OHS CONNECTICUT Office of Health Strategy

Payment Reform Council

October 11th 2018

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of Minutes	5 min
4. House Rules Overview	5 min
5. Review Purpose of Today's Meeting	5 min
6. Revisit Question on Risk	5 min
7. Discussion of Payment Model Options	80 min
8. Next Steps	5 min
9. Adjourn	

Introductions/ Call to Order

Public Comment

Approval of the Minutes

House Rules

House Rules for PTTF Participation

1. Please identify yourself and speak through the chair during discussions
2. Be patient when listening to others speak and do not interrupt a speaker
3. 'Keep comments short (under 2 minutes if possible) and to the point/agenda item (*the chair may interrupt if the speaker strays off topic or talks longer than 2 minutes*)
4. *Members should avoid speaking a second time on a specific issue until every PRC member who wishes to speak has had the opportunity*
5. *Members should take care to minimize interference (please mute all phones, turn off cell phones, limit side conversations or loud comments)*
6. Please read all materials before the meeting and be prepared to discuss agenda/issues
7. Please participate in the discussion—ALL voices/opinions need to be heard
8. *Participation in the meetings is limited to Task Force members and invited guests; all others may comment only during the initial public comment period*
9. After the meeting, please raise any concerns with meeting process/content with the co-chairs

Question on Risk

Insurance Risk & Performance Risk

ACO payment methodologies seek to transfer performance risk to providers who manage care under their influence while minimizing transfer of insurance risk.

Insurance risk is the risk associated with the unknown variation in the utilization and cost of health care. It includes:

- Risk associated with random variation such as high cost claimants (Process Risk)
- Risk associated with using imperfect information to create benchmarks such as population changes (age, gender, or acuity differences), changes in legislation and new technologies impacting variation in patient demand (Parameter Risk)

Performance risk relates to inefficiency or suboptimal delivery of health care services relative to the assumptions or comparisons used to establish the budget. It includes the risk that targeted savings associated with care management will not be realized if the program is implemented unsuccessfully or not at all.

Discussion of Payment Model Options

Discussion of Payment Model Options

Continue Discussion of Eligibility and Risk:

- Determine what criteria should be used to establish eligibility and qualifications of networks and providers.

Begin Discussion of Services to Include in Basic Bundle:

- Determine which primary care services should be included in the bundle and which should be paid fee-for-service.

Continue Discussion of Payment Model Options:

- Determine whether the basic bundle will be the sole reimbursement for most primary care services.

Continue Discussion of Attribution:

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

Eligibility

Tonight's Payment Reform Council Focus:

- What will be the criteria for determining which advanced networks will be eligible for PCM?
- What will be the criteria for determining which providers in those advanced networks will be eligible for PCM?

Practice Transformation Task Force: Working Assumptions

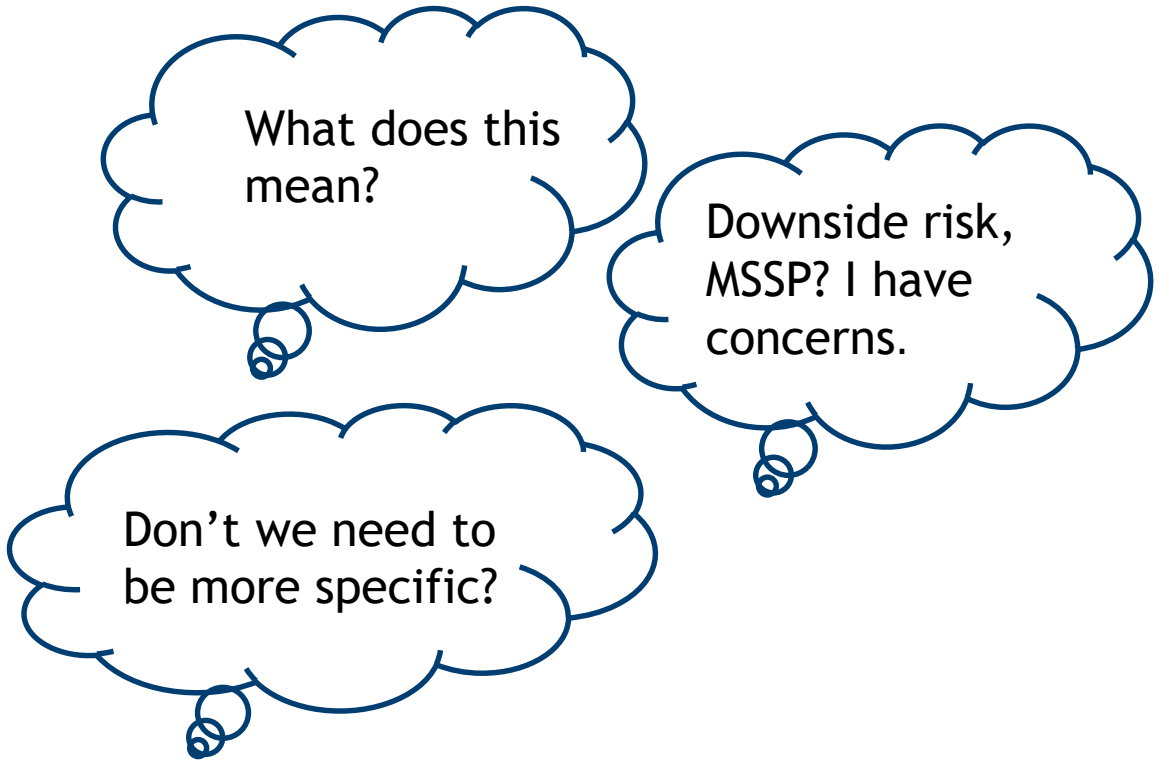
Recommendations from the PTTF Report ….

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*

What we heard from you….



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What is the relationship between PCM and the existing shared savings models?

- PCM is a strategy to support increased and more flexible investment in primary care that supports participants in achieving their goals in shared savings/downside risk models.
- PCM is **not** intended to replace existing shared savings programs. It is intended to be an "add-on" to a shared savings/downside risk program such as MSSP or Next Gen or a similar commercial or Medicaid program.
- **Almost all of CT MSSP ACOs will transition to downside risk in 2 yrs from July 2019 if they stay in MSSP**. Some may leave MSSP but there are compelling reasons to stay in including higher payments to providers, avoidance of certain measurement requirements and related penalties, and the ability to share in savings.
- The current proposed CMS rule contemplates a glide path where it would be possible to have upside savings for the first 2 yrs, then move to downside risk with varying risk corridors (Basic Track - 1st dollar losses at 30%, capped anywhere between 1% - 4% of benchmark, and the Enhanced Track - 1st dollar of losses, not to exceed 15% of benchmark).

What is the relationship between PCM and the existing shared savings models?

We expect PCM will avoid ***adding*** material risk by:

- Basing basic bundle on previous experience, adjusted over time
- Adding in a supplemental bundle to cover the cost of certain additional capabilities – some of which may be provided now in a limited way without sustainable funding
- Risk adjustment
- Increased non-visit based access and expanded care teams, which in turn, can support larger panels

Provider organizations are evaluating their future in risk arrangements. PCM could help Connecticut providers that stay in these programs be better positioned for success.

What Should Be the Characteristics of a PCM "Eligible" Advanced Network?

- Has the legal ability and administrative organization to contract with payers
- Is an entity governed by the participating providers
- Is responsible for the care (typically total care) of a defined population
- Is able to effectively measure the quality and efficiency of care delivery
- Coordinates clinical efforts among all participating providers (e.g. primary care, specialists, inpatient facilities)
- Envisions itself moving to some level of downside risk over the next three years

What Should Be the Characteristics of an "Eligible" Provider from those Advanced Networks?

- Based PRC meeting 1, providers will have a primary care specialty
- Should include entire practices supporting new capabilities
- Should be able to be clearly defined to ensure bundles are calculated and paid appropriately

Advanced Networks will need to support payers
in maintaining complete and accurate roster information as providers leave the practice.

Decision Point

- Is there agreement that PCM eligible advanced networks will participate in a CMS program such as MSSP or Next Gen that incorporates some downside risk throughout its lifespan (or Commercial and Medicaid programs with similar attributes)?
- Any other criteria that advanced networks will need to meet?
- Should there be a provision for practice carve-out if there are circumstances that will limit their participation (such as geographic isolation or recent partnership with the AN)?

Services to Include in the Basic Bundle

Tonight's Payment Reform Council Focus:

For Medicare FFS…

- Which services should be included in the basic bundle?
- Which services should continue to be paid fee for service?
- Should some service categories be optional?

Should **other payers** be able to include additional services in the basic bundle as mutually agreed with the provider organization?

Attributes of Basic and Supplemental Bundles

Basic Bundle

- The basic bundle is a payment for a set of common primary care services, such as office visits. It will support transitioning some PCP patient care to phone, email, text or telemedicine. And, it will give the PCP greater flexibility to spend time managing care team members, participating in learning opportunities and collaborating with colleagues.
- It can represent all of the costs for services in the bundle definition OR partial costs.
- The basic bundle will be calculated using historical claims data.

Supplemental Bundle

- Supplemental bundles are payments to support activities and investments that are not normally or frequently billed as fee for service.
- Covers some currently billable services (ex: care management) but will need to calculated on a different basis than historical experience.
- The supplemental bundle will be based on a standardized target for all providers in a specific carrier's program.
- Providers accepting greater levels of risk will be eligible for higher payments than those who do not.

Building the Basic Bundle

Criteria to consider when selecting services:

- Services that account for a significant portion of primary care practice revenue so that the dollars collected from the bundle are sufficient to support practice transformation
- Services that are an important part of care for the population served by the program
- Services provided by the majority of eligible providers

Based on our last meeting's consensus, we will only include codes billed by primary care providers. (*family medicine, internal medicine with no subspecialty, internal medicine with a subspecialty of geriatrics, pediatrics with no subspecialty, general practice, doctor of osteopathy or nurse practitioner or physician assistance with supervising doctor in one of the preceding specialties*).

As a practical matter, the covered services must be expressed as code sets, the language of insurance payments.

Services often used in PCP bundle

Services in CPC+ "Basic Bundle"

Office Visit, new or established patient

Prolonged Encounter

Encounter Payment for FQHC Visit

Services to Consider Including in Basic Bundle for All Practices

Phone, Email, Text

Telemedicine,

Home Visits, Shared Visits

Preventative Medicine Visit, Preventative Counseling, Annual Wellness Visit

Immunization Administration

Behavioral Health Screening

Cognition Assessment

Services to Consider Adding to Basic Bundle for More Advanced Practices

Hospital Outpatient Clinic Visit

SNF Rounding

Care Management Services - Included in Supplemental Bundle

Health Risk Assessment

Chronic Care Management

Transitional Care Management

Behavioral Health Care Management

Psychiatric Collaborative Care

Services not recommended to include in basic bundle

Some programs have used their bundles to focus on areas of overuse, underuse/insufficient integration, or have rolled in ancillary services.

Codes otherwise bundled into office visit codes

Collection, blood Measure

Blood oxygen level

Services not often performed by a primary care physician, or subject to overuse

Removal of skin lesions, skin tags

Nail trim

Debridement

Intralesional Injection

Common laboratory services, if done as an outpatient

Phlebotomy (CBC, metabolic)

Urinalysis

Lipid profiles

Throat culture/Rapid Strep

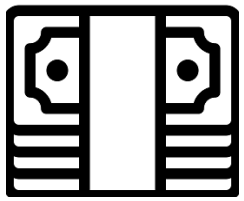
Chlamydia and gonorrhea screens

Decision Points

- Is there agreement that there should be a minimum basic bundle that includes office visits? What else should be included?
- Is there agreement that providers should be able to include additional services in their basic bundle with Medicare and other payers?
- Is there agreement that care management services should be in the supplemental bundle?

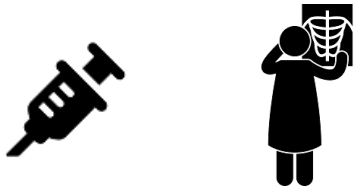
Payment Model Options: Let's revisit the hybrid bundle question

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)?

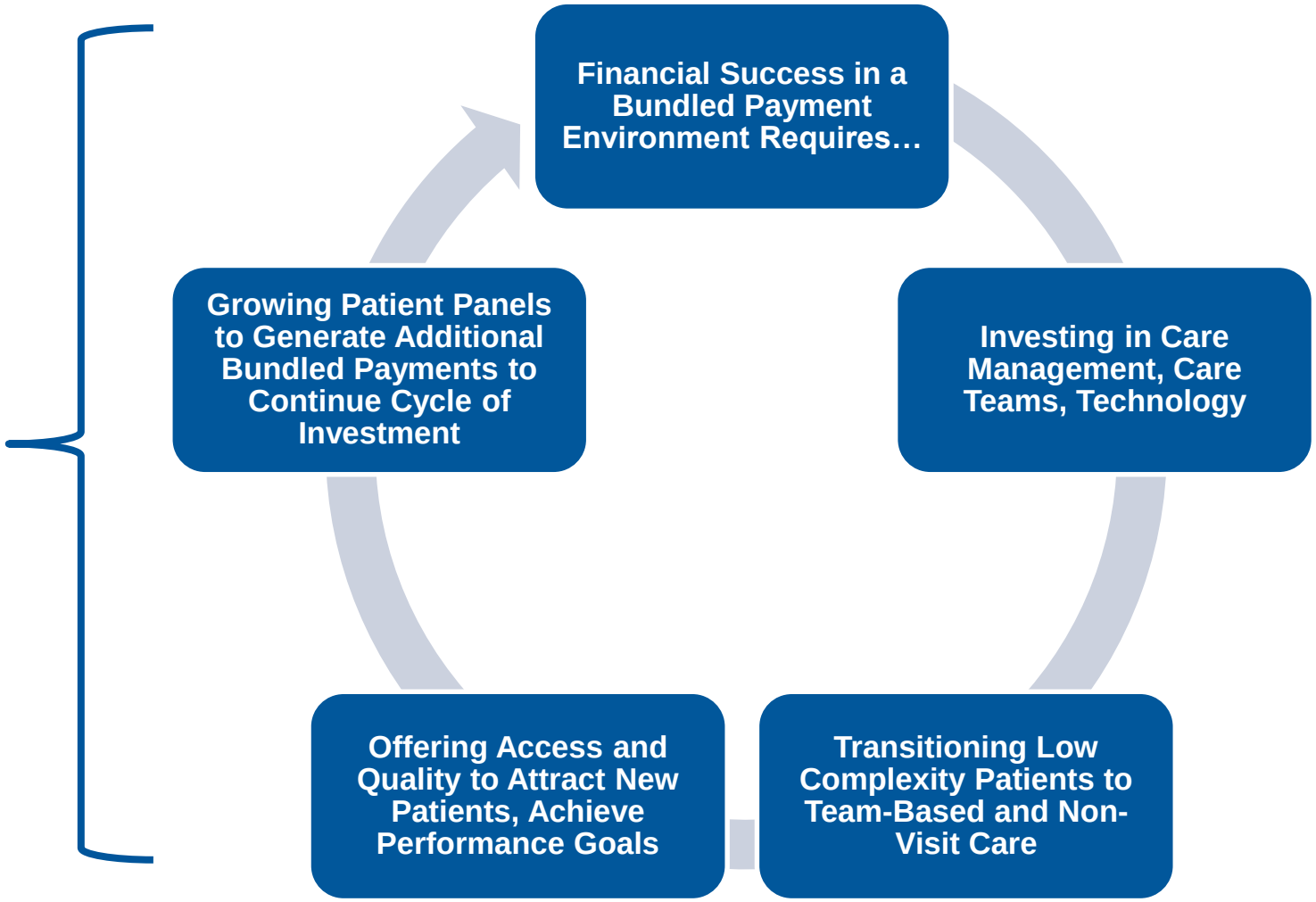
OR

Should both options be offered?

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.



Risk of Revenue Loss with Hybrid Method

At our last meeting we discussed provider concerns for ensuring fair revenue as more services are provided in ways that may not be captured, or captured fully, on a claim.

Moving to Non-FFS Billable Services:
Availability of flexible financial support to expand the breadth and depth of **should** increase the volume of non-billable services. Transitioning some care to non-office based visits delivered by other care team members **will be necessary** for true care delivery transformation and financial success.

- Under a hybrid model, this transition will negatively impact revenue.

Member Liability (copays and deductibles):
Should not have a negative impact on provider revenue assuming carriers leverage shadow pricing or appropriate actuarial value adjustments in paying the bundle.

- In shadow pricing, dollars providers are supposed to collect will be deducted from the bundle in the next month.
- In an actuarial value approach, actuaries will adjust for movement of utilization to non-billable services.

Basic Bundle: Continuing the 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.

Attribution

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

Tonight's Payment Reform Council Focus:

- 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.

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)

Prospective and Retrospective Attribution

Bundled payments are advance payments. Therefore, PCM will leverage prospective attribution.

Prospective attribution places a beneficiary in defined provider population based upon utilization history (e.g. last year or two) prior to target year.

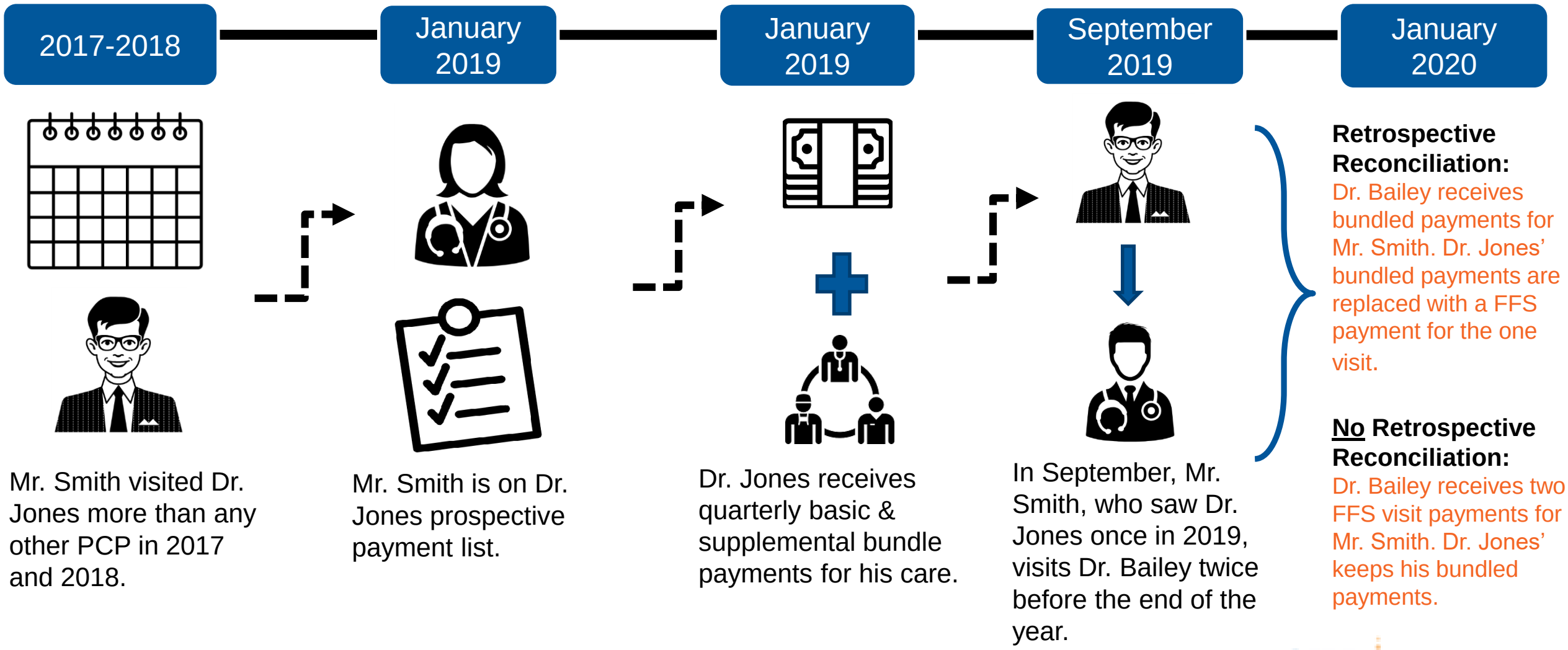
Retrospective attribution “looks back” to see whether a beneficiary continued to meet attribution criteria during target year.

A hybrid approach assigns beneficiaries based on prior year's data, but reconciles the patient attribution list based on performance year data to arrive at final attribution

Programs that use retrospective attribution will finalize payments based on a different population than the one that listed prospectively.

MSSP tracks 1 and 2 combine prospective and retrospective attribution. They use prospective attribution to assign beneficiaries during the performance year but use retrospective attribution in the final financial settlement.

Retrospective Attribution: How it Works



Under either scenario, both physicians are paid for any care provided, so there is no incentive not to see Mr. Smith.

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Pros and Cons of Reconciliation

Benefits of Retrospective Reconciliation

- Ability to get “credit” for additional patients gained.
- Better reflects care delivery during the period.
- Providers may have more incentive to keep beneficiaries engaged throughout the year.

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.
- Administrative burden for payers and providers.
- When assignment changes frequently, communications to beneficiaries can become confusing.

Retrospective Reconciliation

What We've Heard from Connecticut Stakeholders

- We do not have time to do significant outreach to attributed patients while focusing on serving the patients who actually engage. Retrospective attribution may be easier to justify to our providers.
- We have been very upset by the change in funding associated with retrospective attribution. We would like to keep what we have been paid unchanged.
- The administrative challenges associated with settling bundled payments are too significant.
- Retrospective assignment could be confusing to patients.

Decision Points:

Should attribution be reconciled retrospectively?

Should a workgroup be focused on ideas for improving attribution over time?

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

QUESTIONS?

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