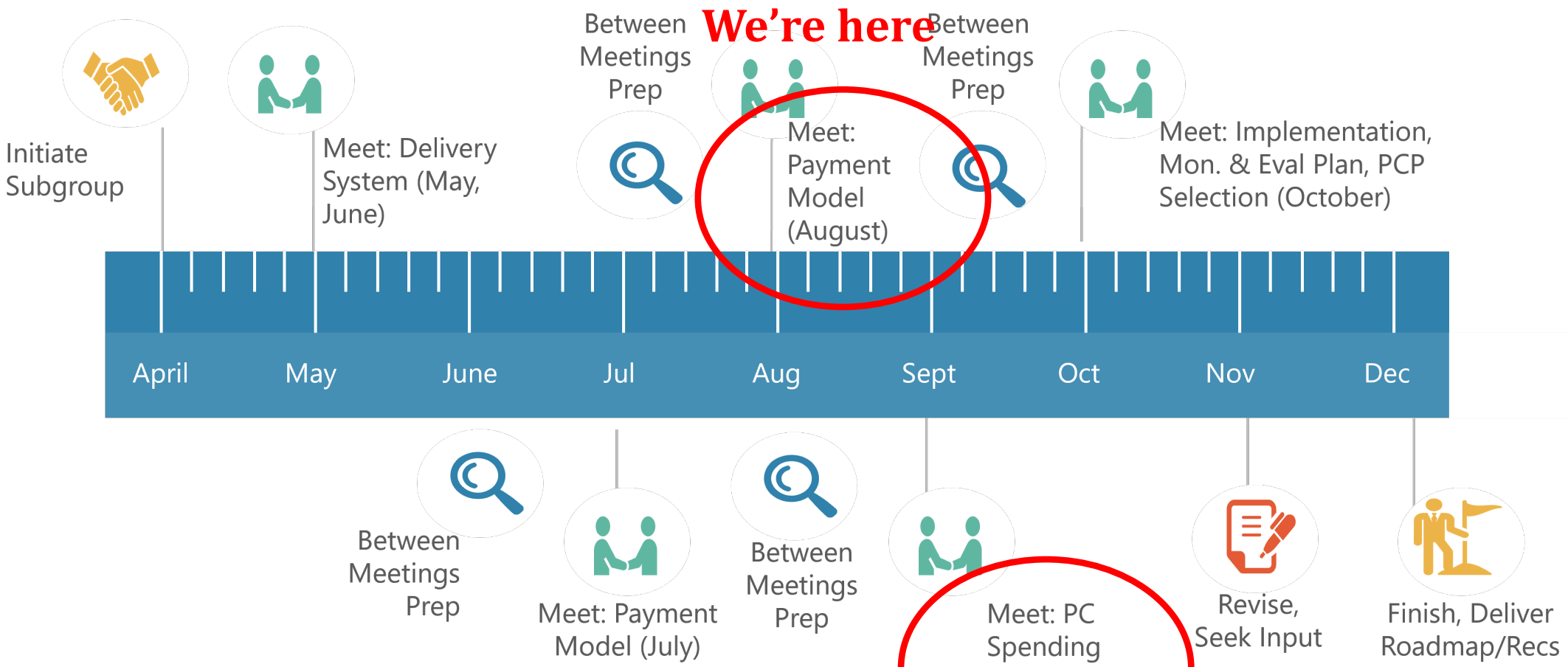
Payment Model	Description
3. Pay FFS for all services and a supplemental capitation payment	▪ A hybrid payment that combines FFS for all services and supplemental, capitated payments for practice engagement in care management infrastructure
4. Chronic condition episode of care bundles	▪ A bundled payment for some or all services delivered to a patient for an episode of care for a specific condition over a defined period to encourage providers to improve efficiency and quality of care. ▪ For chronic conditions, an episode could be (1) based on a sub-type to distinguish a category of a condition and (2) defined as a period—a month or a year—of management of the condition, including physician services, the services of other personnel and, in some cases, hospital stays.

For discussion

- The proposed prospective payment model links practice demonstration of core practice team function mastery to enhanced payments eligibility. Does the group agree with this approach?
- What are the group's reactions to these payment models?
- Are these approaches responsive to practice feedback? Feasible for insurers?
- Does the group have a strong preference for one of these payment models?

Next Steps and Wrap-Up

Subgroup 2021 revised process and timeline



Our intent is to review primary care spending target recommendations in September

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Next steps

- The next Primary Care Subgroup meeting is scheduled to take place September 28 at 1pm.


THANK
YOU