Primary Care Subgroup Meeting
September 28, 2021

OHS
CONNECTICUT
Office *of* Health Strategy

Roll Call

Public Comment (2 minutes/person)

Approval of the July 27th and August 24th 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 the July 27th and August 24th 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: #5 (revisit) and #6 (new)

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 August meeting

1. Subgroup members reviewed and offered feedback on a proposed primary care definition. OHS has accepted the group's recommendation to adopt the National Academies of Sciences, Engineering, and Medicine 2021 definition for high-quality primary care.
2. Subgroup members reviewed updated core practice team functions and provided additional feedback. OHS will finalize the core functions based on the group's feedback and then further define operational details in the future following completion of the Roadmap.
3. Subgroup members reviewed a proposal for a prospective payment model. Conversation among the group centered on how extra payments would support practices, questions about the primary care spending target and broad concerns about value-based payment models.

In August, OHS proposed a 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 services 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

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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

Subgroup members and stakeholders offered other payment models for consideration (1 of 2)

Payment Model	Description
1. Capitate common E&M code services *only* and pay FFS for remaining services	▪ Similar to the OHS proposal, but the prospective payment is only for the most common evaluation and management codes for mid-level outpatient office visits for established patients. FFS payment for all other E&M codes plus all other billed services. ▪ 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., the CMS Primary Care First model)	▪ 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

Subgroup members and stakeholders offered other 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 engaging with the plan's care managers.
4. Chronic condition episode-of-care bundled payments	▪ 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

- What are the group's reactions to these four alternatives to OHS' proposed payment model?
- Does the group have a strong preference for one of these payment models?

Addressing practice barriers to high-quality primary care

- Months ago, OHS sought the group's input on structural impediments and other barriers to the delivery of high-quality primary care that need to be reduced or removed for the Roadmap to be successful.
- There was significant alignment across the submissions. We synthesized your input and grouped the barriers into five identified themes: **payment**, **workforce**, **administrative burden**, **technology**, and **access**.
- Today we seek to review these barriers and identify which ones can be reduced through collective action.

Identified structural impediments and other barriers to high-quality primary care (1 of 5)

Theme	Cited Examples
Payment	- Inflexible payment models - Inadequate payment for comprehensive care or time outside of direct care - Misaligned models across payers - Lack of support for staff training or coordination w/social service providers - Medicaid payment policies

Can these barriers be reduced through the Roadmap's primary care strategy and/or other action? How?

Identified structural impediments and other barriers to high-quality primary care (2 of 5)

Theme	Cited Examples
Admin. Burden	- Paperwork and reporting requirements - Paperwork only a physician can sign - EMR documentation - Pre-authorizations - Chart review requirements

How can these barriers be reduced?

Identified structural impediments and other barriers to high-quality primary care (3 of 5)

Theme	Cited Examples
Technology	- Lack of broadband access across the continuum of care - Lack of access to all patient information - Lack of technology to administer electronic appointment check-ins - Lack of technology for telehealth

How can these barriers be reduced?

Identified structural impediments and other barriers to high-quality primary care (4 of 5)

Theme	Cited Examples
Access	- Access to what is ordered/prescribed by primary care and beyond the financial means of a patient - Transportation - Parking availability - Hours of operation - Limited access to behavioral health services and to some specialists

How can these barriers be reduced?

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Identified structural impediments and other barriers to high-quality primary care (5 of 5)

Theme	Cited Examples
Workforce	- Inadequate supply of PCPs - Underutilization of highly trained clinicians as expanded care team members - Market competition (hospitals hire away from practices with higher pay) - Working knowledge of special populations - Increased referrals to specialists - Inadequate training for Advanced Practice Providers (APPs)

OHS intends to address primary care workforce challenges with other agencies through a separate strategy. Nonetheless, does the Subgroup have recommendations for addressing these barriers?

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The Roadmap will define an implementation plan with activities starting in 2022

- The Roadmap implementation plan will describe who will be responsible for what actions and by when to successfully implement the functions and processes to advance primary care as defined by the Primary Care Subgroup.
- The plan will describe implementation activities starting in 2022.
- Today's discussion is focused on a high-level implementation plan that outlines responsibilities of OHS, payers and practices over the next two years.

Year One (2022) implementation activities (1 of 3)

OHS Implementation Activities
1. Obtain commitment from commercial insurers to achieving the primary care spend target and to the Roadmap. 2. Develop recommendations for how practices should invest additional primary care payments. 3. Develop Roadmap operational details, including: • interpretive guidance for core practice team functions so that practices know what is expected of them and OHS' third-party contractor can objectively assess core practice team function mastery, and • final recommended implementation parameters for the primary care payment model. 4. With advice from OHS' Quality Council, define a subset of primary care measures, derived from OHS' Core Measure Set, that insurers will use in all primary care practice value-based contracts. 5. Develop and release an RFP for an OHS-contracted third party to implement the OHS primary care program and contract for services.

Year One (2022) implementation activities (2 of 3)

OHS Implementation Activities, continued

6. With an OHS-contracted third party, design the following processes:
   - practice application process, practice initial assessment, practice coaching central curriculum for all practice coaching sources, practice recognition process, practice biennial evaluation for continued recognition, learning collaborative(s) curriculum
7. Develop and implement a communications strategy for OHS' primary care program.
8. Assess any policy (or other) barriers to achieving Roadmap objectives and determine actions required.
9. Design a Roadmap monitoring and evaluation plan to assess each element of the Roadmap:
   - How will OHS know if it is succeeding along the way (process measures)?
   - How will OHS know if it succeeded (outcome measures)?

Year One (2022) implementation activities (3 of 3)

Payer Implementation Activities
1. Commit to increasing primary care payment up to the target and to supporting Roadmap implementation, and take necessary follow-up steps.
Practice Organization Implementation Activities
1. Participate in educational activities regarding the OHS primary care program.

Year Two (2023) implementation activities

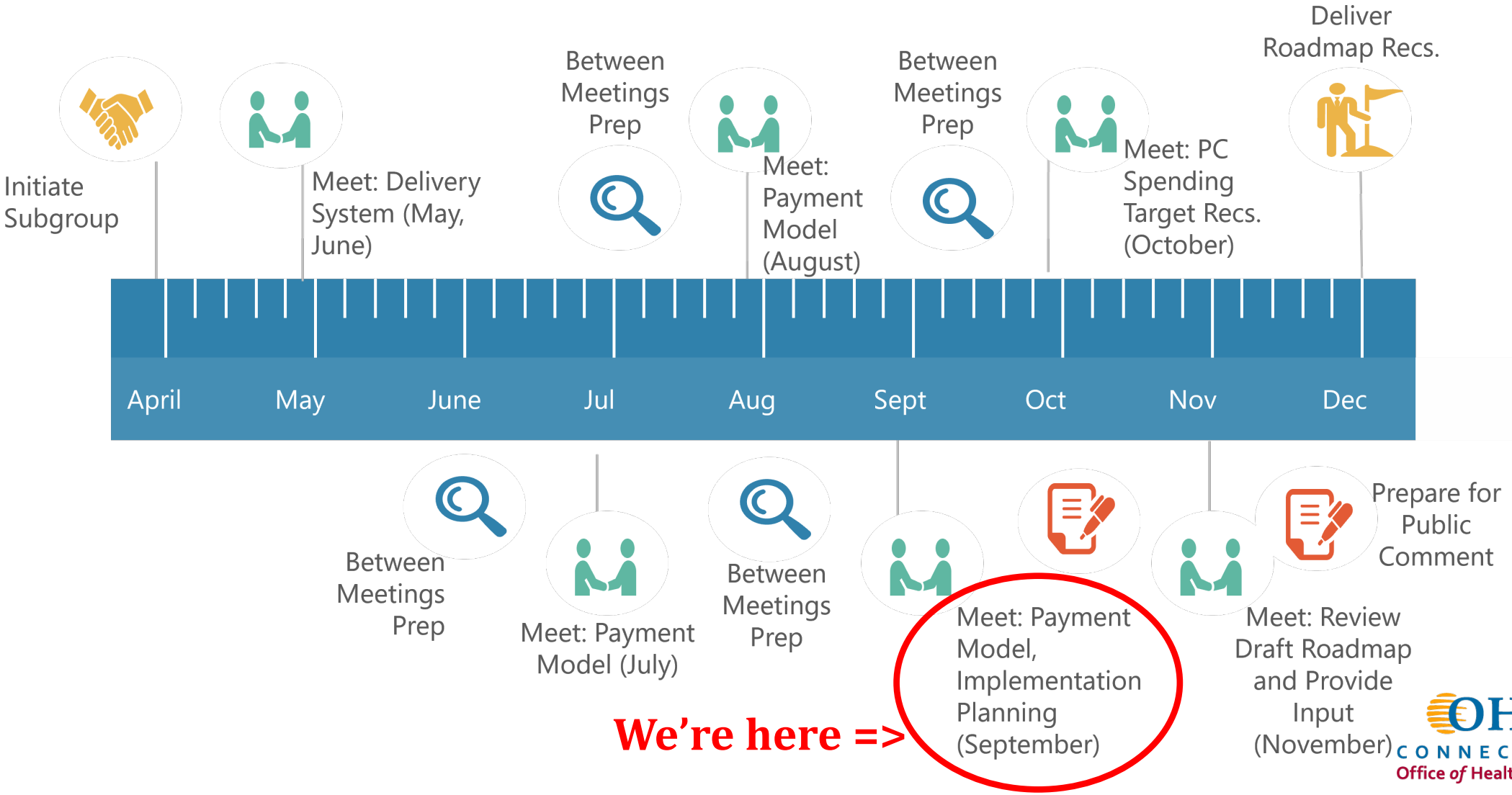
OHS Implementation Activities
1. Implement the primary care program. 2. Begin accepting practice applications to become OHS-recognized. 3. Begin Roadmap monitoring and evaluation. 4. Engage with insurance carriers to ensure primary care commitments are followed through. 5. Engage with primary care practices to understand practice experience with the OHS primary care program.
Payer Implementation Activities
1. Participate in OHS primary care program 2. Engage with OHS to report on primary care commitments
Practice Implementation Activities
1. Apply and participate in OHS primary care program to become OHS-recognized. 2. Engage with OHS to report on practice experience with OHS' program.

For discussion

- Does the group have feedback or reactions to offer regarding the implementation plan?
- Do you identify other key implementation activities that are missing?

Next Steps and Wrap-Up

Subgroup 2021 process and timeline



Next steps

- The next Primary Care Subgroup meeting is scheduled to take place on October 26 at 1pm.


THANK
YOU

Appendix

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

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.

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.