Payment Reform Council

September 27th 2018

Purpose of today's webinar

Begin Discussion of Payment Model Options:

- Determine whether the basic bundle will be the sole reimbursement for most primary care services.
- Determine whether the supplemental bundle should be calculated and paid separately.

Attribution:

- Determine approach for assigning patients to providers so providers can realize payment.

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 (i.e. cherry picking)
- 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
- Keep in mind SIM and project goals: improve health, care quality, patient and provider experience while reducing total cost of care and health disparities

PRC Agendas

Meeting 1:
- 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 patients with more social needs?
- Funds Flow and Settlement

Meeting 4:
- Review Decisions
- Performance Monitoring and Measurement

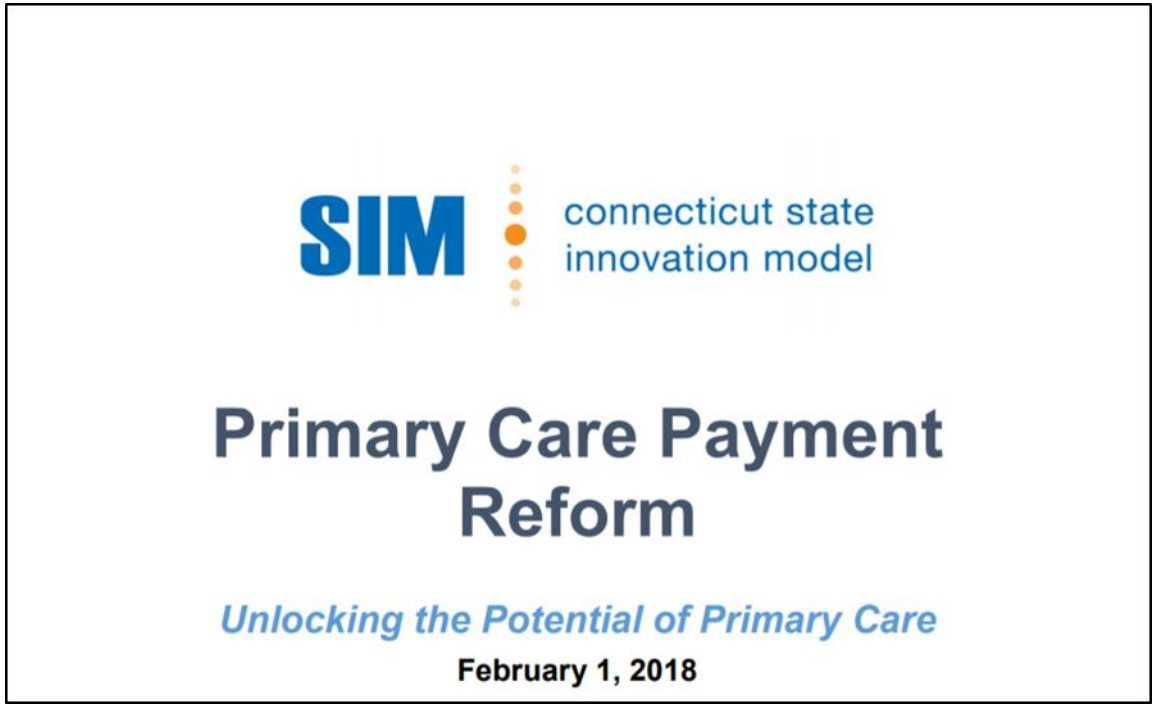
Meeting 5:
- Re-Review of Stakeholder Input
- Review Scenario Modeling

Practice Transformation Task Force: Working Assumptions

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

Recommended criteria:

- *Advanced Networks or FQHCs*
- *Experience with population health and underlying risk contracts*
- *Willing to deploy or develop the required capabilities*
- *Willing to leverage new bundle payment methodologies as defined by the model options*

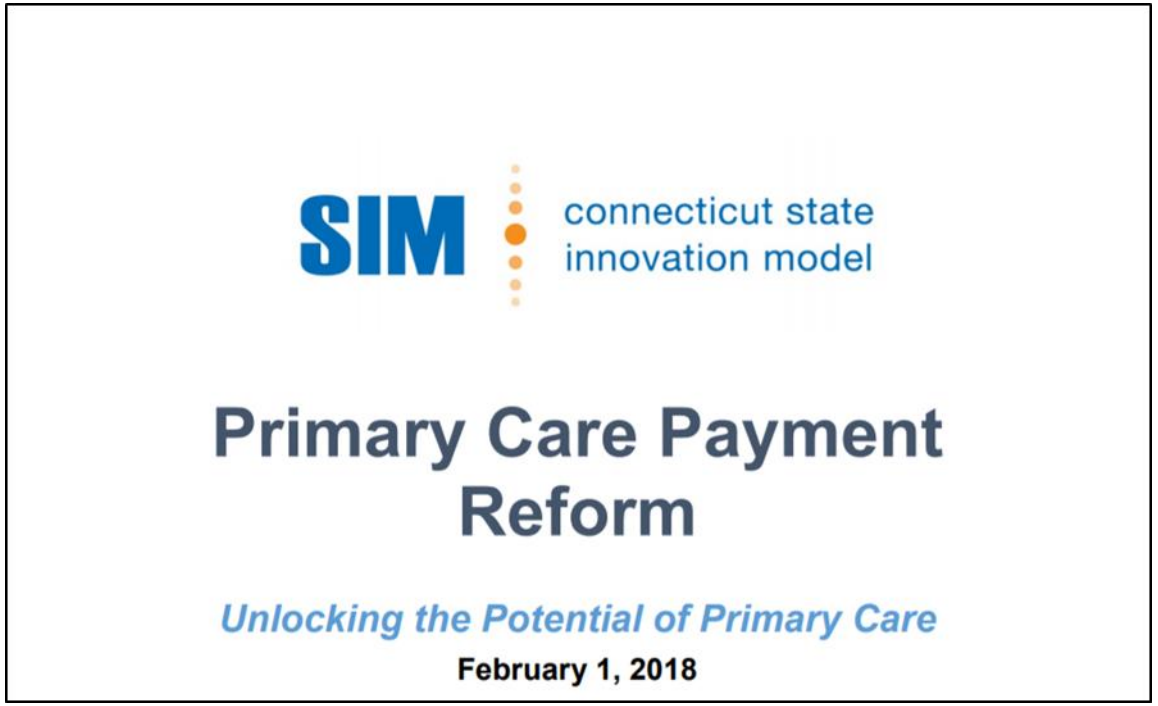


Practice Transformation Task Force: Working Assumptions

Providers with attributed beneficiaries and primary care specialties are eligible for bundled primary care payments.

Primary care specialties defined as:

- *Family Practice*
- *Family practice with subspecialty of geriatrics*
- *Internal Medicine with no subspecialty*
- *Internal Medicine with subspecialty of geriatrics*
- *Pediatrics with no subspecialty*
- *General Practice*
- *Nurse Practitioner with no subspecialty*
- *Physician Assistant with no subspecialty*



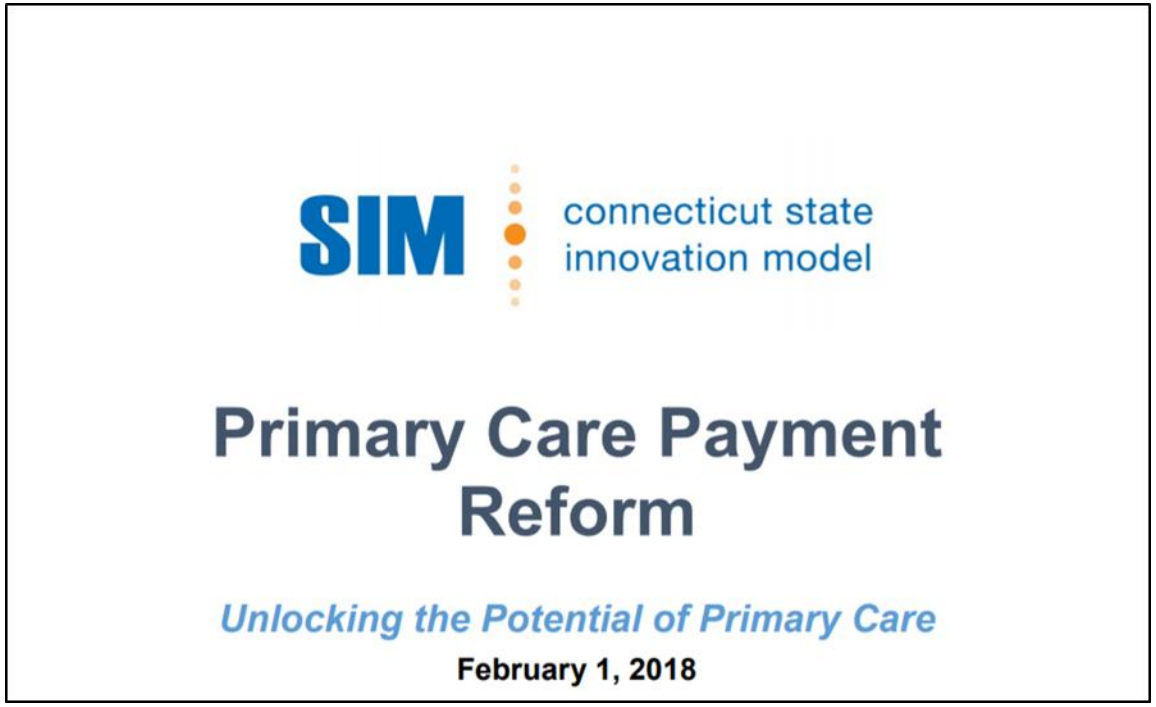
Practice Transformation Task Force: Working Assumptions

The basic bundle will replace at least a portion of fee-for-service payment for most primary care services.

Based on stakeholder input:

- The basic bundle will be provider-entity specific (not based on a standardized base cost target).
- The basic bundle will be calculated using historical claims data.

As part of its work, the PRC will decide whether reduced fee-for-service payments are still made, which services the basic bundle covers and which services will remain fee-for-service.



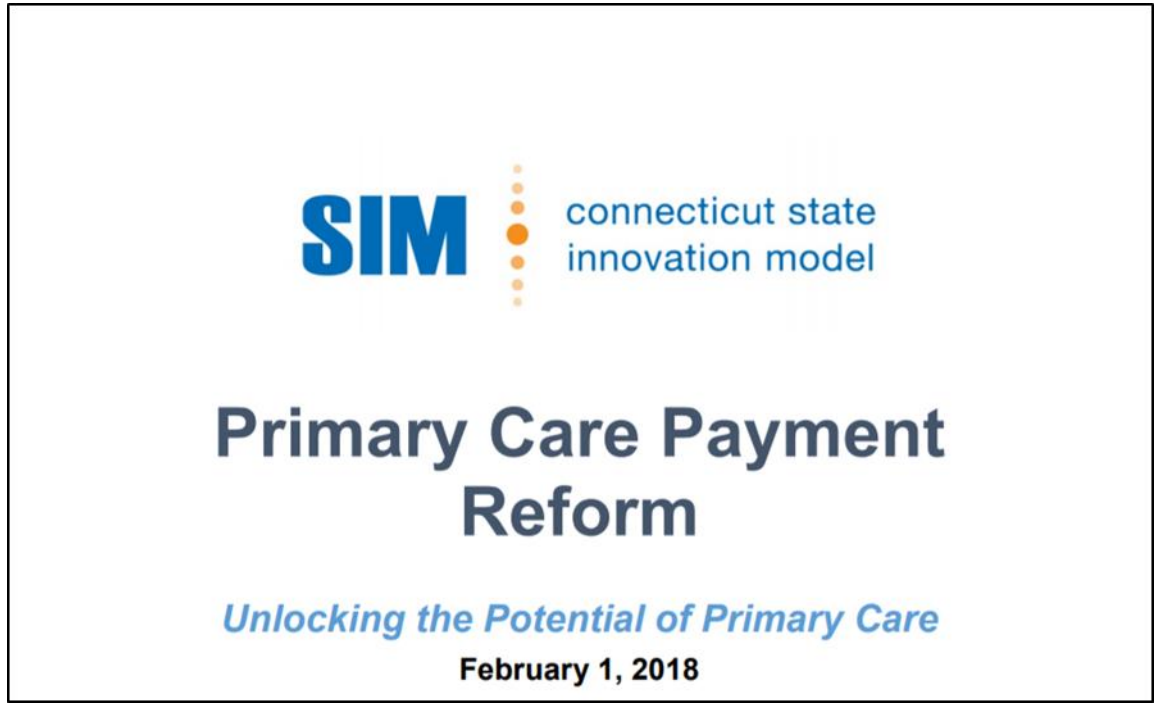
Practice Transformation Task Force: Working Assumptions

The supplemental bundle will fund programs, services, and other investments not currently billable in a fee-for-service environment.

Based on stakeholder input:

- The supplemental bundle will be standardized by payer.
- Payments will differ based on patient characteristics and provider capabilities or performance rather than historical unit costs.

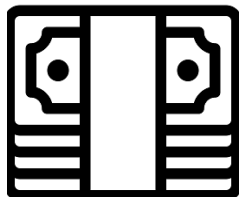
As part of its work, the PRC will make specific recommendations for Medicare funding levels and establish guidance for other payers whose programs will be influenced by their unique budget and larger programmatic goals.



Payment Model Options Outlined in PTTF Report

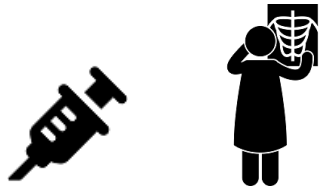
PARTIAL *PRIMARY CARE BUNDLE*

Basic Bundle Reimburses for Patient Care
(hybrid model could include reduced FFS payments for office visits)



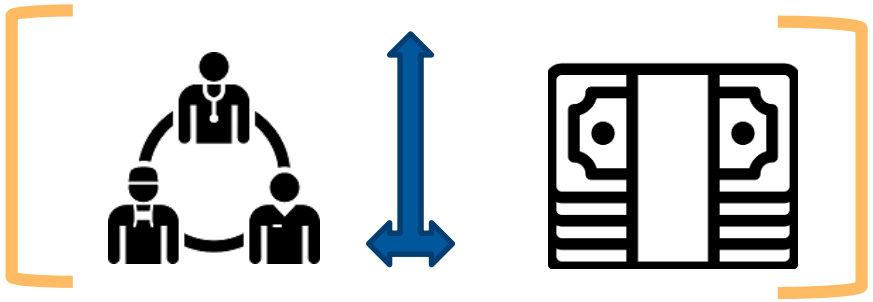
Supplemental Bundle Supports New Investments

FFS Payments for Certain Additional Services

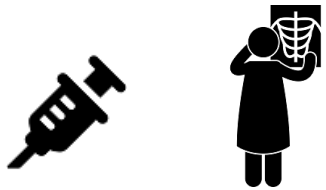


NEAR FULL *PRIMARY CARE BUNDLE*

Single Upfront Payment Supports New Investments and Reimburses for Patient Care



FFS Payments for Certain Additional Services



External Prerequisite:

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

Recap: Why will a “bundle” achieve our payment model goals?

Payment Model Goals

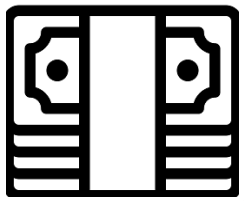
- Effective, Efficient, Convenient Care
- Programs that meet the needs of different patient populations
- Expanded care teams give patients access to diverse skillsets and allow physicians to operate at the top of their license
- Support and encourage provider investments in new care models (telemedicine, home visits, e-consults)

Attributes of Bundled Payment

- Flexibility to provide the best care based on clinical need and patient convenience, without billing considerations
- Can vary based on patient characteristics rather than volume of service
- Substantially reduces documentation burden for new care models
- Payments are more stable than fee-for-service
- Payments are prospective

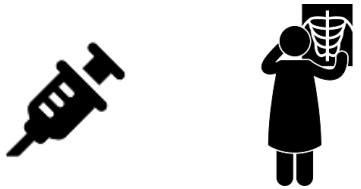
Payment Model Options: Key Questions

Basic Bundle



Supplemental Bundle

Fee for Service Payments



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

Tonight's Payment Reform Council Focus

Should the basic bundle be the sole reimbursement mechanism for bundle services (i.e. most PCP services)?

OR

Should practices receive reduced FFS payments for bundle services in addition to a smaller bundle (e.g. 50% bundle/50% FFS)?

OR

Should multiple options be offered?

What's the basic bundle?

- The basic bundle is an advance payment to allow practices to invest in transforming care.
- It can represent all of the costs for services in the bundle definition OR partial costs (i.e. hybrid).
- In a hybrid model, practices receive a reduced fee-for-service payment for bundled services **and** a smaller basic bundle.

The CPC+ Hybrid

Goals:

- Flexibility to deliver comprehensive care inside or outside of an office visit.
- Incentive neutrality, making a practice agnostic as to whether they deliver a service in person or via another modality.
- More time to increase the breadth and depth of services provided at practice sites and for population health improvement.
- Find a “sweet spot” between reduced FFS payments and “upfront” payments to incentivize site-of-service neutrality.

Learnings:

- Too many hybrid options creates unnecessary complexity. Hybrid ratios range from 10% to 65% of revenue bundled.
- During informal conversations, some CPC+ providers in Oregon shared primary care bundles are not very meaningful when they represent a small about of revenue and are paid quarterly.
- Hybrid models that remain heavily FFS can impede care transformation.

Should the basic bundle be the sole reimbursement mechanism for most primary care services?

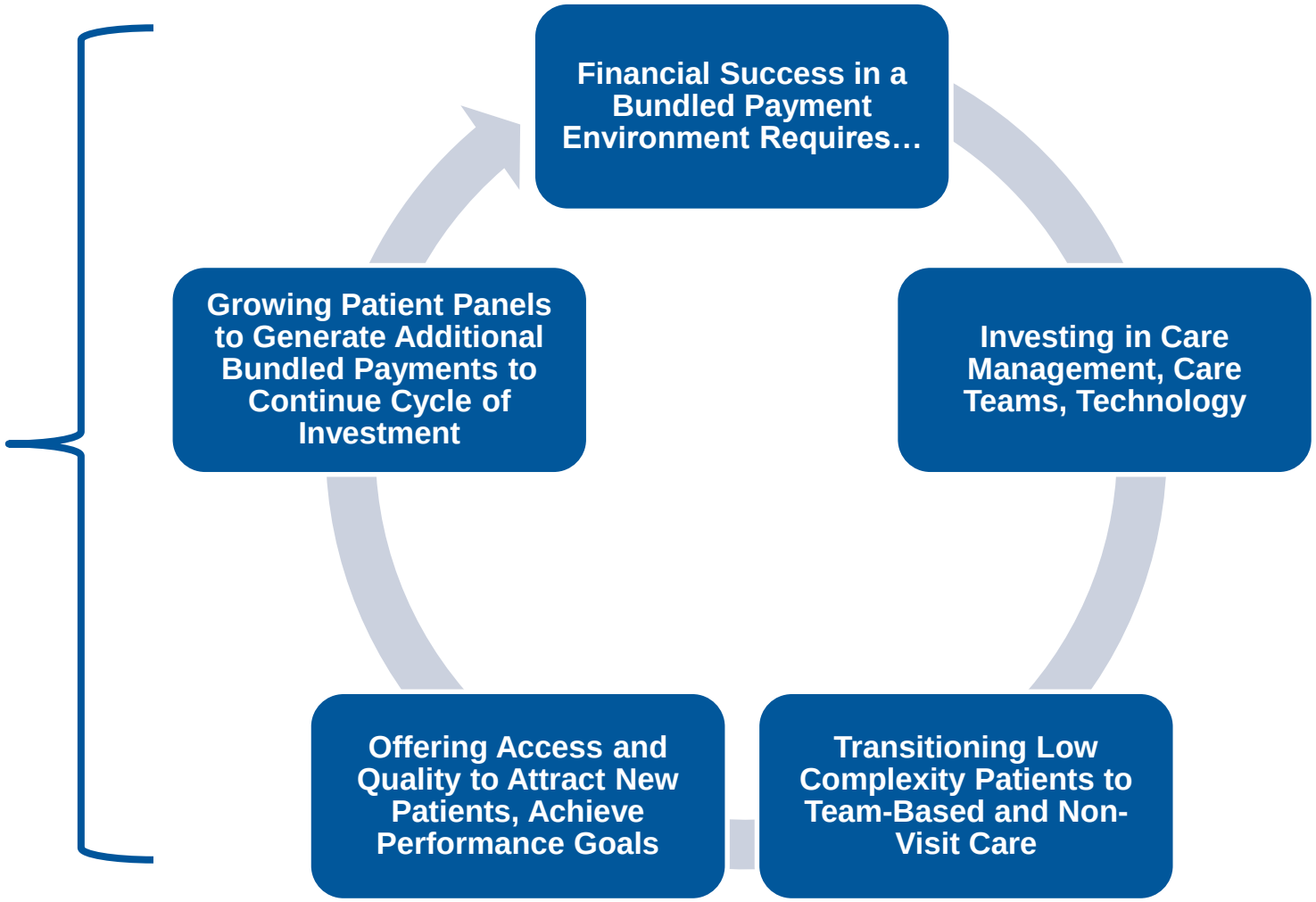
What We've Heard from Connecticut Stakeholders:

- Providers and payers are split. Some said care delivery changes will occur more quickly if the move to bundled primary care payments is 'all in.' Others said a "glide path" would be preferable for advanced networks with less experience in value-based payment.
- Some consumer advocates expressed concern that a move toward bundled payment could incent underservice. A model option that maintains partial fee-for-service payment could be another way to address this concern.
- Employers had no specific recommendation on this point but expressed strong support for model options that result in meaningful gains in care delivery and reductions in total cost of care.
- Across stakeholders, there was a strong preference for model options that support broad participation and position all for success.

Some stakeholders said a hybrid model felt "safer." It may be riskier.

A hybrid model, *particularly one with too little revenue coming through bundles*, may hinder care delivery transformation because practices will still be *somewhat* dependent on visit-based revenue.

Care delivery transformation is critical to long-term success.



Transitioning to a Bundled PCP Payment: The Math

PRIMARY CARE

By Sanjay Basu, Russell S. Phillips, Zirui Song, Asaf Bitton, and Bruce E. Landon

DOI: 10.1377/hlthaff.2017.0367
HEALTH AFFAIRS 36,
NO. 9 (2017): 1599–1605

THE PRACTICE OF MEDICINE

High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care

Moving to a bundled payment produced financial gains for 95% of practices **when** more than 63% of annual payments were bundled. (**Health Affairs, September 2017**)

EXHIBIT 2

Mean annual revenues, costs, and net surplus per FTE physician before and after a shift to team- and non-visit-based care, by payment strategy

	Payment strategy		
		Capitation	
Metric	Traditional FFS	50%	100%
BEFORE SHIFT			
Revenue	$530,181	$556,690	$583,199
Costs	451,893	451,893	451,893
Net surplus	78,288	104,797	131,306
AFTER SHIFT			
Revenue	$528,877	$613,641	$698,405
Costs	492,987	492,987	492,987
Net surplus	35,890	120,654	205,418

SOURCE Authors' calculations. **NOTES** The capitation payment fee was set at 110 percent of the previous year's total fee-for-service (FFS) payment, as explained in the text. Changes in net surplus per full-time-equivalent (FTE) physician per year (that is, the difference between revenue and expenditures at each practice, after accounting for physician salary) due to the shift were –$42,398 for traditional FFS, $15,857 if 50 percent of patients had capitated payment, and $74,112 if 100 percent of patients had capitated payment. Confidence intervals are available from the authors upon request.

Basic Bundle: Ideas for Discussion

1) Should the basic bundle be the sole reimbursement for bundle services (i.e. most PCP services)?

OR

2) Should practices receive reduced FFS payments for bundle services in addition to a smaller bundle (e.g. 50% bundle/50% FFS)?

OR

3) Should practices be able to choose?

Other Considerations:

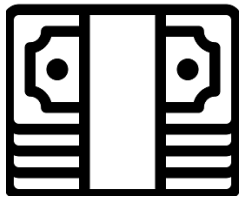
- Any hybrid model option should include a significant portion of revenue paid via the bundle. CPC+ uses 40/60 or 65/35 for mature participants. A 50/50 split could be offered for simplification.

- If a hybrid model option is offered, providers could be required to move to a 100% basic bundle over time.

Please note these options are intended to serve as a foundation. Additional model options may be added as the Payment Reform Council explores other model features such as which services will be included.

Payment Model Options: Key Questions

Basic Bundle



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Supplemental Bundle

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Fee for Service Payments

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

Today's Payment Reform Council Focus:

- Should the supplemental bundle be calculated and paid separately from the basic bundle?

What's the supplemental bundle?

- Non-visit based payments to support activities and investments that are not normally billable as fee for service.
- Based on a standardized rate applied to all providers in the carrier's program.
- Payments will differ based on patient characteristics and provider capabilities or performance rather than historical unit costs.

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Should the supplemental bundle be calculated and paid separately from the basic bundle?

What We've Learned from Research, Experience Elsewhere:

Paying the Supplemental Bundle Separately Allows for…

- A risk adjustment strategy aligned with patients' care management needs.
- The introduction of more equity in payments across primary care providers.
- A portion of the supplemental bundle being subject to accountability metrics, if desired by the PRC.
- Easier funds flow for various types of ANs. This portion of the reimbursement could be paid to the AN even if, for some ANs, the basic bundle is paid to the practices

Should the supplemental bundle be calculated and paid separately from the basic bundle?

What We've Heard from Connecticut Stakeholders:

Stakeholders said calculating and paying the supplemental bundle separately was preferred.

Decision Point:

Is there agreement that the supplemental bundle should be calculated and paid separately?

Attribution

How will we assign patients to providers for the purpose of realizing payment?

Payment Reform Council Focus:

- Confirm use of MSSP and Next Gen attribution methodology as basis for Medicare fee-for-service beneficiary PCM attribution.
- Confirm recommendation for other payers: Begin with each payer's existing methodology and adjust over time.
- Discuss whether attribution should be reconciled retrospectively.
- Identify goals for future improvements to the attribution process:
  - Helping the highest need beneficiaries, such as ER "superutilizers" connect with PCPs.
  - Offer credit for non-office visit touches and time spent with non-MD/DO/NP/PA care team members.

Attribution

What We've Heard from Connecticut Stakeholders

- There is no ideal attribution method.
- It's too hard to change quickly.
- Let's start with what we know and improve it over time.
- Patient churn presents an efficiency and revenue challenge for practices.
- Make sure any attribution method maintains consumer choice and access to primary care providers and specialists.

Proposed PCM Attribution for Medicare FFS

Patient Self Report = Patient Assigned

Gold standard but not always available (MSSP, Next Gen)

OR

Majority PCP Charges = Patient Assigned

If patient does not self-report, then patient behavior (charges) dictates (MSSP, Next Gen).

Prospective Patient List Provided to ACO

Prospective list supports AN care management and budgeting (CPC+, MSSP, Next Gen)

Quarterly Updates

Process would vary by program (CPC+, MSSP, Next Gen)

Final Retrospective Reconciliation

Subject to review by providers as part of the settlement process (MSSP)

Proposed PCM Attribution for Medicare FFS

One Key Difference to Keep in Mind:

MSSP and Next Gen employ a two-step attribution process.

- **Step 1**: Look at which ACO's **primary care physicians** provided the most primary care services (*at least 10% of all PCP services under Next Gen*).

- ~~**Step 2:** If no primary care services are received, look at which ACO's specialists provided the most primary care services.~~

PCM will not include patients attributed in Step 2.

(~18% of patients nationally)

Proposed PCM Attribution for Medicare FFS

Should attribution change *retrospectively*?

MSSP tracks 1 and 2 attribute beneficiaries to providers at the beginning and **update** assignments quarterly and prior to the final financial settlement.

MSSP tracks 3 and NexGen attribute beneficiaries to providers at the beginning. These programs **remove** those who do not meet criteria before the final financial settlement.

Reminder: Basic bundles will be based on the historical experience of the attributed population and fee-for-service populations.

Benefits of Retrospective Reconciliation

- Ability to get "credit" for additional patients gained.
- Better reflects care delivery during the period.

Challenges of Retrospective Reconciliation

- Risk of having fewer attributed patients than expected.
- Managing beneficiary/patient churn can be an efficiency and revenue challenge for practices.

PCM Attribution Recommendation for Other Payers

Recommendation: Use Existing PCP Attribution Methodology

Additional Considerations for Other Payers:

- Attribution should be transparent. Payers should provide PCPs with a roster of attributed patients at the beginning of the measurement period. This roster will change with periodic updates, based on an agreed upon schedule, and upon reconciliation.
- A correction process should balance the desire to accurately assign patients to the provider that rendered most of their care with providers' need to have sufficient predictability and stability in their populations for budgeting.
- A patient should be attributed to only one provider at a time.
- PCPs should be paid fee for service for services delivered to anyone who is not attributed to their group even if that patient cannot be attributed to anyone else.
- Benefit designs, patient outreach and communications should encourage strong engagement with a PCP care team.
- Over time, attribution methodologies should be updated to reflect PCP interactions via non-office-based visits and care delivered by other team members.

Decision Points:

Is there agreement that existing MSSP and Next Gen attribution methodologies should be used?

Is there agreement on the recommendation and additional considerations for other payers?

Should attribution be reconciled retrospectively?

Ideas for improving attribution over time?

PRC Agendas

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QUESTIONS?

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Appendix

Case Study: Iora Health

Overview: Iora Health has 29 practices in 11 states, including Connecticut and Massachusetts. It offers a comprehensive primary care payment model, which includes a risk-adjusted budget, incentives for meeting patient experience, quality, or utilization targets, and/or shared savings arrangements.

Approach: Care focuses on providing patients with support to follow recommended treatment and improve their health. Iora relies heavily on non-physician staff, particularly health coaches (e.g., community health workers). Care team provides patients practical and emotional support, reinforces patient education and actively participates in care delivery. Behavioral health is fully-integrated.

Results: Reductions in hospitalizations of its patients by 35% to 40% and reductions in total health care costs of 15% to 20% since 2010. Patient retention rate was 98% in 2017. Also in 2017, about 90% of patients had their blood pressure under control.