Payment Reform Council
Payment Methods “101”

September 2018

Purpose of today's webinar

- Provide PRC members with a common set of definitions and concepts that will be discussed during Council meetings
- Serve as a reference during future conversations
- Help frame the decisions before the PRC

Today's webinar will cover:

1. Why Focus on Primary Care?
2. Guidance from the Primary Care Transformation Task Force
3. Focus on Advanced Networks and FQHCs
4. Payment Model Options under Consideration
5. Payment Reform Council Agendas

Primary Care Modernization: Payment Reform Council

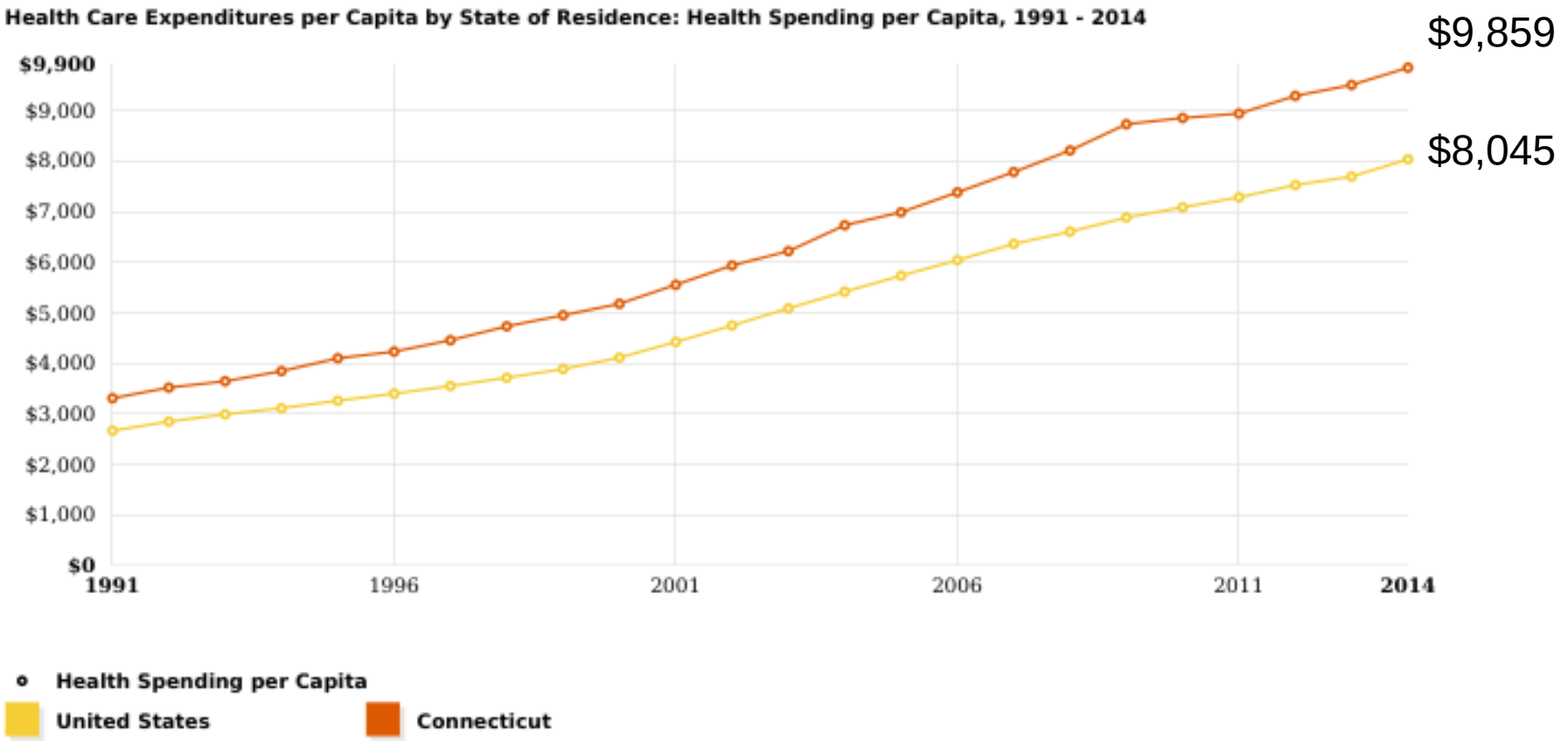
Goal: Develop payment model **options** for Medicare Fee-for-Service that increase flexibility to make primary care more convenient, community-based and responsive to the needs of patients, and ensure a return on investment.

And, make recommendations to other payers for the minimum requirements to be deemed aligned.

Payment Reform Council Key Principles

- Consider input from consumers, providers, payers and employers
- Review financial effect of capabilities recommended by the Task Force
- Determine methods of accountability and safeguards to protect against underservice and patient selection
- Design an implementation strategy that ensures a return that offsets the investment – builds over time
- Customize “best in class” federal and state initiatives for CT

Health Care Spending in Connecticut



SOURCE: Kaiser Family Foundation's State Health Facts.

- Among Highest Per Capita in the US
- Steeper Increases than Nation
- Low % of spending on PCP care

(5% vs 10-12% in high-performing models)

Physician Burnout is a National Public Health Issue

Many physicians, including more than half (55%) of primary care physicians, face burnout or a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment.

Burnout rates for all physician specialties has risen 25% increase in that last 4 years.

Top Drivers:

- Too many bureaucratic tasks, feeling like a cog in a wheel
- Too many hours at work
- Increased computerization of practice

Only 27% of a physician's time is spent on direct clinical care,
a recent time-motion study conducted by the AMA and Dartmouth-Hitchcock Health.

Why it Matters: Physicians experiencing high levels for burnout may leave the profession. Meanwhile, Connecticut projects a 15% increase in the current workforce will be needed by 2030 to support an aging, growing and increasingly insured population.

(Medscape Lifestyle Report 2017: Race and Ethnicity, Bias and Burnout Carol Peckham | *January 11, 2017)*

Why Focus on Primary Care?

1. Research, experience of others shows us it works

2. CT providers and patients tell us its needed

3. Aligns with national focus on primary care as critical path to achieve overall savings while improving health and outcomes

Primary Care Modernization: The Work To Date

Stakeholders have identified many goals for a new model of primary care in Connecticut, including:

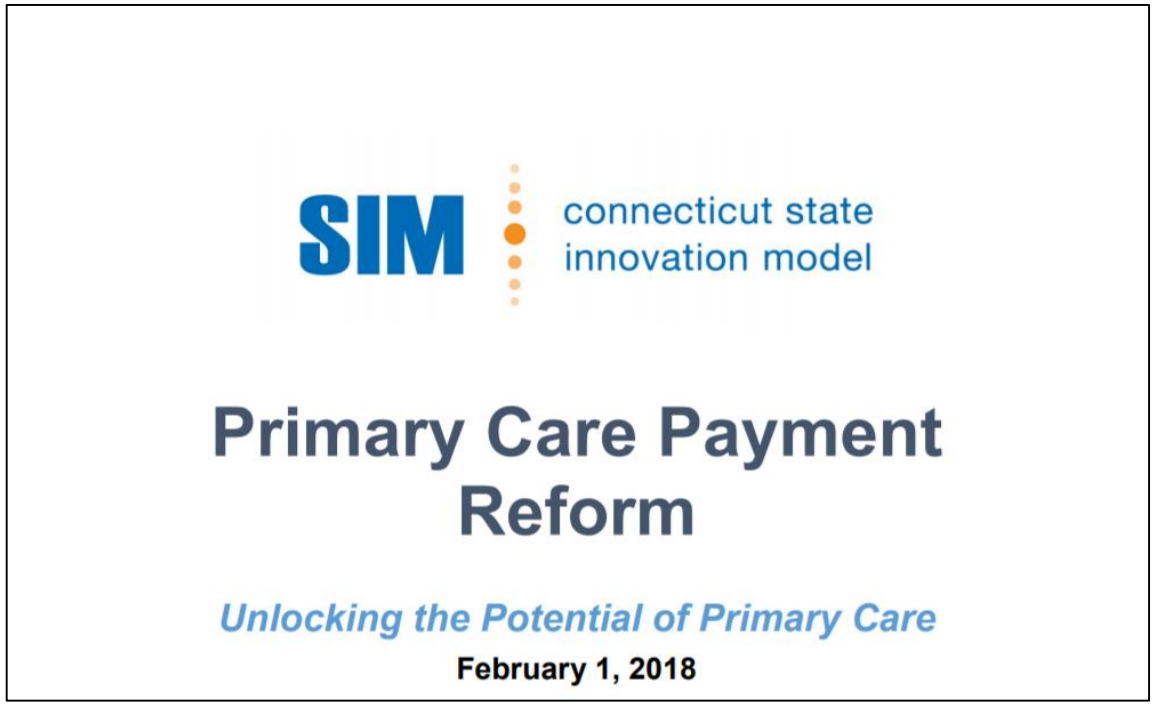
1. Support patient-centered, coordinated care and a better patient experience.

2. Help patients prevent disease, identify health problems early and better manage chronic illnesses so fewer emergency room visits and hospitalizations are needed.

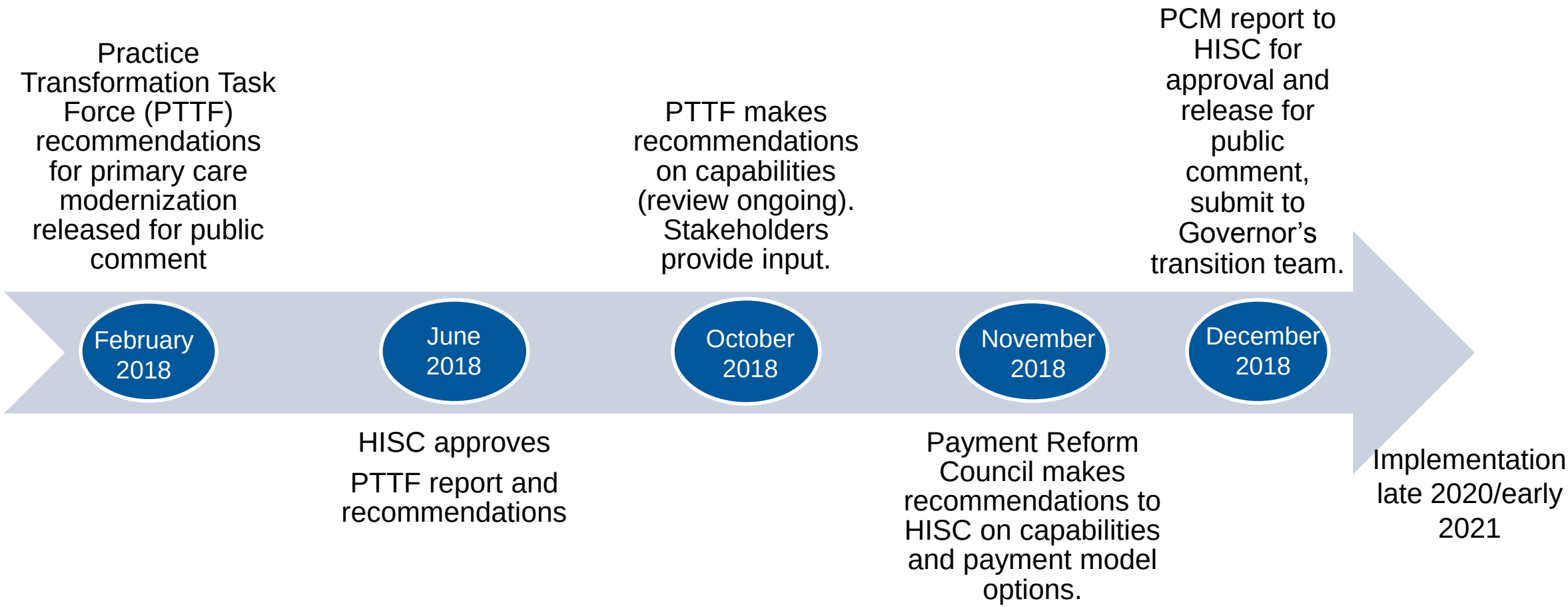
3. Expand care teams and improve access outside the traditional office visit.

4. Double investment in primary care over five years through more flexible payments.

5. Reduce total cost of care while protecting against underservice.



PCM Design Phase Milestones



Care Delivery Goal: Increase the Ability of Primary Care to Meet Patients' Needs

Expanded Care Teams	 Pharmacists, Nurses	 Care Coordinators, Community Health Workers, Navigators	 Health Coaches, Nutritionists
Additional Ways to Support & Engage	 Phone/Text/e-mail	 Home Visits	 Telemedicine
Investments in Technology	 Patient generated data & Remote patient monitoring	 Precision & Genomic Medicine	 E-Consults
Integrated, Coordinated Services	 Behavioral Health Integration	 Practice Specialization (e.g., geriatrics, chronic pain)	 Community Integration

Payment Model Option Components

Basic Bundle
- ***Based on historical spend***
- ***Adjusted over time?***
- ***Which services to include?***
- ***Still pay additional, reduced fee for office visits?***

Supplemental Bundle
- ***Paid separately?***
- ***Risk adjusted?***
- ***At risk for quality?***

Fee for Service Payments
- ***What services will still be paid fee for service?***

MSSP or Other Shared Savings or Downside Model Risk Puts Pressure on Total Cost of Care

Payment Reform Council Focus:
- Develop detailed and specific payment model options for Medicare FFS
- Develop recommendations for other payers that articulate minimum requisites to be deemed an aligned model.

Payment Model Concepts

Below are some the topics we will discuss during the Council's meetings.

Today, we will define these topics and share questions the PRC will consider related to these topics.

- Eligible Groups
- Conditions for Participation
- Types of Providers Eligible for New Payment Methodologies
- Basic Bundle Components
- Supplemental Bundle Attributes
- Attribution
- Risk Adjustment
- Settlements and Reconciliation
- Performance Measurement
- Funds Flow (productivity monitoring and compensation)

Eligible Groups, Conditions for Participation, and Provider Eligibility

For this project, the PTTF recommended:

1. **Eligible Groups** should meet criteria to contract for primary care payment innovations.

   Recommended criteria: *Advanced Networks or FQHCs with experience with population health and underlying risk contracts with Medicare or commensurate levels of risk engagement with Commercial or Medicaid products.*

2. **Conditions for Participation** should be met including:
   Willing to deploy or develop the required capabilities
   Willing to leverage new payment methodologies as defined by the model options

3. **Providers** with attributed Beneficiaries AND primary care specialties are **eligible** for bundled primary care payments.

   The specialties include:
   - Family Practice
   - Internal Medicine with no subspecialty
   - Internal Medicine with subspecialty of geriatrics
   - Pediatrics with no subspecialty
   - General Practice
   - Nurse Practitioner
   - Physician Assistant

Services in the Basic Bundle

Definition: Services, as defined by codes, included in the upfront, basic bundled payment.

These services should:

- Account for a significant portion of primary care practice revenue
- Be provided by a significant number of eligible providers

This work will not directly address historical differences in rates.

Payment Reform Council Focus

- Determine the specific service categories that should always be included in the bundle, categories that should be optional, and categories that should not be included.
- Determine whether the basic bundle will cover 100% of revenue from bundle services or if a reduced FFS payment for these services will exist.

What goes into the Supplemental Bundle?

Definition:

- Non-visit based payments to support activities and investments that are not normally billable as fee for service.
- Amount determined by the number of beneficiaries attributed to a given practice per month and case mix of the attributed beneficiary population.

Providers accepting greater levels of risk are usually eligible for higher supplemental bundle fees than those who do not.

Payment Reform Council Focus:

- Should it be risk adjusted? Based on population categories? Or, based on a percent inflator to the bundle?
- How should we calculate supplemental bundles to sufficiently cover the cost of new capabilities?

Attribution

Definition: A process used to **assign beneficiaries to a provider group or ACO for the purpose of making payments and evaluating performance**. It is also referred to as assignment.

- In Connecticut, most Beneficiaries are not required to select a PCP by their health plan. They may be able to voluntary select their PCP or they are assigned to the PCP based on utilization history.
- Utilization criteria may prefer providers with the most recent services, most frequent services, or accounting for the greatest portion of medical expenses.

Attribution can retrospective, prospective, or both.

Payment Reform Council Focus:

- Discuss recommendations on the use of retrospective reconciliation (which is a final update of beneficiary attribution to support a financial settlement).
- Identify goals for future improvements to the attribution process including helping the highest need beneficiaries, such as ER "superutilizers" connect with PCPs.

Adjustment for variations in illness burden and other patient factors across practices

Definition: Risk adjustment provides an important incentive to manage complex populations. It adjusts the amount of the payment based on the types of conditions, severity of conditions, and other characteristics of the patients.

It is different from what is sometimes called "risk sharing."

Relevant Uses:

- Make payments for patients with differences in expected service needs and resource use
- Compare performance over time to measure effects of interventions and minimizing impact of underlying changes in illness burden
- Compare performance across physicians and minimizing impact of differences in patient populations
- Provide data to help providers identify patients with the greatest need for management

Characteristics of Adjustment for Illness Burden

- Can be based on data including diagnostic (claims data), pharmacy, demographic or other status (disability, for example).

- The data is typically analyzed using a grouper-based methodology. Many groupers are available. All have different categories/characteristics and weighting schemes.

- At a high-level, there's two approaches:
  - Concurrent: Explains variation in a population in the current period
  - Prospective: Estimates risk in a future period

This project will consider adding social determinants of health into the adjustment.

Payment Reform Council Focus:

- Discuss need for risk adjustment of the basic and supplemental bundle.
- Make recommendations for including social determinants of health in risk adjustment.

Population Segmentation

Definition: Rating/cost categories that best predict future costs.

One potential approach to population segmentation is called the "Bridges to Health" model which suggests eight population segments that are reasonably distinct and have differing needs for healthcare management:

1. Healthy individuals
2. Pregnant mothers and infants
3. Acutely ill individuals with serious disabilities who are stable
4. Individuals with chronic conditions but have normal functioning
5. Individuals with chronic conditions who have limited reserve and experience exacerbations
6. Frail individuals (with or without dementia)
7. Individuals in a short period of decline before dying

Payment Reform Council Focus:

- Discuss whether this type of approach is appropriate for adjusting the care management fee.

Reconciliation/Settlement

Definition: Prospective payments (those made in advance) may be subject to reconciliation for attribution or total cost of care.

Some national models, like CPC+, have provisions for reconciling actual utilization of services with the upfront, basic bundled payment to allow for correction of significant over and under payments to providers.

If FQHCs are paid on a bundled basis, some programs will apply provisions to ensure they are not paid less than the FFS value of services delivered. This facilitates compliance with federal regulations applicable to health center payments.

Payment Reform Council Focus:

- Discuss monitoring changes in the amount of primary care delivered by providers participating in the bundle and whether the bundle should be subject to reconciliation.

Patient Selection and Underservice

Definitions:

Patient Selection refers to avoiding patients whose care is expected to cost more and selecting patients whose care is expected to cost less.

Underservice or underutilization is care that is not sufficient or appropriate in type, location, intensity, or timeliness to meet the patients **medical** need.

Payment Reform Council Focus:

- Discuss methodological criteria (such as risk adjustment) and other patient protections to hold programs accountable for meeting the best interests of patients.

Performance Monitoring and Measurement

Definition: Metrics, analytics and data sharing that provide ongoing feedback regarding the stakeholder satisfaction, quality, and cost of health care services and programs to consumers, providers and carriers.

- Indicators are usually compared to historical performance or a benchmark that is considered an appropriate target for performance.
- Providers and carriers produce many metrics and stakeholders typically determine which set of measures will be most useful to monitor.
- Measures focus on things providers and carriers can influence and are actionable.
- Most programs leverage both leading measures, or things that can be examined shortly after program implementation, and longer term measures in performance measurement.

Payment Reform Council Focus:

- Discuss whether existing process improvement activities are sufficient track changes in quality, costs, and satisfaction.
- Determine whether new reporting should be considered to reflect the costs and capabilities associated with the new payment methods.

Funds Flow

Definition: Each Advanced Network and FQHC pays their physicians using a wide range of methods, ranging from salaries to fee-for service. Funds flow also represents the payments made by payers to providers or provider entities.

Payment Reform Council Focus:

Consider how compensation of individual practitioners may need to change to better align the model or decide that it is best for the ACO/FQHC to retains the flexibility to decide compensation methods are for its practitioners.

PRC Agendas

Meeting 1:
- Eligibility, Conditions for Participation, Qualification for Receiving Payments:
- Payment Model Options and Hybrid Bundle
- Attribution: How does a practice realize payment for a particular patient?

Meeting 2:
- What are the minimum services in the base bundle?
- What are the minimum services in the supplemental bundle?

Meeting 3:
- Risk Adjustment: What if a practice has more sick patients or patient with more social needs than other practices?
- Funds Flow and Settlement

Meeting 4:
- Review Decisions
- Performance Monitoring and Measurement

Meeting 5:
- Re-Review of Stakeholder Input
- Review Scenario Modeling

QUESTIONS?

Contact:
Alyssa Harrington, aharrington@freedmanhealthcare.com
Vinayak Sinha, vsinha@freedmanhealthcare.com

Appendix

Practice Transformation Task Force

Unlocking the Potential of Primary Care Recommendations

1. Connecticut's payers should implement primary care payment reform to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.
2. Payers and providers are encouraged to use prospective bundled payments that reduce or eliminate reliance on visit-based care. Payers should offer entry-level options that limit the risk associated with bundling and an incremental strategy that enables practices to build their capabilities over time.
3. Primary care payment models should use prospective primary care bundles or care management fees to increase by at least double the funding dedicated to primary care as a percentage of the total cost of care.

Practice Transformation Task Force

Unlocking the Potential of Primary Care Recommendations

4. Primary care payment models should be coupled with an alternative payment model, such as a SSP, that rewards practices for controlling the total cost of care.
5. Primary care payment models should include the cost of new services in prospective primary care bundled payments or care management fees, which should be exempt from cost-sharing.
6. Primary care payment models should use risk adjustment to adjust payments to account for underlying clinical and social-determinant differences in the patient populations served by different primary care practices.
7. Fee-for-service (FFS) payment may play a limited role as part of a blended primary care payment model to incentivize certain services and protect against under-service.

Practice Transformation Task Force

Unlocking the Potential of Primary Care Recommendations

8. Primary care payment models should include a bundled payment option in which primary care practices receive resources to manage mental health and substance use conditions and assume accountability for associated outcomes.
9. Primary care payment models should maximize the flexibility that primary care teams have to expend resources on health promotion and coordination with community services, including the use of community health workers.
10. Payers that utilize primary care payment models should ensure that quality of care is measured and rewarded and that practices demonstrate that they are investing in and have implemented transformational change.
11. Primary care payment models should be multi-payer, cover the majority of a practice's patient population, and provide practices with external coaching support and technical assistance.

Features of CPC+ Initiative

Primary care medical home model developed by the Center for Medicare and Medicaid Innovation (CMMI). The goal of the program is to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.

- Comprehensive prospective CMFs beyond historic primary care payment rates
- Provides a quarterly bundled payment based on the practices' prior year's financial experience. This payment equals a percentage of revenue generated by specific office visit Evaluation and Management (E&M) codes (generally sick visits), PLUS an additional 10% of the previous year's selected E&M financial experience
- Includes some FFS reimbursement for certain services to reduce the risk of underservice to patients
- Supports markets where a significant number of payers are willing to participate and follow a similar financial structure (FFS + CMF + potentially some level of bundled payment) and program criteria (so practices can adopt common work flows and quality initiatives)