STATE OF CONNECTICUT
State Innovation Model
Payment Reform Council

Meeting Summary
September 27, 2018

Meeting Location: Connecticut Behavioral Health Partnership 500 Enterprise Drive, Suite 3D, Hartford Room, Rocky Hill

Members Participating: Thomas Woodruff, Joseph Quaranta, Naomi Nomizu, Eric Galvin, Robert Block, Peter Bowers, Robert Carr, Ken Lalime, Jess Kupec, Peter Holowesko

Other Participants: Mark Schaefer**,** Jeannina Thompson, Gail Sillman, Alyssa Harrington, Ellen Bloom, Laurie Doran, Pano Yeracaris, Janice Perkins, Jeanne O'Brien, Robert Kosior, Jennifer Searls, Kirsten Anderson, Mary Jo Condon

Not in attendance: Terry Nowakoski, Kate McEvoy, Fiona Mohring, Tiffany Donelson

1. Introductions
The meeting was called to order at 6:00pm

2. Public Comment
There were no public comments.

3. Discuss Payment Model Options

Purpose of the Meeting

Laurie Doran gave an update and reviewed the purpose of the meeting:

1. Begin discussion of payment model options to determine whether the basic bundle will be the sole reimbursement for most primary care services and whether the supplemental bundle should be calculated and paid separately.
2. Determine approach for assigning patients to providers (attribution) so providers can realize payment.

Recap of Primary Care Modernization Goal and Payment Reform Council Key Principles

Laurie Doran explained that the goal of the Primary Care Modernization initiative is to 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. It will also make recommendations to other payers for the minimum requirements to be deemed aligned. A key component of the work is to gain the important input of consumers, providers, payers and employers. Laurie Doran then reviewed the key principles of the Payment Reform Council, which are to review the 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 over time, and customize "best in class" federal and state initiatives for Connecticut, all while keeping in mind the SIM and project goals (which are to improve health, care quality, and patient and provider experience while reducing total cost of care and health disparities). A Council Member requested "access" and "double investment in primary care" be added to this list.

Review of Working Assumptions

Laurie Doran discussed how eligible groups should meet criteria to contract for primary care payment innovations and that the recommended criteria are Advanced Networks or Federally Qualified Health Centers, including experience with population health and underlying risk contracts, a willingness to deploy or develop the required capabilities, and a willingness to leverage new bundle payment methodologies as defined by the model options. A Payment Reform Council member inquired about the working definition of an advanced network. Mark Schaefer replied that the MSSP has its own definition, but that the Connecticut Office of Health Strategy uses the term Advanced Network to refer to any primary care organization that has at least one shared savings program contract.

Dr. Schaefer discussed that when the state approaches Medicare, Medicare must see CT as having a commitment and that downside risk will need to be a part of that commitment. A Payment Reform Council member asked whether as Medicare becomes more restricted, then the PCM model would follow. Mark Schaefer explained that the starting point would be MSSP and what is known for certain is what tracks are available for today. A Payment Reform Council Member reminded the group to take a temperature of the market because the sense is it's not particularly positive. Dr. Schaefer explained that the extra payments made to primary care today are essentially a favor, so we must hardcode the funding to sustainable commitment in primary care.

A Payment Reform Council member acknowledged that asking primary care doctors to take downside risk while the rest of the delivery system doesn't take risk will not work. Dr. Schaefer replied that we are not looking at primary care to fund downside risk, we are looking at the network itself to participate in the shared savings/downside risk program. Ms. Doran acknowledged that a lot of primary care providers and other provider organizations are moving into risk anyway because that is where they are seeing value. A Payment Reform Council member responded that any smart provider is going to say, "Well, these are the circumstances in which I would take risk."

A Payment Reform Council member inquired about the definition of risk in this project. Ms. Doran touched on insurance versus performance risk and told the Council she would send a pre-read so that everyone can properly prepare for the next Payment Reform Council meeting.

A Payment Reform Council member asked where the money will come from to double the investment in primary care and stated that simply using risk alone to do this will not work. You must move money around, and you must have willing participants. Dr. Schaefer stated that we can and should consider a value-based insurance design conversation, and we can look at how we can strengthen what's going on in that conversation.

Ms. Doran explained how providers with attributed beneficiaries and primary care specialties are eligible for bundled primary care payments. Ms. Doran discussed how primary care specialties are defined as family practices, family practices with a subspecialty of geriatrics, internal medicine with

no subspecialty, internal medicine with a subspecialty of geriatrics, pediatrics with no subspecialty, general practice, nurse practitioners with no subspecialty, and physician assistants with no subspecialty. There was a suggestion to refine this list regarding Nurse Practitioners and Physician Assistants. A Payment Reform Council member asked if physicians in GI, for example, will not be a part of this payment model, then there is a way to separate this. Laurie Doran confirmed, and explained that in general, the commercial plans seem to be leveraging primary care attributions anyway. There doesn't seem to be a broad use of specialists in the attribution process.

Ms. Doran went on to discuss how the basic bundle will replace at least a portion of fee-for-service payments for most primary care services. A Payment Reform Council member asked if there will be a customized bundle for each, and Ms. Doran confirmed there will be. Ms. Doran then went on to discuss how the supplemental bundle will fund programs, services, and other investments not currently billable in a fee-for-service environment. Ms. Doran added that this does not mean you couldn't do a slightly different schedule for providers taking higher or lower risk. A Council member asked what will vary, to which Ms. Doran replied that the focus of our work is on Medicare. The working assumption is that carriers will set their supplemental budgets based on the capabilities we are asking people to provide. Carriers will not negotiate something different based on anything other than having more capabilities or having more patients.

Dr. Schaefer explained that one approach might be to have everyone's patients have a risk score at one of the five levels. For supplemental payments, it's a level playing field, and you adjust for what that practice is willing to do.

Dr. Schaefer continued by explaining employers tell us we are spending a lot of money purchasing services from the carrier (health plan). A Council Member went on to say that yes, there is some money there, but it is doubtful this could fully fund what we are envisioning, adding that this big investment sounds a lot like CPC+. Dr. Schaefer added that it is important for us to reduce wasted physician time, and the biggest win for physicians is for us to reduce the documentation. A Council Member pointed out that reduced documentation would be a significant selling point for providers.

The Payment Reform Council determined it would continue the discussion during its next meeting.

<u>How the Bundle Will Achieve Payment Model Goals</u>

Ms. Doran reviewed how the basic bundle is an advanced payment to allow practices to invest in transforming care. It can represent all 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. A Council Member inquired over the issue with quarterly, and it was noted that if it's not a part of the revenue stream, it will not change behavior that much.

A Council Member asked if the bundle will adjust for risk and comorbidity, to which Ms. Doran confirmed that people will start with a bundle adjustment for historical expense. A Payment Reform Council Member acknowledged that reengineering a practice for 10% is obviously too low, but that there is a sweet spot in the middle and did share the concern that if it's too small, a meaningful transformation cannot take place.

The Payment Reform Council determined it would continue the discussion at its next meeting.

The Supplemental Bundle

Ms. Doran posed the question of whether the supplemental bundle should be calculated and paid separately from the basic bundle. It was explained that the supplemental bundle would include non-visit-based payments to support activities and it would be based on a standardized rate applied to all providers in the carrier's program, and payments would differ based on patient characteristics and provider capabilities or performance rather than historical unit costs. A Council Member inquired over the difference between performance and unit cost. Ms. Doran explained that if Practice A was able to do advanced telemedicine and had a robust care management program, but Practice B didn't, Practice A would be paid more than Practice B.

It was then discussed whether the supplemental bundle should be calculated and paid separately from the basic bundle. Ms. Doran explained how this would stratify the population into eight cohorts, and the basic wisdom is that a healthy child would need lower supplemental resources than an elderly person who has dementia. A Council Member noted that risk adjustment doesn't do the best job in primary care needs.

Dr. Schaefer went on to explain that the supplemental bundle that the supplemental bundle is intended to right-side the availability of upfront funds to support the care team, but we will have to talk about how prescriptive to be. The Council discussed how panels have a lot of salary positions and the dollars end up in different places, so it would be simpler this way. It's a lot easier to measure, but that if it's a small group, you'll have less supplemental funding. Dr. Schaefer noted that some of the supplemental funds would be invested in a way that provides shared resources. The Payment Reform Council determined the supplemental bundle would be calculated and paid separately.

4. Discuss Attribution Methodologies

Ms. Doran posed the question of how to assign patients to providers for the purpose of realizing payment.

The Council went on to discuss PCM Attribution for Medicare FFS and recommendations for other payers. Ms. Doran explained that if a patient is not attributed under this model, the patient would default to fee-for-service model. Dr. Schaefer went on to explain that a more consumer-friendly way of driving primary care would be to waive all primary care cost-sharing. He expressed that he would be interested in continuing the discussion on opportunities to use consumer engagement and benefit design to support model success.

A Council Member asked how one would track patient cost-share in a fully capitated model. Ms. Doran suggested one approach is to use shadow pricing, and then it's a reconciliation to offset bundle payments that you've received.

Ms. Doran then asked the group if there was an agreement that existing MSSP and Next Gen attribution methodologies should be used, whether there was agreement on the recommendation and additional considerations for other payers, if attribution should be reconciled retrospectively, and if there were any ideas for improving attribution over time. Members were unsure if there was

enough understanding to answer the question on reconciliation and asked to be educated on this process a little more.

There was general agreement on the recommendation to base attribution on current methodologies but to continue this discussion to make recommendations for future improvements to attribution over time. The Payment Reform Council decided to resume its discussion of retrospective reconciliation during the next meeting.

5. Next Steps:

Alyssa Harrington explained that the Council will not be meeting on October 4th, but the following week on October 11th.

The meeting adjourned at 8:24pm.