Payment Reform Council

May 16, 2019

AGENDA

1. Introductions/Call to order
2. Public comment
3. Approval of Minutes
4. Purpose of Today's Meeting
5. Review Savings, Performance Measurement and Accountability
6. Discuss Response to CAB Public Comment
7. Discuss Stakeholder Feedback on PCM model
8. Update on Medicare Primary Care Programs
9. Next Steps and Adjourn

Introductions/Call to Order

Public Comment

Approval of the Minutes

Purpose of Today's Meeting

Purpose of Today's Meeting

- Review projected savings, performance measurement and accountability
- Discuss Response to CAB Public Comment
- Discuss stakeholder feedback on PCM model
- Update on Medicare primary care programs

Review Savings, Performance Measurement and Accountability

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

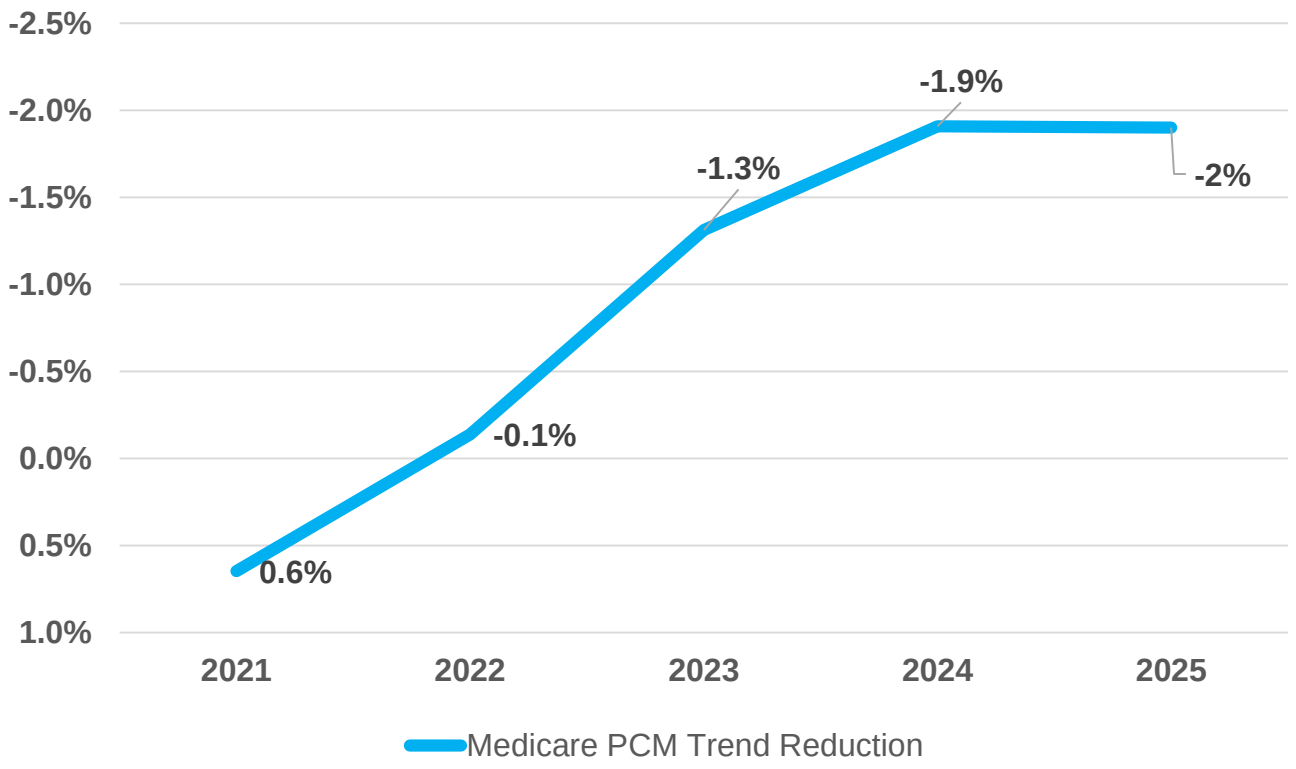
PMPM savings reflects the estimated per member, per month savings across the entire Medicare population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Medicare Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%, inpatient costs decrease 10%. *(PWC 2016)*	$32.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$4.03
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 6%. *(Strumpf, 2016; The Commonwealth Fund March 2012)*	$2.70
Specialized Practices: Pain Management/MAT	Total medical expense decreases 45%. *(Duke 2017)*	$2.10
Specialized Practices: Older Adults with Complex Needs	Skilled nursing facility utilization decreases 16%. *(Gross 2017)*	$15.03
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$2.34
Remote Patient Monitoring	Avoidable readmission costs decrease 50%. *(Broderick 2013)*	$0.33

SAVINGS INCREASE AS CAPABILITIES IMPROVE OUTCOMES

Based on an extensive review of the evidence, modeling shows PCM would drive immediate reductions in avoidable utilization and those savings would more than cover the cost of the program by year two.

PCM Impact on Medicare Total Cost of Care



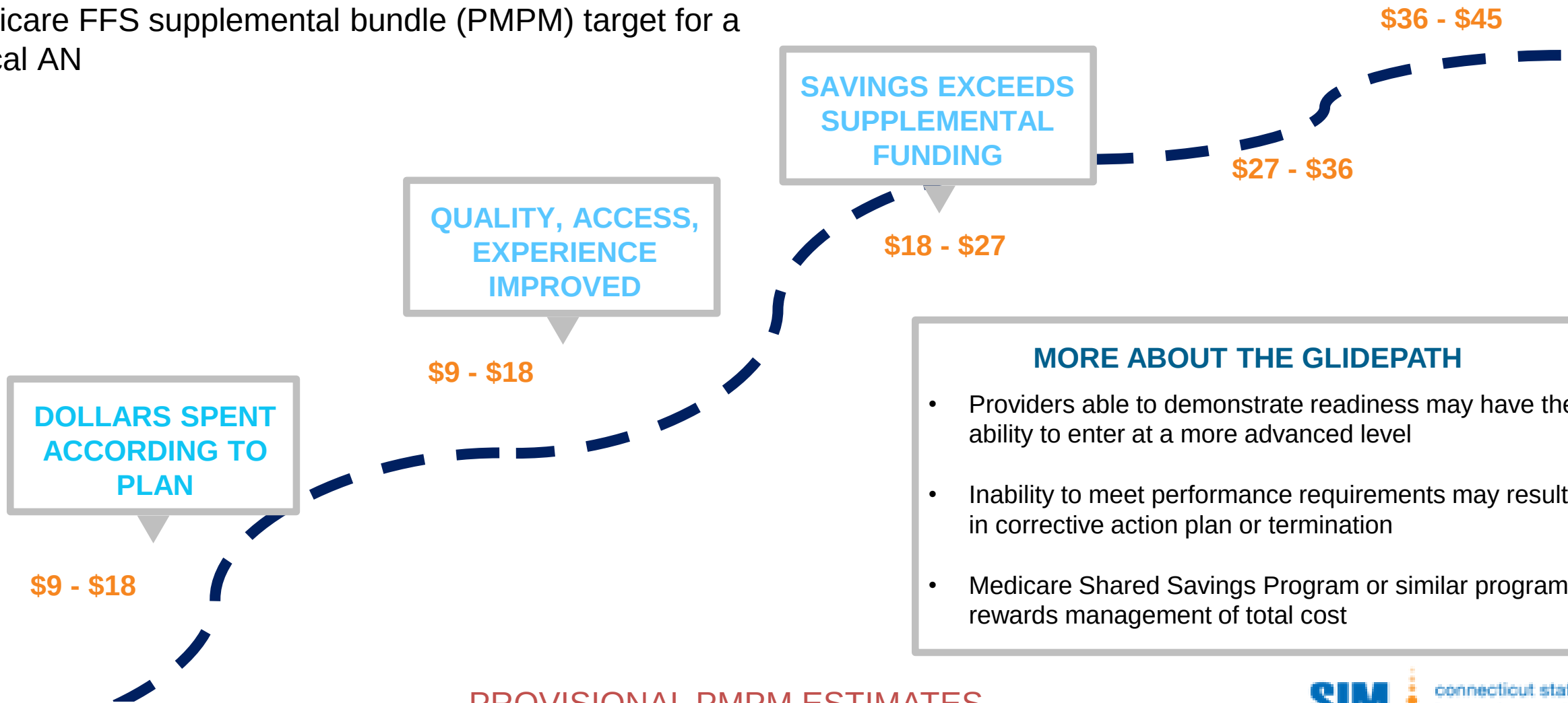
PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment in year 2 for Medicare
- Nearly 2 percent annual reduction in total cost of care by year 5
- Less spending on low value services and more spending on high value services
- Approximately 4.7% spend redeployed to primary care

GLIDEPATH ENCOURAGES SMART INVESTMENT

Supplemental payments will increase gradually and “proof of performance” will be required to advance.

Medicare FFS supplemental bundle (PMPM) target for a typical AN



MORE ABOUT THE GLIDEPATH

- Providers able to demonstrate readiness may have the ability to enter at a more advanced level
- Inability to meet performance requirements may result in corrective action plan or termination
- Medicare Shared Savings Program or similar program rewards management of total cost

CAPTURING DATA ON PRIMARY CARE ACCESS

Using a standardized format, practices would document all patient touches by all practice-associated personnel.

Access Tracking Report ABC Healthcare								
Practices included: Acton, Bridgefield, Essex, Marston and Overbrook								
Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).								
Attributed Patients		**Categories**						**Total**
Total Number of Patients Attributed		**PCP**	**Care Manager (RN, MSW)**	**Pharmacist**	**BH Clinician**	**CHW**	**Other (Navigator, Coach, Nutritionist)**	**All Clinical Encounters & Contacts**
RAW TOTALS	6,149	21,390	19,262	18,137	9,827	8,201	7,230	84,047
RAW AVERAGES (PER ENROLLEE PER YEAR)		3.48	3.13	2.95	1.60	1.33	1.18	13.67
RISK ADJUSTED AVERAGES		3.34	3.01	2.84	1.54	1.28	1.13	13.14

CAPTURING DATA ON PRIMARY CARE ACCESS

Types of encounters captured for all practice-associated personnel. This would provide greater insight into care delivery than available today.

Access Tracking Report
ABC Healthcare
April 1, 2018-March 31, 2019 (rolling 12 months)

Practices included: Acton, Bridgefield, Essex, Marston and Overbrook

Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).

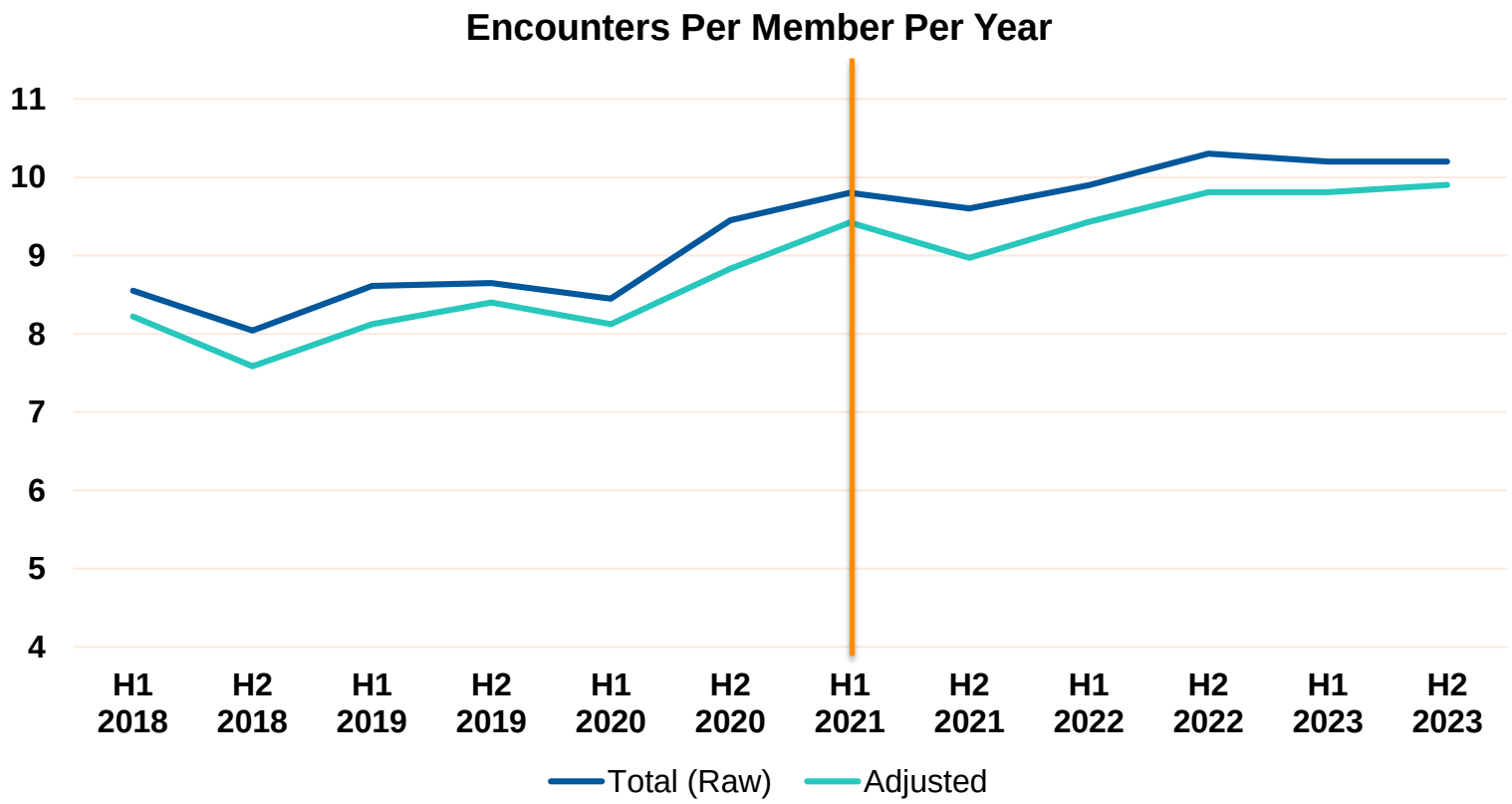
Attributed Patients		PCP				
Total Number of Patients Attributed		Office Visits	Telemedicine Visits	Home Visits	Phone/Text/E-mail contacts	Total Clinical Encounters
RAW TOTALS	6,149	7,230	2,987	1,172	10,001	21,390
RAW AVERAGES (PER ENROLLEE PER YEAR)		1.18	0.49	0.19	1.63	3.48
RISK ADJUSTED AVERAGES		1.13	0.47	0.18	1.56	3.34

GENERATING THE REPORT

- AN/FQHC configures EHR to capture all care team contacts, by patient and by type of contact
- PCP and care team personnel record their patient contacts in the *normal course of business* similar to other visit types
- AN/FQHC runs a quarterly summary report (de-identified) and uploads or transmits the report in a standard format to OHS and participating payers.
- Summary report includes contacts/patient by type of coverage (Medicare, Medicaid and commercial)

SHARING DATA ON PRIMARY CARE ACCESS

As part of program monitoring, the state could report both practice and system performance over time. As an example, the total encounters for one group might appear as shown below, with the vertical line representing the start of bundled payments.



TRANSFORM CARE ACROSS THE DELIVERY SYSTEM

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.

GOALS

BETTER ACCESS
- Convenience
- Timeliness
- Flexibility

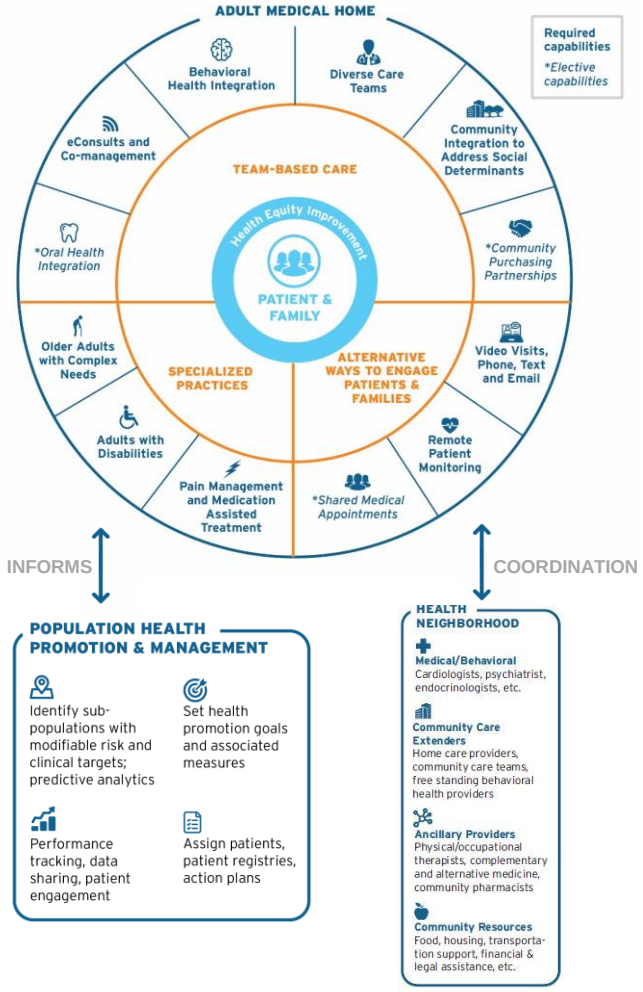
BETTER PATIENT EXPERIENCE
- Courteous and welcoming
- Listens and shares decision-making
- Advises and informs
- Coordinates and navigates

BETTER QUALITY
- Preventive care outcomes
- Chronic care outcomes
- Health equity

REVITALIZE PRIMARY CARE
- PCP and care team satisfaction
- Make primary care a more rewarding profession
- Incent incremental improvements in value

LOWER COST GROWTH
- Reduce cost growth
- Improve affordability for consumers

INPUTS



ENABLERS

FLEXIBLE PAYMENTS

BASIC BUNDLE
Advance payment for primary care provider time

SUPPLEMENTAL BUNDLE
Advance payment for primary care team staff and infrastructure

Shared savings program rewards total cost of care management

CONSUMER SAFEGAURDS
- Payments adjust for clinical and social risk
- Reporting demonstrates higher level of patient service and support

QUALITY MEASUREMENT
Quality and experience scorecard ties performance to shared savings rewards

ACCOUNTABILITY
"Proof of performance" required to qualify for supplemental payment increases

IMPACT

HEALTH OUTCOMES IMPROVE
- Diabetes & blood pressure control
- Improve rates of preventive screenings (e.g. colonoscopy)
- Reduce health inequities (e.g. race, ethnicity, income)
- Reduce percent of residents with risk factors (e.g. weight, tobacco)
- CAHPS scores improved
- Physician retention, satisfaction, recruitment increased (PCPs per 100,000)
- ED costs reduced 20%; Hospital costs reduced 10%;
- Medicare skilled nursing facility use reduced 16%;
- Commercial outpatient costs reduced 6%
- Spending on specialty care reduced 6% in Medicare and 3.6% in commercial

AFFORDABILITY IMPROVES
- 2% net reduction in total cost;
- 4.7% of Medicare, 4% commercial spend redeployed to primary care

Review of Consumer Advisory Board Public Comment Response

Introduction

Terminology

- Followed more recent convention of using the term “bundled payment” to refer to payment methods that bundle the costs associated with specific services, procedures or conditions. See e.g., Harvard Business Review:
  - https://hbr.org/2016/07/how-to-pay-for-health-care
  - https://hbr.org/2016/07/the-case-for-capitation
- Term capitation is often used to refer to models in which a provider organization or managed care organization is paid a monthly premium for all or nearly all of the costs of care.
- To avoid confusion we use the term bundled payment rather than capitation to refer to the bundling of primary care services, whether rendered by a PCP (Basic Bundle) or by members of the primary care team (Supplemental Bundle).
- Given the above, it is important to note that the Payment Reform Council has not recommended capitation in the form of a monthly payment for all of the costs of care.
- Regardless of terminology, we recognize the concerns of some advocates that bundled payment may result in less care for a population, such as people with disabilities.

Introduction

Sections of Public Comment Response

A. Comments and Questions Submitted by the Consumer Advisory Board (CAB) on 2/13/19

B. Comments and questions originally received from Members of the Consumer Advisory Board in 2018, with original responses and updates

C. Attachment Consumer Advisory Board Public Comment to Practice Transformation Task Force Meeting, October 9, 2018 from Arlene Murphy, Consumer Advisory Board

D. Attachment: Public Comment to Payment Reform Council from Patricia Baker, Connecticut Health Foundation and Lisa Honigfeld, Child Health and Developmental Institute Children's Fund of CT dated November 6, 2018

E. Attachment: Capitation Letter from People with Disabilities and Advocates for People with Disabilities Public Comment to Practice Transformation Task Force dated November 16, 2018

F. Consumer Input, Questions and Concerns for Implementation – Design Groups

A. Comments and Questions Submitted by the Consumer Advisory Board (CAB) on 2/13/19

1. Consumers have expressed concerns that the proposed bundled payment would be at downside risk for all or most of care. This means that providers could lose reimbursement if they do not generate enough savings in all medical expenses.
    - "very important question about how we design a payment system with new financial incentives and risks to providers that, at the same time, ensures that providers do not increase their revenue by denying care or turning away patients who require the most care"
    - "intent is to make it *more viable* to provide flexible and preventive care, in the office and in the community, by paying primary care providers adequately and in advance, so they can hire diverse care team members and routinely provide better services to patients"
    - "goal is to balance the incentives for increased, flexible, preventive and integrated care with safeguards against misuse of the payment model to the detriment of patients"
        - Providing higher risk-adjusted payments for patients with complex medical and social needs;
        - Monitoring the volume of patient encounters and "touches" to flag under-service;
        - Consumer surveys to determine whether primary care services are more accessible and convenient;
        - Deploying quality measures to hold providers accountable for good health outcomes.

A. Comments and Questions Submitted by the Consumer Advisory Board (CAB) on 2/13/19

1. Consumers have expressed concerns that the proposed bundled payment would be at downside risk for all or most of care. This means that providers could lose reimbursement if they do not generate enough savings in all medical expenses (continued).
   - "The Payment Reform Council (PRC) is not specifically recommending or requiring downside risk"
   - "The PRC has recommended that the PCM primary care payments be coupled with the Medicare Shared Savings Program (MSSP) or another shared savings program model that provides accountability for total cost of care"
   - "It is likely that the Council will leave the question of downside risk to the discretion of payers other than Medicare, whether commercial or Medicaid, should they decide to participate in PCM"

A. Comments and Questions Submitted by the Consumer Advisory Board (CAB) on 2/13/19

2. It is unclear how the payment model would improve care for patients and families. For example, some of the most important elements of primary care reform (care coordination, community integration) would be funded through the Supplemental Bundle. The Basic Bundle appears to only include payment for physicians, physician assistants, advanced practice nurses and telehealth.
    - Defined and re-iterated the purpose of the Basic and Supplemental Bundle
    - For example, noted Supplemental Bundle "would be an upfront, monthly payment to hire community health workers, navigators, care coordinators, health coaches and pharmacists to provide team-based care. It would also allow them to introduce patient financial incentives and also to cover occasional one-time non-health care expenses to improve outcomes such as carpet cleaning for someone with asthma."
    - Referred readers to the compendium of two page summaries of the capabilities that the bundled payments are intended to enable. These two-page summaries outline the benefits to patients, families and providers and also to the goal of improving health equity.

A. Comments and Questions Submitted by the Consumer Advisory Board (CAB) on 2/13/19

3. It has not been demonstrated how the proposed payment model would address Connecticut's significant health disparities. For example, providers may be required to evaluate social determinants of health. However, funding maybe insufficient to address identified needs. How will the payment model support the services needed to respond to these assessments?
    - "The above referenced compendium of two page summaries describes how each capability will help to reduce health disparities. In general, the PCM capabilities that would be supported by the proposed model would work together to address barriers to care such as language differences, cultural differences, lack of transportation, lack of childcare, lack of flexibility to take time from work, and low literacy. The PCM model would also invest in patient support and care coordination that would increase early testing and prevention, and assist all patients with securing and maintaining needed medications."

A. Comments and Questions Submitted by the Consumer Advisory Board (CAB) on 2/13/19

4. It has not been demonstrated how the payment model supports the infrastructure needed to measure, evaluate and address access, quality or care and patient experience?
    - “The PRC recommends that providers be permitted to use the Supplemental Bundle funds to pay for infrastructure costs needed to measure and address access, quality of care and patient experience as they relate to the proposed PCM capabilities.”

B. Comments and questions originally received from Members of the Consumer Advisory Board in 2018, with original responses and updates

Many of the questions submitted in Section B asked about specific capabilities, such as behavioral health integration, in which case we referred the questioner to the corresponding two-page summary.

Questions were also raised about patient risks/protections and whether we have developed a package of quality and under-service measures…

Primary Care Contact Reporting – "This innovation represents a leap forward from prior methods of monitoring patient care. We anticipate that providers will be required to track all clinical patient encounters and contacts including face-to-face and virtual contacts (e.g. phone, text, email and video visits) with all clinical and non-clinical staff. Patient encounters will be entered into the electronic health record…OHS, payer partners and stakeholder advisors might utilize the Access Tracking Report to inform decisions about whether each AN/FQHC could continue participation or be subject to a corrective action plan."

Consumer Experience Surveys – "PCM will include care experience surveys that include questions about ease of access. This will allow us to use consumer experience to directly inform whether we are achieving our access goals"

Mystery Shopper Surveys – "As an additional measure of protection, we are recommending the conduct of periodic mystery shopper surveys to measure whether access to new patients in primary care is improving. Such surveys would also enable us to measure whether the intended goals for improved access are occurring for patients with significant clinical and/or social risk or other special needs"

B. Comments and questions originally received from Members of the Consumer Advisory Board in 2018, with original responses and updates

Questions were also raised about workforce capacity…

"OHS met with the Department of Labor's Office of Workforce Competitiveness (OWC) to examine how best to support an expansion in the available workforce to support diverse care teams, including CHWs. OWC is willing to help develop a workforce strategy once the PCM design is finalized and it is certain what members of the workforce will be needed and in what capacity. They are also interested in considering how best to retrain current capacity.

Recognizing that the full complement of care team members, including CHWs, will not be available at the start of PCM, the Task Force proposed a staged implementation strategy. We anticipate that Advanced Networks and Federally Qualified Health Centers will deploy diverse care teams on a limited basis, within available workforce constraints, in the first year and expand over a period of five years. This will give the workforce market more time to adjust to the demand for workforce members that is brought about by PCM initiative."

In addition, the Community Health Worker Advisory Committee has developed recommendations with respect to the training, promotion, utilization and certification of Community Health Workers as well as establishing a framework for sustainable payment models for compensation…legislation is pending that would establish CHW along the lines of these recommendations.

C. Attachment Consumer Advisory Board Public Comment to Practice Transformation Task Force Meeting, October 9, 2018 from Arlene Murphy, Consumer Advisory Board

This comment raised concerns "about time frames, materials not getting to participants with enough time to prepare and the need to know what happens with consumer questions, comments and issues raised in the Design Group discussions. Recommended…

1) Consumer Representatives must receive materials with enough time to review and consider them.

2) Questions and issues raised by Consumer Representatives must be documented, answered and addressed.

3) Consumer Representatives must receive updates, decisions and amended materials related to their Design Group work.

PCM consultants made adjustments to the process to address these concerns, however, concerns about the consumer voice in the design group process have continued

D. Attachment: Public Comment to Payment Reform Council from Patricia Baker, Connecticut Health Foundation and Lisa Honigfeld, Child Health and Developmental Institute Children's Fund of CT dated November 6, 2018

This comment recommended inclusion of preventive services in the Basic Bundle and a greater focus on health promotion and population health.

PRC added preventive visits to the Basic Bundle for pediatrics. Response noted that Supplemental Bundle is aligned with the commenters request for flexibility, a greater focus on health promotion and population health, e.g., support pediatric care team collaboration with community supports, more time with families, and evidence based innovations such as group well child visits and literature promotion, and offer of universal home visits for parents of newborns.

The second part of the comment referred to the inclusion of non-health outcomes such as school readiness in the PCM payment model.

In response, we agreed with the importance of rewarding outcomes including rewards for non-health outcomes such as school readiness as discussed in the Health Enhancement Community Technical Report. By establishing these measures within the HEC Framework, we create the opportunity for rewards to flow to PCM participating Advanced Networks and FQHCs, as well as other cross-sector partners whose efforts will be instrumental to improving outcomes that require community-wide investments and advancements.

E. Attachment: Capitation Letter from People with Disabilities and Advocates for People with Disabilities Public Comment to Practice Transformation Task Force dated November 16, 2018

This comment focused on the potential risks associated with the Basic Bundle (under-service with respect to primary care access) and the introduction of downside risk as part of the associated total cost of care (shared savings/losses) payment model.

Response included review of the Access Tracking Report and other transparency/accountability measures to ensure that patients are getting better access, as described previously. We also noted that it has not yet been decided whether PCM will include the Basic Bundle and that we have been asking stakeholders whether they feel the benefits of the Basic Bundle outweigh the risks in light of the proposed transparency reporting. We have sought input as to whether it would be better to ask all payers to adopt the new telehealth codes and fees rather than including telehealth capabilities in the Basic Bundle. This would support much (but not all) of the flexibility that we are trying to achieve via the Basic Bundle.

E. Attachment: Capitation Letter from People with Disabilities and Advocates for People with Disabilities Public Comment to Practice Transformation Task Force dated November 16, 2018

This comment focused on the potential risks associated with the Basic Bundle (under-service with respect to primary care access) and the introduction of downside risk as part of the associated total cost of care (shared savings/losses) payment model (continued).

With respect to access, we indicated that we believe that adjusting upward the amount of the bundled payments to take into consideration disability status and other complex medical and social needs will create incentives to accept people with disabilities into all participating primary care practices. In addition, we are proposing to test out these access assumptions, by surveying individuals with disabilities to determine whether they have an easier time finding a PCP and also whether they are finding it more convenient to access the PCP or care team when support is needed.

We reiterated that the PRC will likely leave the question of downside risk to the discretion of payers, whether Medicare, commercial or Medicaid, should they decide to participate in PCM. In the case of Medicare, the newly revised Medicare Shared Savings Program will require downside risk, regardless of whether CT implements the PCM initiative.

F. Consumer Input, Questions and Concerns for Implementation – Design Groups

This section compiles an extensive range of comments that consumers made during the design groups.

With respect to each design group, we provided a link to the skeleton that informed the design group, which in many cases was modified based on discussion with consumers and other stakeholders. In addition, we provided a link to the two page capability summary for every design group that resulted in one or more capability summaries. These summaries describe the consumer benefits, provider benefits, anticipated quality impact, and implications for health equity. Consumer impact and health equity implications have been a common thread throughout the PCM consumer engagement.

Review Stakeholder Feedback

Stakeholder Feedback Overview

We've met with 6 payers, 6 advanced networks, 2 physician training groups, 6 employers, etc. We've heard strong support for nearly all elements of the model.

In particular, strong support for….

- Capabilities
- Supplemental bundle glidepath and proof of performance requirement
- Risk adjustment strategies for basic and supplemental bundle
- No requirement to harmonize attribution
- Access Tracking Reports

TRADE OFFS OF THE BASIC BUNDLE

The basic bundle would allow primary care teams to treat patients based on clinical need and patient preference without the constraints of fee-for-service. However, as CMS adds codes and fees for additional services, some wonder if this would be a preferable approach for all payers.

Benefits of Basic Bundle

- Maximum flexibility
- Lightened coding burden
- Option to reduce consumer cost share*

Benefits of Additional Codes and Fees

- Ease of administration for payers
- Certainty regarding services provided
- Familiarity and reliability for providers

Requirements of Both Approaches

- Documentation to ensure patient access and capabilities achieved
- Adaptation of billing systems
- Changes in culture and workflow to maximize effectiveness

** For commercial only*

Basic Bundle Feedback To Date

- Could be “transformative”; more access to virtual care and care teams; more time dedicated to the most complex patients
- Practicing physicians may be resistant to change
- Many health plans moving in this direction, but not there yet
- Require detailed tracking and safeguards, or providers may “not work as hard”
- Don’t make it mandatory. Allow providers and payers to choose whether to offer the basic bundle initially or phase in over time.
- Monitor use of specialists, urgent care, ED and quality metrics

Other Stakeholder Feedback To Date

- Would prefer flexibility to partner with community-based providers to offer care described in “Specialized Practices” capability
- Consider change “specialized practices” to “specialized clinics” to clarify intent
- Clearly articulate networks’ responsibilities regarding population health and health promotion analytics such as 1) develop, implement and refine operations to support continuous health promotion and quality improvement 2) help practices identify and connect with patients in need of support
- Consider requiring at least 80% of practices within ANs/FQHCs to be on the same or compatible electronic health record platforms. Newly acquired or affiliated practices should harmonize within two years.
- Consider establishing a practice specific supplemental bundled that applies to all beneficiaries for the entire year. CMS proposes moving in this direction with future population based payments having identified using a member-specific payment adds significant administrative complexity. The practice specific fee would represent the unique profile of the beneficiary population but would be stable.

Update on Medicare Primary Care Programs

New Medicare Primary Care Programs

- Primary Care First ***(not available to CT providers)***
- Direct Contracting provides risk-sharing payment model options

PCM Consideration:

- PCM supports a provider development strategy that enables readiness for risk and assuming accountability for achieving enhanced reductions in avoidable use and waste.
- PCM currently aligns with the Medicare Shared Savings Program (MSSP) and Pathways to Success. It could evolve to align with new options based on interest of CT stakeholder partners.

Next Steps

- Conclude remaining stakeholder engagement meetings
- PRC will review a draft report summarizing capabilities and payment model
- Report to be sent to HISC for approval to send to public comment

QUESTIONS?

Contact: Vinayak Sinha
vsinha@freedmanhealthcare.com

Adjourn