Payment Reform Council

December 17th 2018

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of Minutes	5 min
4. Review Purpose of Today's Meeting	5 min
5. Revised Supplemental Targets	30 min
6. Performance Measurement, Accountability	30 min
7. Alternative Approach to Risk	30 min
8. Next Steps and Adjourn	5 min

Introductions/ Call to Order

Public Comment

Approval of the Minutes

Revised Supplemental Bundle Targets

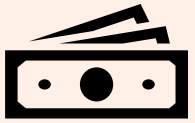
Why don't providers make these investments today?

Under most programs today, providers must generate <u>at least a 2:1 return</u> to share in savings.

Typical Shared Savings Arrangement

Advanced Network **spends** $1 on Community Health Workers

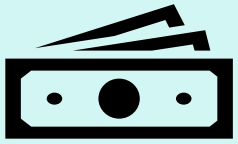
For every $1 invested, total cost of care decreases $1.80



Medicare gives 50% of savings to network ($0.90)

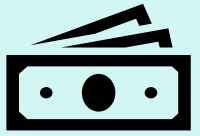
$1.00 (network spend)
- $.90 (shared savings)
= $0.10 (network loss)

Primary Care Modernization



Network **receives** $1 upfront payment to hire Community Health Workers

For every $1 invested, total cost of care decreases $1.80.



Medicare gives 50% of <u>net</u> savings to network ($0.40)

$1.00 (payer spend)
$ .80 (net savings)
-$.40 (payer share)
= $0.40 (network gain)

Opportunity for Partnership with Medicare

PCM offers Connecticut the opportunity to partner with Medicare to develop a customized approach to value-based payment.

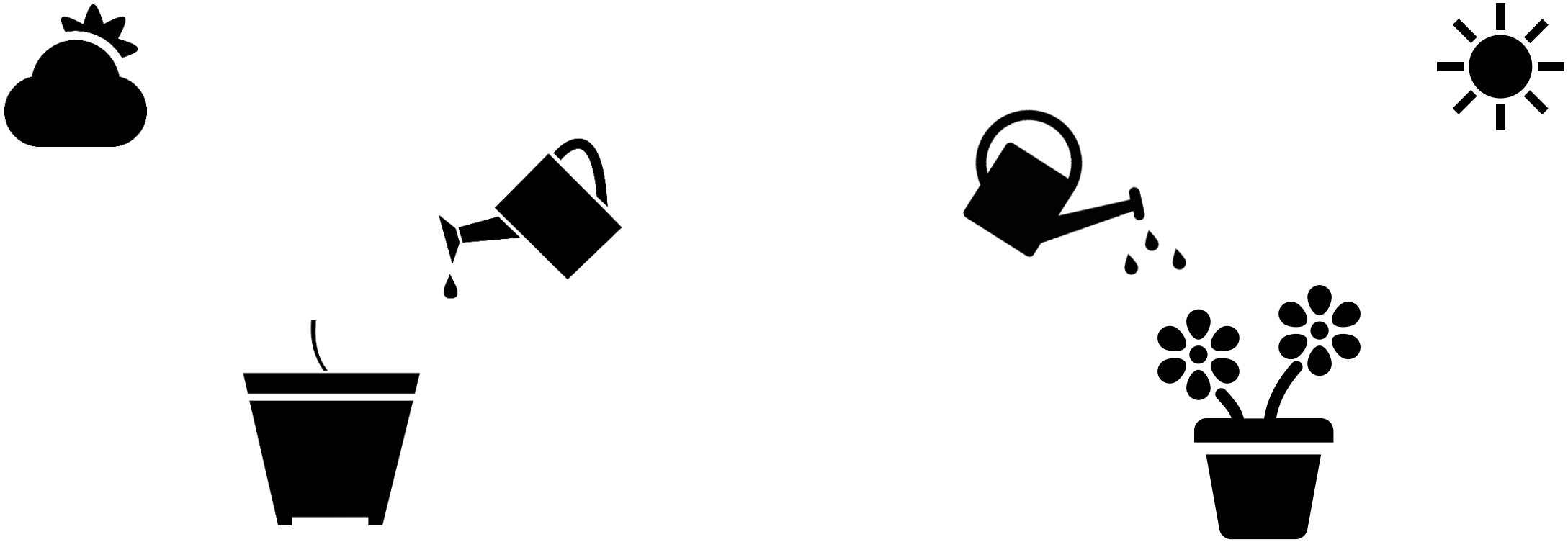
- CMS appears poised to move forward with transitioning to downside risk, with the goal of improving quality and reducing total cost of care.
- PCM gives the state **an opportunity to negotiate different terms for Connecticut** that better reflect our goals for patient care, readiness of providers and protections for consumers.
- PCM also provides an opportunity for Connecticut to receive additional investment in primary care – **estimated at $50 to $100 million a year** – to invest in a transformed primary care system.

The Importance of Medicare Participation

- **Important Patient Population**: Primary care transformation will not be successful if it does not impact care delivery for the sickest patients, many of whom have Medicare coverage including dual eligible beneficiaries and older adults with complex needs.
- **Free Rider Concern**: Implementing the capabilities will cost money. Medicare beneficiaries will be among the patients that benefit most from the capabilities and consequently Medicare needs to make a proportionate investment.
- **Dual-Eligible Financing**: Medicaid may determine it would like to cover investments in expanded care teams and other transformation activities. If this occurs without Medicare participation, the state would shoulder the full cost of those new services and receive none of the savings.

The Importance of Medicare Participation (cont'd)

Without shared investments, we will never see optimal results. Without shared accountability, we will never see sufficient investments.



CMS Current, Evolving Approach to Risk Sharing

- MSSP currently requires ANs and FQHCs to achieve a certain level of savings before the provider organization can share in the savings. **This is called a minimum savings rate**.
- Similarly, MSSP protects ANs and FQHCs from being responsible for losses until a certain amount of losses are incurred. **This is called a minimum loss rate**.
- These thresholds are intended to ensure the savings and losses are "real" and not "by chance."
- The ranges depend on the MSSP "track" and in some cases, the size of the provider organization.
- ***These ranges are expected to change under future iterations of MSSP.***

Today's Ranges:

- **Track 1**: 2%-3.9%. No risk for losses, so the minimum loss ratio does not apply.
- **Track 1+, 2, 3**: Choice of a "fixed corridor" of 0%-2% or a "variable corridor" of 2%-3.9%.

Ask of CMS with Respect to Medicare

- Establish supplemental bundle payments starting at $9* in year one and with opportunity to increase by $9 each year for five years, contingent on performance metrics being met.
- For the first year, providers would not be at risk for losses. **Medicare** would receive 100% of savings.
- Each year's **additional increment** supplemental bundle dollars **would not be** included in the calculation of total medical expense for purposes of determining shared savings and losses.
- Each year, the **prior year's** supplemental bundle dollars, **net of the additional increment**, **would be** included in total medical expense.

*This figure is provisional, subject to additional claims analysis and scenario modeling

Possible Medicare Model Design Options

	Year 1	Year 2	Year 3	Year 4	Year 5
Supplemental Bundle Target	$9 PMPM	$18 PMPM	$27 PMPM	$36 PMPM	$45 PMPM
Portion Included in Total Medical Expense	$0	$9 PMPM	$18 PMPM	$27 PMPM	$36 PMPM
Risk Sharing Arrangement	No Risk Sharing	Same as Medicare program requirements, which vary based on length of time in program, revenue/organization size and track.			

- Medicare dollar amounts are hypothetical subject to Medical claims analysis and scenario modeling.
- Medicare dollar amounts would be adjusted based on clinical, behavioral and social needs.
- AN/FQHCs could enter at Year 2. ANs/FQHCs could elect to stay at the same level for up to two years. Payers may require ANs/FQHCs stay at the same level up for four years, based on performance. Continued underperformance can result in termination after year four.
- ANs/FQHCs would phase-in capabilities as investments increased.

Conditions for Participation

Year 1: AN/FQHC completes successful application which includes plan for achieving capabilities.

Year 2: AN/FQHC completes progress report showing positive progress on plan execution.

Year 3: Financial results show savings in excess of Year 1 supplemental payment. If this level of savings is not achieved, ANs/FQHCs will not advance to Year 3 and will not receive additional increment in supplemental funding and may be subject to a corrective action plan.

Year 4: Financial results expected to show savings in excess of Year 2 supplemental payment. If savings are not in excess of Year 1 supplemental payment, AN/FQHC may be terminated from the program. If savings are not in excess of Year 2 supplemental payment, AN/FQHC will not advance to Year 4 and will not receive additional increment in supplemental funding and may be subject to a corrective action plan.

Year 5: Financial results expected to show savings in excess of Year 3 supplemental payment. If savings are not in excess of Year 2 supplemental payment, AN/FQHC may be terminated from the program. If savings are not in excess of Year 3 supplemental payment, AN/FQHC will not advance to Year 5 and will not receive additional increment in supplemental funding and may be subject to a corrective action plan.

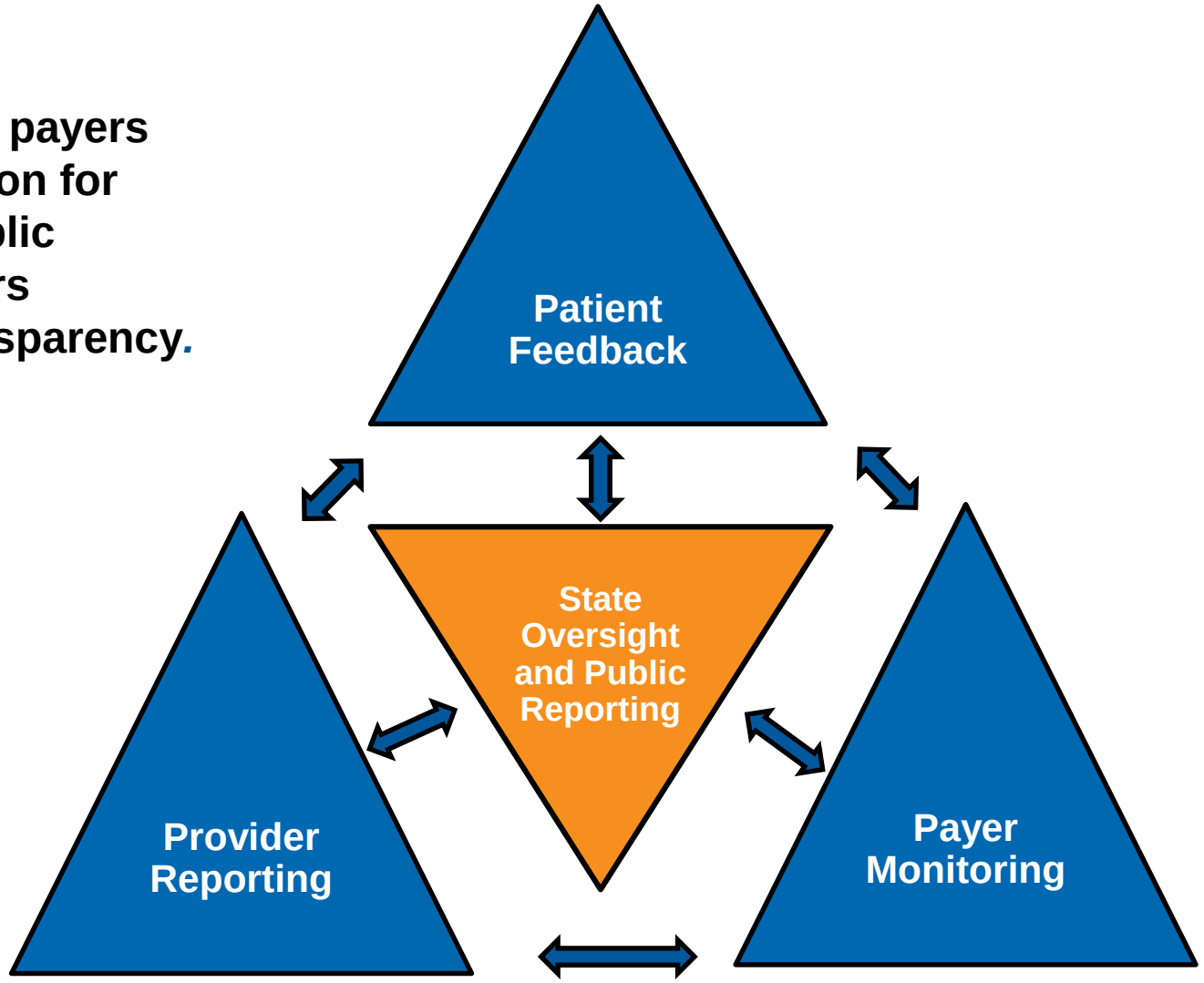
Accountability and Performance Measurement

PCM Accountability Principles

- Individual payer shared savings arrangements and corresponding scorecards and other reporting requirements will remain in place, be applied to PCM and be the foundation for performance measurement in PCM.
- Within the commercial space, state would request that payers harmonize on the quality measures used for shared savings programs in Connecticut for PCM participating entities
- PCM must include additional methods of accountability that demonstrate achievement of PCM transformation process, quality, care experience and savings goals and the absence of underservice and patient selection.
- The state should enable public performance reporting, which will include reporting by race, ethnic language and disability status.

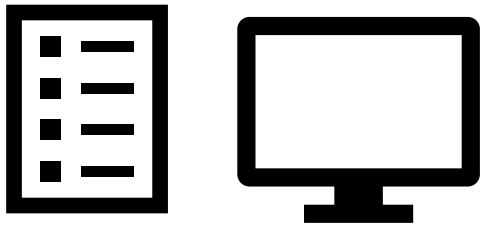
PCM Accountability Matrix

Patients, providers and payers would submit information for state oversight and public reporting, offering layers accountability and transparency.



Specific Ways to Address Underservice and Patient Selection

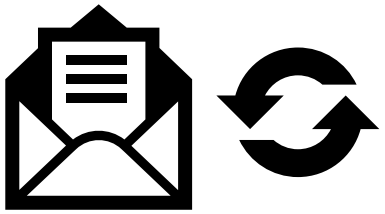
Protecting Against Underservice:



Claims data and electronic health records capture office and telemedicine visits, other interactions with care team members and hospital stays and readmissions per member.

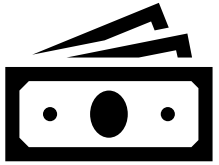
Data is shared publicly through routine provider reports and other sources.

Protecting Against Patient Selection:



Patient experience surveys and consumer feedback loop relay patient perspective.

Attribution method prioritizes patient selection of provider.



Layered risk adjustment recognizes additional cost of social and behavioral needs.

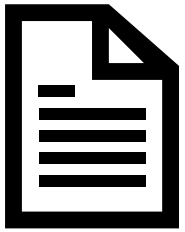
Mystery shopper to monitor access.

How is underservice monitored?

A Focus on Level of Patient Support and Engagement

Today

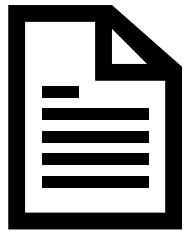
Claims



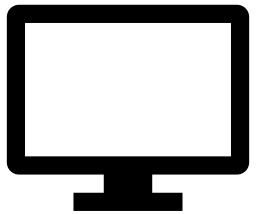
PCP visits/member

Under PCM

Claims



EHR



PCP visits/member

Other PCP contacts/member

Other Care Team
contacts & visits/member

Data in Action – Outside Reconciliation

Under PCM, data could be used to identify significant changes in care patterns that might reflect underservice, referrals aimed at maximizing revenue or unexpected needs for care.

CPC+ offers a path for one component of this approach. It is described below but, if recommended, would need to be adapted to fit the PCM attribution method.

Outside-of-practice partial reconciliation reviews how often attributed patients visit providers at other practices.

The process flags practices with substantial increases and decreases in the office visits delivered by these other practices.

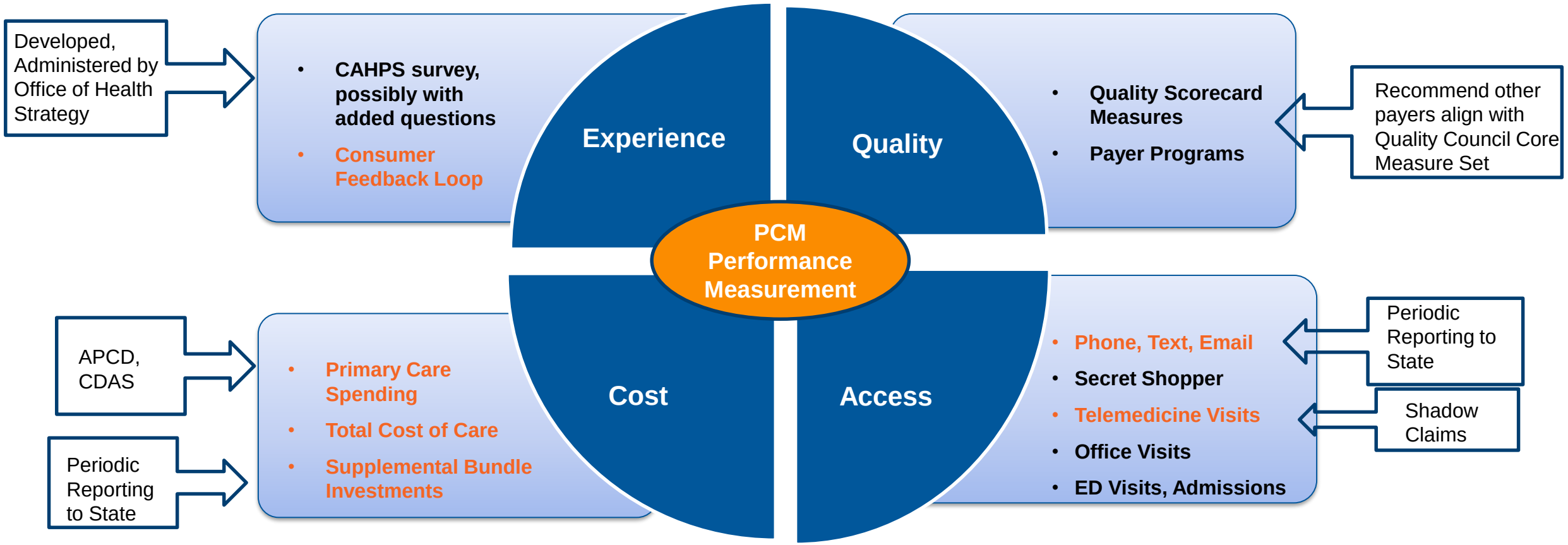
- If visits to other practices increase substantially, CMS recovers some payments to the attributed PCP.
- If visits to other practices decrease substantially, CMS increases payments to the attributed PCP.

Goals:

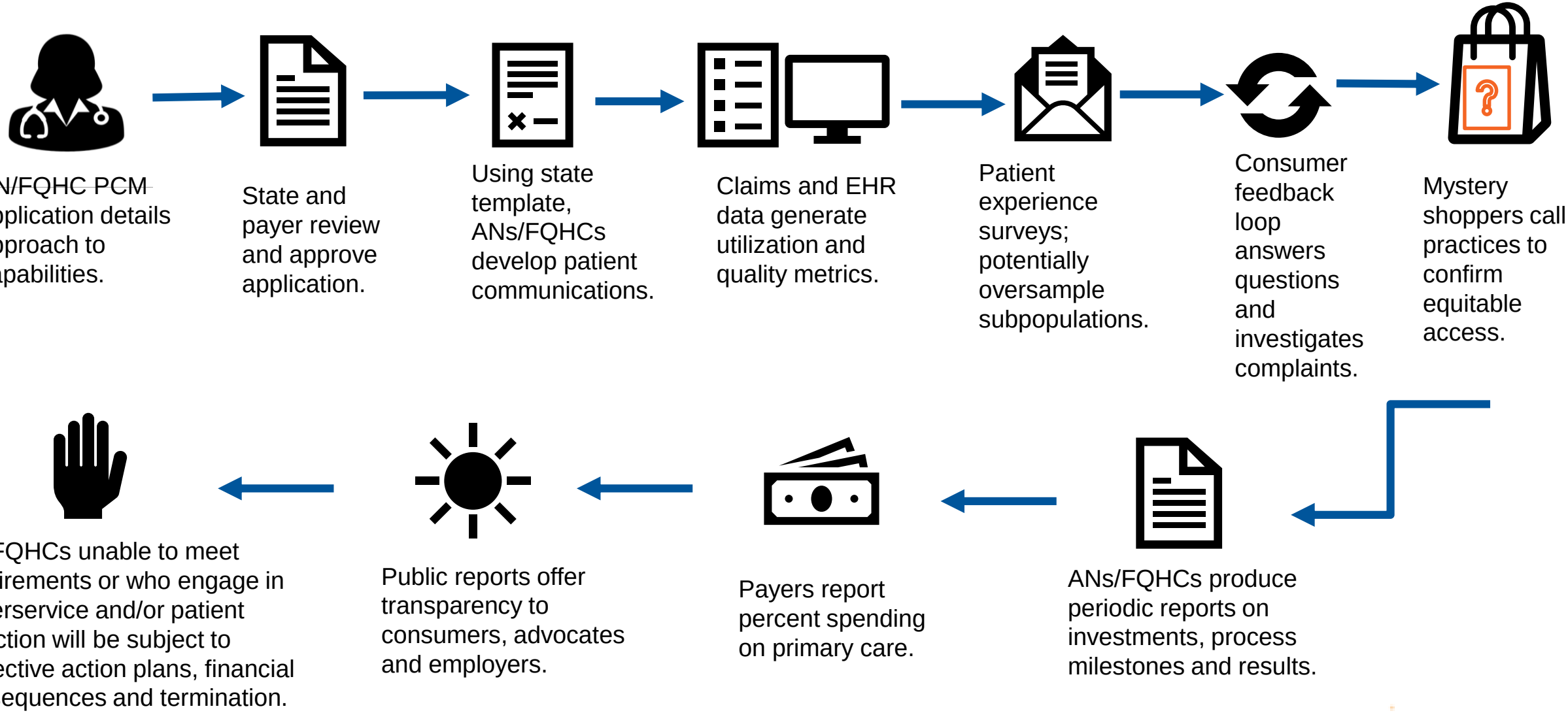
- Protect CMS against paying more than it expected.
- Ensure practices receive fair compensation for care delivered.
- Eliminate incentive to deliver in care in a way that captures bundled payments and then refers patients to other providers for additional care delivery.

Measuring Progress to Achieving PCM Goals

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



Strawman PCM Accountability Process



Alternative Approach to Risk

Options for Consideration

- PCM was intended to be coupled with shared savings models (MSSP/Next Gen) that financially align providers with the goal of improving care delivery and patient experience while reducing cost.

- Medicare has proposed that downside risk will be required to participate in MSSP and most likely other ACO programs.

- We've discussed possible ways to support providers as they make new investments in care delivery to impact patient outcomes and cost of care. They include:
  1) Gradually build supplemental bundle payments into calculations of total cost of care for determining shared savings and losses.
  2) Cushion providers from a greater percentage of losses than under the standard Medicare program and/or allow providers to more generously share in savings.

- We'll come back to these next time but today we want to discuss alternatives.

Potential Alternative "Risk-lite" Approach:

- Consumer advocates have raised concerns that these downside risk options might be intended for Medicaid and that such an approach, if applied to Medicaid beneficiaries, would result in stinting on care.
- If Medicaid participates, we would recommend that Medicaid consider other model options that might address these concerns.
- We would like to review one such model, which might be considered by Medicaid, and which might also be considered by other payers as an entry level option for providers that do not demonstrate readiness to accept and manage risk at the outset of the program.

Potential Alternative "Risk-lite" Approach:

Strawman is based on CPC+ Track 2, which is similar in design and aims to PCM.

CPC Plus Track 2	Care Management Fees	Performance-Based Incentive Payment	Medicare Physician Fee Schedule
	$28 average per beneficiary per month (PBPM) including $100 PBPM to support patients with complex needs	$4 PBIP tied to quality, patient experience and utilization performance	Hybrid bundled payment for office visits: Reduced FFS w/ primary care bundle
Potential PCM Adaptation	**Tier 1 Supplemental Bundle Payment**	**Performance-Based Incentive Payment**	**Full Basic Bundle**
	$18-$20 average target, with increased payments for high-needs populations	$4 PBIP tied to quality/patient experience and utilization performance	Full basic bundle payment. Same as other PCM AN/FQHCs.

Potential Alternative "Risk-lite" Approach:

- Providers receive the $4 PBIP at the beginning of each year.
- Only the PBIP is returned at the end of the performance years if quality and utilization targets have not been met; risk cautious provider can simply bank the PBIP for the year.
- Elimination of total cost of care accountability addresses concerns about incentives to reduce necessary specialty referrals, diagnostic tests and procedures.
- Purchasers may be concerned that reduced pressure on cost accountability reduces the likelihood that return on investment will be achieved in excess of supplemental payment.

QUESTIONS?

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