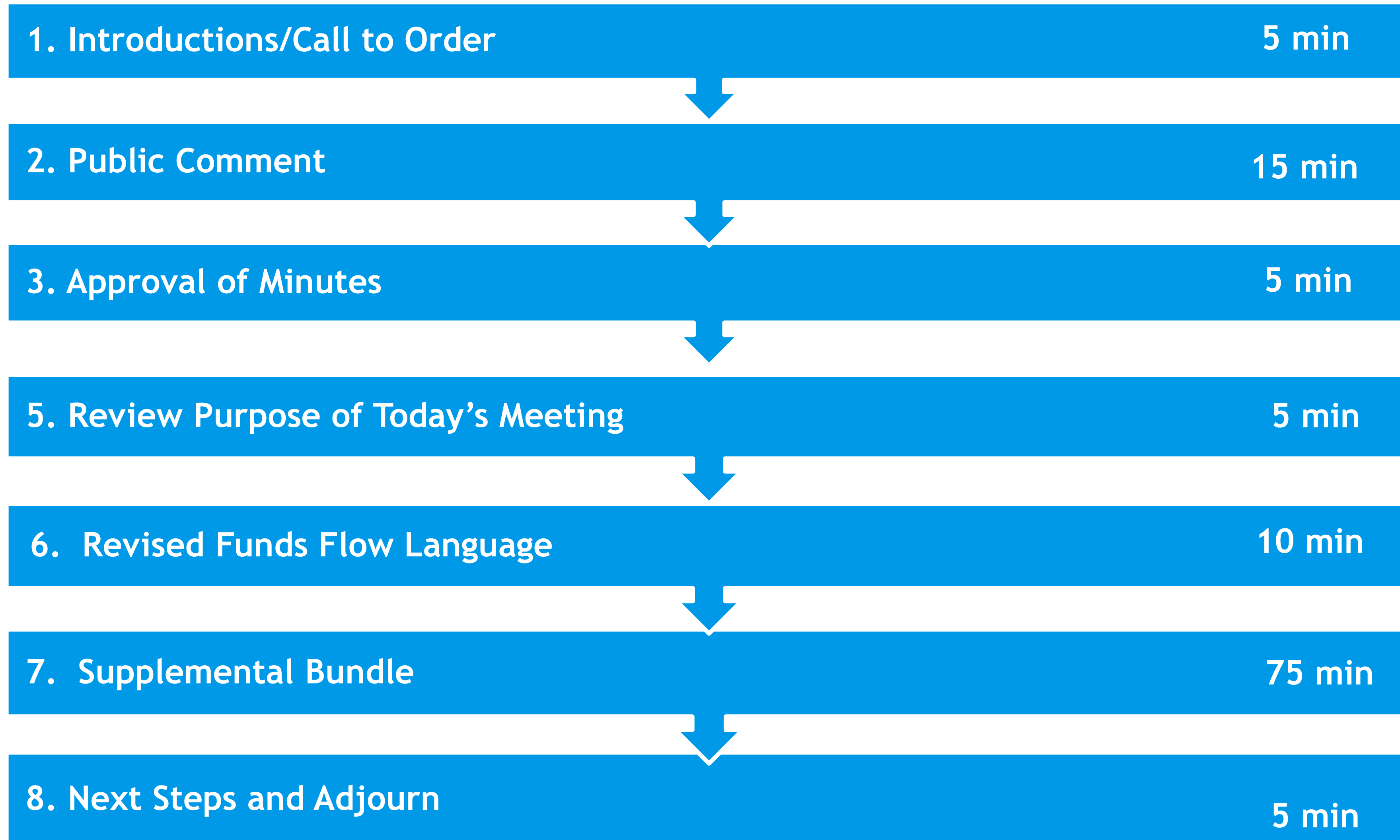
CONNECTICUT
Office of Health Strategy

Payment Reform Council

November 15th 2018

Meeting Agenda



Introductions/ Call to Order

Public Comment

Approval of the Minutes

Confirming Revised Funds Flow Language*

Supplemental Bundle:

Supplemental bundle is calculated for each AN and paid to the AN.

Funds will be used to support primary care transformation and limited to the allowable uses identified by the primary care modernization design process.

Provider Compensation:

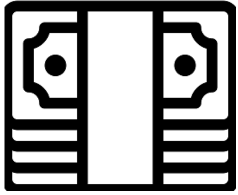
ANs determine internal compensation structure within their organizations.

Individual provider compensation not be directly related to a provider's contribution to total cost of care in a manner that incents underservice or patient selection (i.e. cherry picking).

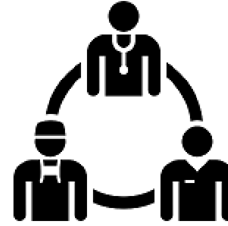
*Revised language in blue.

The Supplemental Bundle

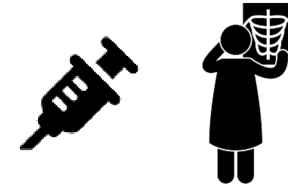
Basic Bundle



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

How should the supplemental bundle be calculated and risk adjusted?

Conversation Goals:

1. Discuss possible approaches to calculating and risk adjusting the supplemental bundle.
2. Gain sufficient feedback to present a strawman model for your review and approval at our next meeting.

Attributes of Basic and Supplemental Bundles

Basic Bundle

- An advance payment for primary care services, such as office visits.
- It will represent all the payment for services in the basic bundle.
- It will be calculated using historical claims data and adjusted for population differences, trend and other factors.
- The basic bundle is a mechanism to purchase the time PCPs historically billed for office visits, and in turn, offer PCPs and patients more flexibility.
- PCP time remains focused on patient care. Other activities may include managing team members, learning and collaboration opportunities.

Supplemental Bundle

- An advance payment to support activities and investments not ***typically*** billed fee for service.
- It will be based on a standardized target for all providers in a specific carrier’s program, which aims to introduce more equity in payments.
- Payments will differ based on patient characteristics and provider capabilities or performance. Risk adjustment strategy will be aligned with patients’ care management needs.
- Payments should be reasonable relative to the capabilities requested, accountable, non-duplicative and affordable.
- Providers accepting greater levels of risk will be eligible for higher payments than those who do not.

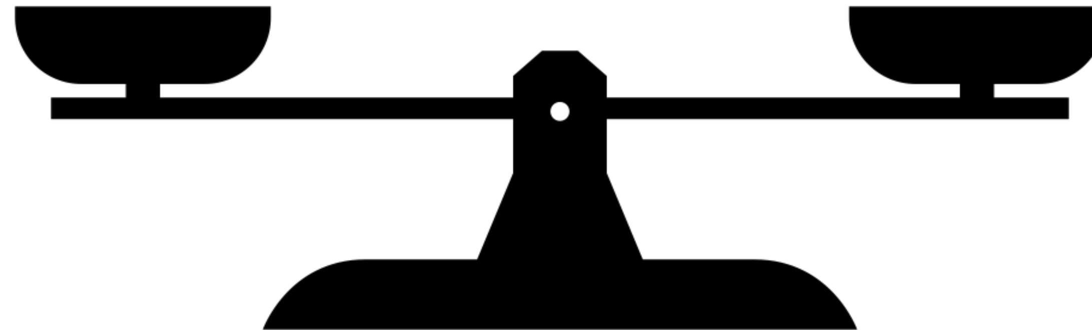
Calculating the Supplemental Bundle

Goal: Achieve Balance in Calculating the Supplemental Bundle

The supplemental bundle should offer sufficient investment in care delivery transformation to improve access, health outcomes, equity, patient experience and provider satisfaction.

Care Transformation

Sustainability



Over time, the supplemental bundle should generate a return on investment and be included in calculations of total medical expense.

What is sufficient investment in care transformation?

To begin the process of determining the supplemental bundle payments, we looked to others and the specific capabilities under consideration for PCM.

Our Approach:

1. Review literature to gain better understanding of other models.
2. Estimate the cost of specific capabilities* proposed by the PCM Design Groups and Practice Transformation Task Force.
3. Use cost estimates and publicly available data on Connecticut ACOs to model scenarios.
4. Model possible impact on total medical expense, percent investment in primary care.

**Update on the capabilities under review by the Practice Transformation Task Force included in the appendix.*

Supplemental Bundle: Learning from Others

PCM may envision a bolder set of transformative capabilities, but these and other multi-payer models offer a starting point for determining an appropriate payment structure for the supplemental bundle.

Model	Capabilities	Supplemental Bundle Fee Average/Range	Impact on Quality	Impact on Cost
CPC	Risk-stratified care management; Access and continuity; Planned care for chronic conditions and preventive care; Patient and caregiver engagement; Coordination of care across the medical neighborhood	$15 PMPM average,	Hospitalizations and ED visits down 1-2%	0-2% cost savings, per year; high performing states ~4%
Colorado	Improved access, care coordination, clinical tools, member materials and other resources and support to primary care practices	$20 PMPM average, split across PCP practice, regional care collaboratives and state data partner	15–20% reduction in hospital readmissions; 1% percent lower rate of increase in ED use;	Less than 1% per year
Minnesota	Clinics meet a rigorous set of requirements related to their ability to provide care that is coordinated, patient-centered, and team-based.	$10-60 PMPM, plus 15% additional for patients with a behavioral health diagnosis or patients who speak English as a second language	Better adjusted quality of care for patients with diabetes, lipid screening, asthma, depression, colorectal cancer screening;	9% reduction in total costs over 5 years

Learning from Others: Takeaways

Supplemental Bundle Range: Most multi-payer programs average $10-20 PMPM, with significantly higher spend for patients with the most complex needs. Programs with narrower PCMH requirements were typically under $10 PMPM.

Reasonable Expected Reduction in Total Cost of Care:

- Most programs generated 1-2% in savings each year, after program costs were included
- Why?
    - First, need to overcome trend
    - Second, need to figure in investment in supplemental bundle
    - Then, need to compare performance to others
    - And, CMS may want to recoup expenses + generate additional return

Proposed Permitted Uses of the Supplemental Bundle in Connecticut

- Compensation of care team members to meet capabilities requirements.
- Infrastructure investments to meet capabilities requirements.
- Investments in health information technology and other new technologies.*
- Expenses associated with behavioral health integration and community integration.
- Training and technical assistance.

What are we missing?

Should some uses be prohibited or restricted?

Should practices interested and able to meet elective capabilities requirements or willing to take on higher levels of total cost of care risk be eligible for higher supplemental bundle payments?

* PCM assumes foundational investments in HIT. All eligible clinicians must be using latest certified EHR technology (CEHRT) to support interoperability, demonstrate advanced quality objectives and have the ability to communicate clinical care.

Should the supplemental bundle be “at risk”?

Three ways the supplemental bundle could be “at risk:”

1) Require return of payment (or portions of payment) if funds not used for approved purposes.

2) Payments included in the calculation of total medical expense for purposes of determining shared savings and losses.

3) Payments subject to reductions if certain performance targets (quality, cost, utilization, patient experience) are not met.

Should payers recoup supplemental bundle payments not used for approved purposes?

Recommendation: Yes

Proposed Approach:

- Require practices to report to the state and payers (CMS, Medicaid, commercial) how funds were used. Consider making elements of these reports available to the public.

- If funding was not used or was not used for approved purposes, the AN would have the option to pay back the funds or propose to use them in the following year for an approved purpose, subject to payer approval.

- Supplemental bundle funds not used within two years for an approved purpose would be recouped.

Should supplemental bundle payments be included in the calculation of total medical expense?

Recommendation: Yes

Rationale: Including the supplemental bundle as part of total medical expense balances the need for accountability with the recognition that some capabilities will need time to show return on investment.

What do we see in other programs?

NextGen offers up to $6 PMPM of supplemental funding, called infrastructure payments. The model includes 100% of infrastructure payments in its calculation of total medical expense, regardless of savings or losses.

Advance Payment demonstrations offer infrastructure payments up to $8 PMPM. CMS receives 100% of the shared savings up to the advanced payment amount. If the ACO does not generate sufficient savings to repay the advance payments, CMS will continue to receive shared savings in subsequent performance years and any future agreement periods to make up for the shortfall. If the ACO drops out of the program, CMS pursues recoupment where appropriate.

Providers participating in both **CPC+ and MSSP** are paid Care Management Fees. These fees are included in the calculation of total medical expense for shared savings and shared loss calculations.

Should supplemental bundle payments be included in the calculation of total medical expense?

- Supplemental bundle is included in total medical expense, no modification to MSSP framework.

  Total Medical Expense = Basic Bundle + Supplemental Bundle + All Other Medical Costs

- Supplemental bundle is included in total medical expense but payer shares in downside after supplemental bundle is covered.

  Total Medical Expense = Basic Bundle + Supplemental Bundle + All Other Medical Costs

  However, <u>provider</u> takes responsibility for losses up to the amount of the supplemental bundle.

- Supplemental bundle is included in the calculation of total medical expense. Risk arrangements minimize or eliminate ANs potential for losses through a "risk corridor," essentially a cushion that would protects ANs against bearing the full impact of losses.

  Total Medical Expense = Basic Bundle + Supplemental Bundle + All Other Medical Costs

  However, <u>payer</u> takes responsibility for losses up to the amount of the supplemental bundle.

Possible Scenarios

CMS has proposed rules that would introduce downside risk for all MSSP participants. These scenarios show how PCM supplemental payments might be handled in such models. All scenarios below assume 30,000 patients attributed to the AN. Attributed patients are expected to spend an average of $10,300, known as "expense benchmark." The savings scenario assumes care cost an average of $100 per patient less than expected. Loss scenarios assume care cost an average of $300 more per patient than expected.

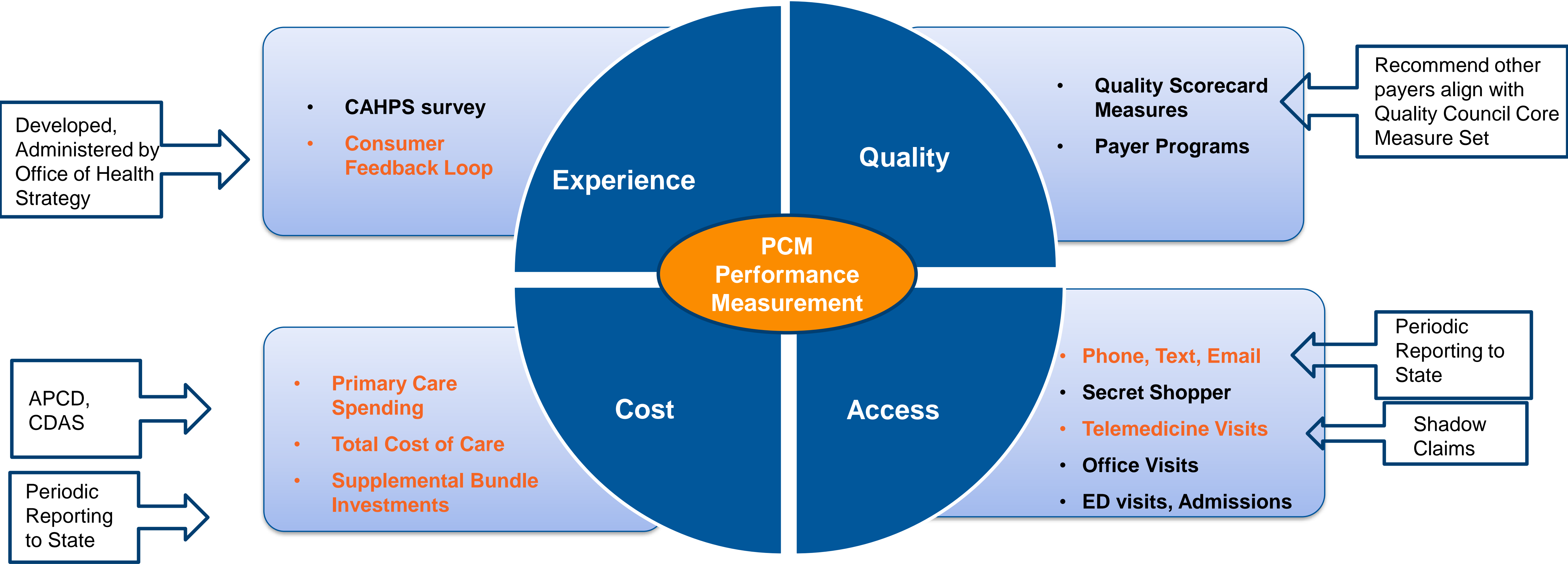
	Scenario One	Scenario Two	Scenario Three	Scenario Four
	Savings Achieved	Loss - No Change to MSSP Settlement	Loss - Supplemental Bundle Covered by Provider	Loss - Protective Downside Corridor
Total Bundle	$ 6,000,000	$ 6,000,000	$ 6,000,000	$ 6,000,000
Total Medical Expense (including Bundle)	$ 306,000,000	$ 318,000,000	$ 318,000,000	$ 318,000,000
Benchmark in total expenditures	$ 309,000,000	$ 309,000,000	$ 309,000,000	$ 309,000,000
Savings/Loss	$ 3,000,000	$ (9,000,000)	$ (9,000,000)	$ (9,000,000)
Savings/Loss Rate	1.0%	-2.9%	-2.9%	-2.9%
Minimum Savings Rate	1%	1%	1%	1%
Minimum Loss Rate	1%	1%	1%	2% baseline benchmark (attachment point)
Savings Savings/Loss Percentage	50%	50%	100% until bundle is covered, then 50%	50%
Shared Savings/Loss	$ 1,500,000	$ (4,500,000)	$ (7,500,000)	$ (1,500,000)

Performance Measurement in PCM

- PCM shares many goals with MSSP and the other shared savings and downside risk programs it will sit on.
- These programs already track, report and incent performance across many of the same measures PCM design work has identified.
- PCM should leverage these existing performance measurement programs and public reporting efforts.
- PCM should also include additional methods of accountability to respond to PCM specific goals.
- Where possible, performance measurement data should be disaggregated to better understand progress toward achieving health equity.

Performance Measurement in PCM

Measures and programs in orange would need to be developed. Implementation ideas are provided in the boxes.



Should the supplemental bundle be reduced when ANs fail to meet performance targets?

Recommendation: No

Rationale:

- PCM is paired with MSSP and the other shared savings and downside risk programs that already incent and penalize performance on many of the measures PCM would employ.
- Fear of having to repay the supplemental bundle funds might make providers hesitant to fully invest such funds in care transformation.
- There are other methods to hold providers accountable for meeting the specific goals of PCM.

Other Methods of Accountability

- Periodic Reporting
  - Supplemental Bundle Investments (forecast, actual)
  - Use of phone, text, email
- Well-Publicized Consumer Feedback Loop
- Mystery Shopper Program
- Administrative action for failure to satisfy performance measurements:
  - Corrective Action Plan
  - Termination for Serious Offenses
    - Based upon underservice, cherry picking, non-performance – materiality standard?
    - What would constitute non-remediable failures?

Should the Office of the Health Strategy play a role in compliance oversight or should this be the sole responsibility of Medicare and other individual payers?

Supplemental Bundle Risk Adjustment

Supplemental Bundle Risk Adjustment

Our Thinking: Since supplemental bundle funds will largely go toward supporting care management, behavioral health integration, community integration and investments in new technologies, ideally these payments should be adjusted to align with the patient populations needs in those areas.

The Challenge: Many risk adjustment methodologies are built for a different purpose – to estimate total cost of care of a patient population. Therefore, it may be necessary to revise or build upon these methodologies to ensure PCM supplemental bundles are sufficient and fair.

Learning from Others: Vermont OneCare ACO

Vermont leverages multiple sources of supplemental funding:

- A level per member per month payment for each high-risk patient.

- An additional per member, per month payment for every high-risk patient that identifies the provider as their ‘Lead’ in the management of their care.

Vermont divided patients into four cohorts based on care needs:

1) Healthy/Well,
2) Early Onset or Stable Chronic Illness,
3) Complex/High-Cost with Acute Catastrophic Conditions, and
4) Full Onset Chronic Illness and Rising Risk

Learning from Others: CPC+

- CPC+ includes a care management fee (CMF), which is similar to a supplemental bundle, to improve care coordination, implement data-driven quality improvement, and enhance targeted support to patients identified as high risk.

- CMFs vary based on the level of provider engagement in the CPC+ program and the patient's risk of incurring medical costs or expected total cost of care. However, in recognition of the significant care management needs of patients with dementia, those patients are automatically included in the highest risk tier.*

PCM could employ a similar approach for a broader range of conditions.

** More information on the tiers is available in the appendix.*

Discussing a Possible Risk Adjustment Approach for Supplemental Bundles in PCM

What if we…

1) Started with the payer's current total cost of care risk adjustment methodology.
2) Determined cohorts of patients most likely to require significant additional support in the form of care management, behavioral health services, community resources or other PCM capabilities. Possible populations might include patients with a behavioral health diagnosis, patients experiencing homelessness as indicated on claims, and patients living in at-risk zip codes.
3) Developed a method to identify these patients. Possible data sources could include claims, shadow claims, demographic information (SDOH), EHR data (future), others?
4) Assigned patients to various categories of supplemental bundle fees based on their medical, behavioral and social needs by adding an additional weight to the patient's underlying risk score or by assigning patients with certain needs to specific supplemental bundle categories, regardless of underlying risk score.

Possible Approaches to Adjust for Patients with Complex Social and Behavioral Health Needs

Approach 1: Additional weight layered on top of the patient's risk score.

- Patient's clinical risk score = 1.05, which means the patient is expected to cost 5% more than the average patient.
- Patient's SDOH risk adjustment factor = .10, which means the patient's social needs are estimated to increase his or her costs by an additional 10%.
- Patient's total risk score = 1.15, which would mean the AN would be paid 15% more to care for the patient based on his or her clinical and social needs.

Approach 2: Patients with certain needs assigned to specific supplemental bundle categories, regardless of underlying risk score.

- All patients with a diagnosis of dementia would be assigned to the highest risk adjustment category, regardless of other clinical, social or behavioral health needs.

QUESTIONS?

Contact:

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

Appendix

Learning from Others: CPC+

Track 1 has 4 risk tiers and Track 2 had 5 risk tiers. Each risk tier corresponds to a specific monthly CMF payment:

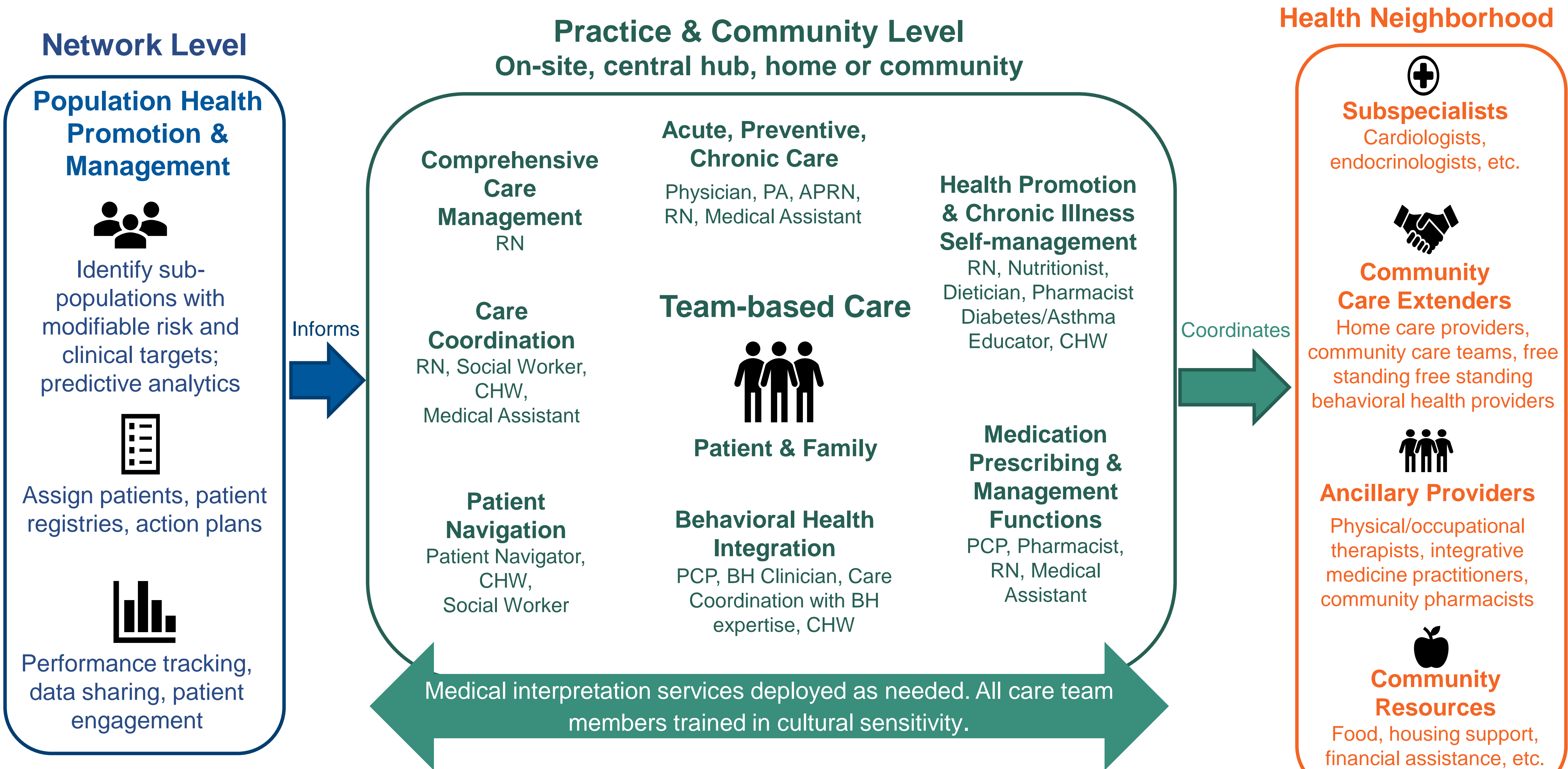
Risk Tier	Track 1	Track 2
Tier 1: Risk Score <25th percentile	$6 PMPM	$9 PMPM
Tier 2: Risk Score 25th percentile ≤ risk score < 50th percentile	$8 PMPM	$11 PMPM
Tier 3: 50th percentile ≤ risk score < 75th percentile	$16 PMPM	$19 PMPM
Tier 4: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30 PMPM	$33 PMPM
Tier 5: Risk score ≥ 90th percentile or Dementia diagnosis	NA	$100 PMPM

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

PTTF Capabilities' Provisional Recommendations – IN PROGRESS

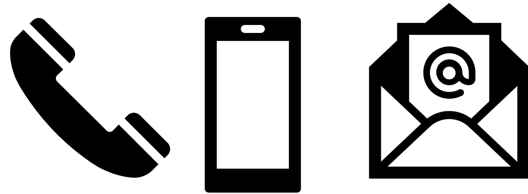
Capability	Included in Model	Core or Elective	Deployed in All Practices or Subset	Basic	Supplemental	State Supports
Phone/text/email	Yes	Core	All	PCP time	Other care team members' time	
Telemedicine	Yes	Core	All	PCP time	Coverage for training, other care team members' time	
Remote Patient Monitoring	Yes for certain conditions	Core for conditions w/ efficacy & cost savings		PCP time	Other care team members' time	
eConsults	Yes	Core	All	PCP time Phone and internet	Specialist's time	
Oral Health Integration	Yes but revisiting		Maybe only pediatrics	PCP team	Training for staff	
Home Visits	Yes	Elective	For certain populations		Staff time other than PCP	
Shared Medical Appointments	Yes	Elective		Outreach, space set up, RN/NP at visit	Facilitator BH/Coach	
Infectious Diseases	No	N/A				
Genomic Screening	Tabled until further evidence	N/A				
Functional Medicine	Explore integrative medicine	N/A				
Diverse Care Teams	Yes	Core	All		Care team members' compensation	
Pain Management, MAT	Yes	Core	Basic training for all, subset specialize			
Adult Behavioral Health Integration	Yes but continue development	Core	All			
Pediatric BHI						
Community Integration	Yes	Elective			Payment to partner orgs	
Older Adults						
Persons with Disabilities						
Pediatric Practices						

Expand Primary Care Team Functions and Roles



Support and Engage Patients in Alternative Ways

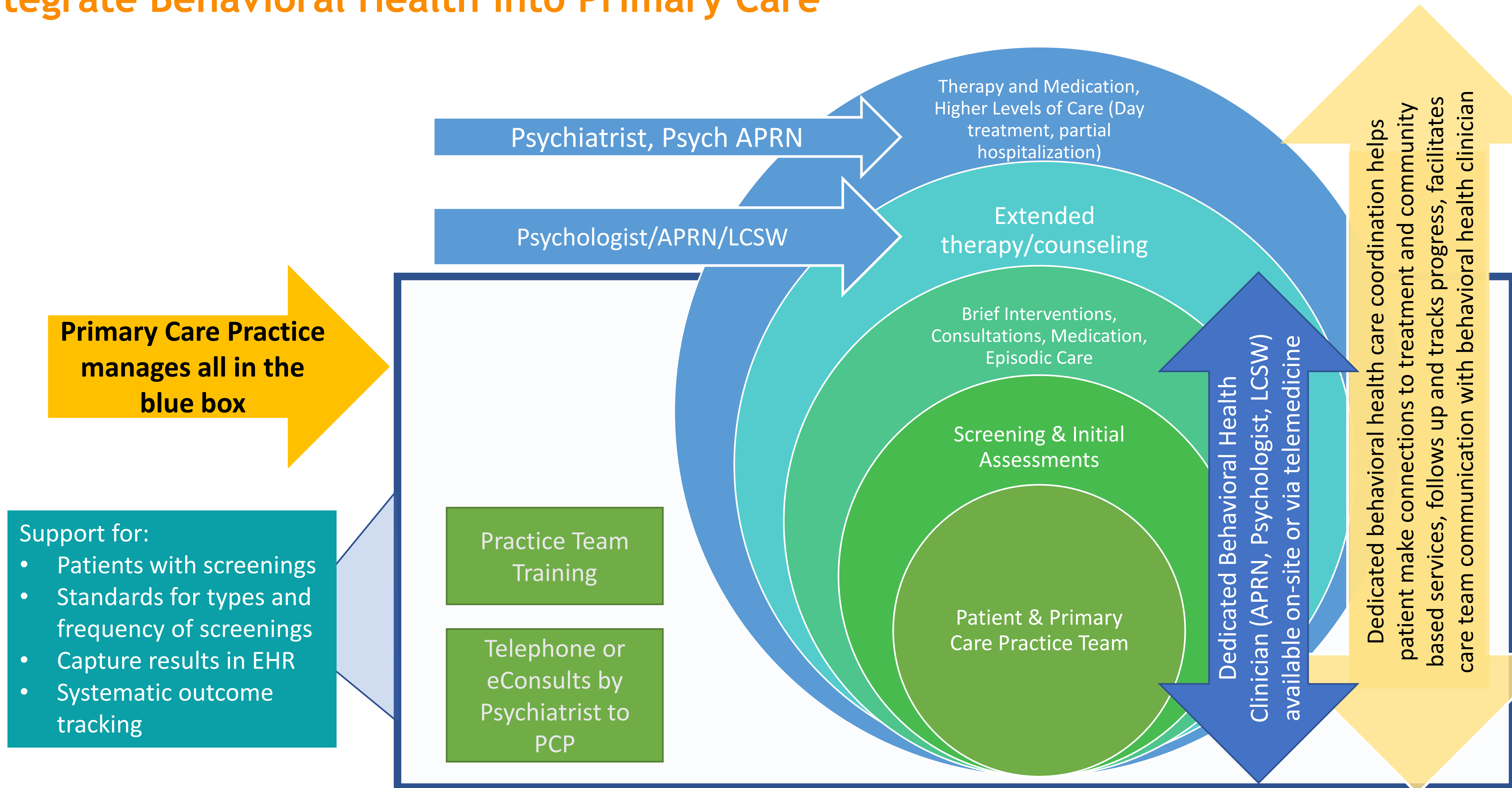
Telehealth and other non-visit based technologies help address access to care barriers like transportation, especially for populations experiencing health disparities.



Phone, Text, Email Encounters give patients and care team members expanded opportunities to establish contact outside of an office setting for non-urgent care needs.

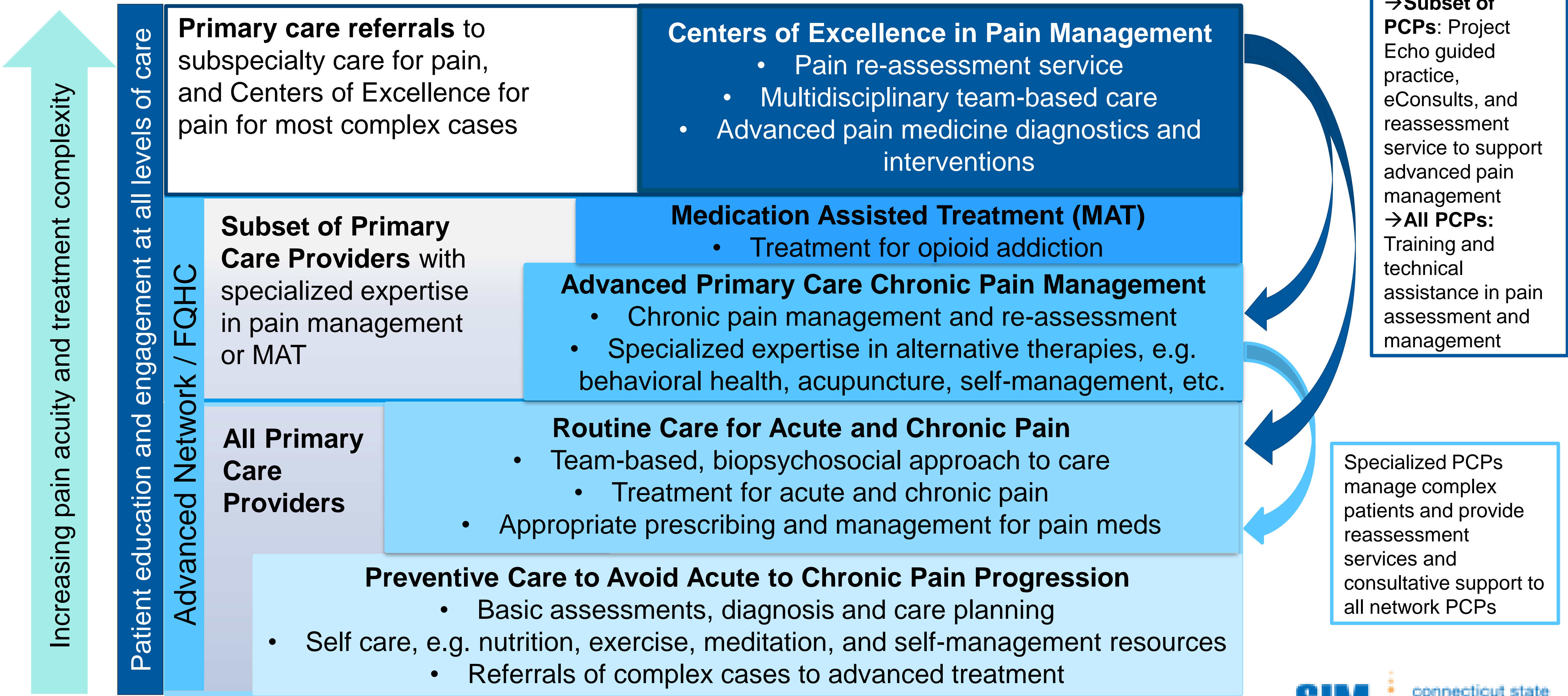
Telemedicine Visits between clinicians and patients through video conference increases access to primary care for routine care, non-urgent acute needs and behavioral health needs that do not require an office visit.

Integrate Behavioral Health into Primary Care



Based on feedback prior to September 25, 2018

Increase Expertise in Pain Management



DRAFT Offer Specialized Care for Older Adults with Complex Needs (under review by PTTF)