Practice Transformation Task Force

November 27, 2018

Meeting Agenda

1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of Minutes	5 min
4. House rules refresh	5 min
5. Purpose of Today's Meeting	5 min
6. Review Payment Reform Council Provisional Recommendations	85 min
7. Next Steps	5 min
8. 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 (less than 2 minutes if possible) and to the point/agenda item (*the chair will 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 PTTF 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 or other issues with members of the Executive Team (Elsa, Garrett, Lesley)

Purpose of Today's Meeting

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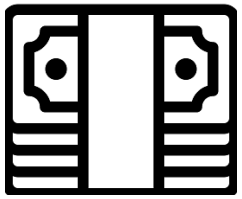
- Review Payment Reform Council provisional recommendations to date and next steps

Payment Reform Council Provisional Recommendations

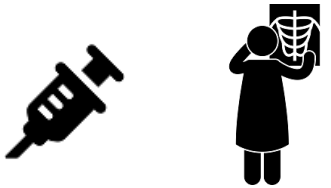
Payment Reform Council Consideration of Task Force Model Options

Basic Bundle



Supplemental Bundle

Fee for Service Payments



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

Payment Reform Council Key Questions

1. What are the qualifications for ANs and FQHCs to participate in PCM? What are the qualifications for practice sites and providers to participate in PCM?
2. What is included in the basic and supplemental bundles? What will remain fee for service? Will some services included in the basic bundle also be paid a reduced fee for service payment?
3. How will patients be attributed to providers?
4. How will bundles be adjusted for differences in patient populations and over time?
5. How will the model protect consumers?
6. How will providers be held accountable for achieving the capabilities?

Qualifications for Participation in PCM

Advanced Network/FQHC

- Has the legal ability and administrative organization to contract with payers
- 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)
- Will participate in Medicare programs (MSSP, Next Gen), or similar program via Medicaid/Medicare/Commercial

Rationale:

- Include participants that are well-positioned for success
- Put sufficient pressure on total cost of care

Questions being discussed:

- What will be the risk criteria of the underlying total cost of care program (MSSP, Next Gen)?
- Will the state have an oversight role in deeming which ANs meet the qualifications?
- Will ANs/FQHCs need to show some level of existing health information technology infrastructure to participate?

Qualifications for Participation in PCM

Practice (as defined by TIN) within AN

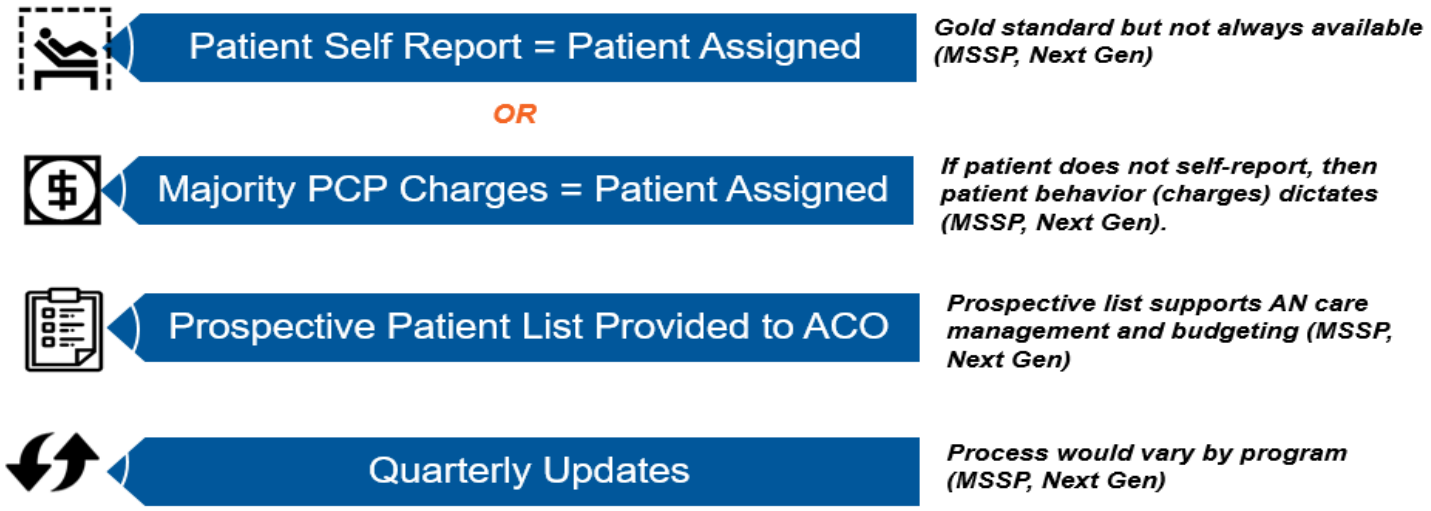
- Providers will have a primary care specialty
- All practices must meet core capability requirements
- Should be able to be clearly defined to ensure bundles are calculated and paid appropriately
  - Medicare: If participating in MSSP/Next Gen, needs to participate in PCM and vice versa
  - Other Payers: Commercial plans will leverage existing contracting structures.

Rationale:

- Ensure primary care bundle represents a meaningful portion of care provided.
- Practices should be well-positioned for success.
- Deploying the capabilities across the greatest number of practices will maximize the investment, minimize administrative burden and protect against the possibility of patients being shifted across practices to increase profit.

Attribution

PRC recommends payers' base attribution on existing methods and adjust as needed. One recommendation is to prioritize patient reporting of PCP over number of visits and cost.



Rationale:

- Recognize the need for consumer choice
- Leverage existing infrastructure and policies
- PRC did not recommend retrospective reconciliation for Medicare FFS because there was not enough added benefit for the effort and resource it would require.

Basic Bundle

- Payment for a set of common primary care services, such as office visits.
- Will support transitioning some PCP patient care to phone, email, text or telemedicine.
- Gives the PCP greater flexibility to spend time managing care team members, participating in learning opportunities and collaborating with colleagues.
- Services in the basic bundle would not be paid fee-for-service for attributed patients.
- Will be calculated using historical claims data and adjusted over time.
- Basic bundle payments will flow the same way that FFS payments currently flow.

Rationale:

- Base on historical spend and adjust over time to account for differences in patient populations, inflation, changes in service provided and other factors.
- Basic bundle dollars are “keep the lights on” payments for practices. The easiest way to ensure payments get to practices efficiently is by following the same path as today’s FFS payments.

Basic Bundle

"Strawman" Services Included in the Basic Bundle for Medicare FFS*:

- **Included for all Practices:** Office Visit, new or established patient, Prolonged Encounter, Encounter Payment for FQHC Visit, Behavioral Health Screening, Cognition Assessment, Phone/Email/Text, Telemedicine, Home Visits (only relevant in limited circumstances and for certain populations – pediatrics, older adults and people with disabilities) and Shared Visits (optional and only applicable in some circumstances).
- **Not Included at this Time**: Hospital, SNF Rounding, Immunization Administration, Preventive Medicine Visit, Preventive Counseling, Annual Wellness Visit

Rationale:

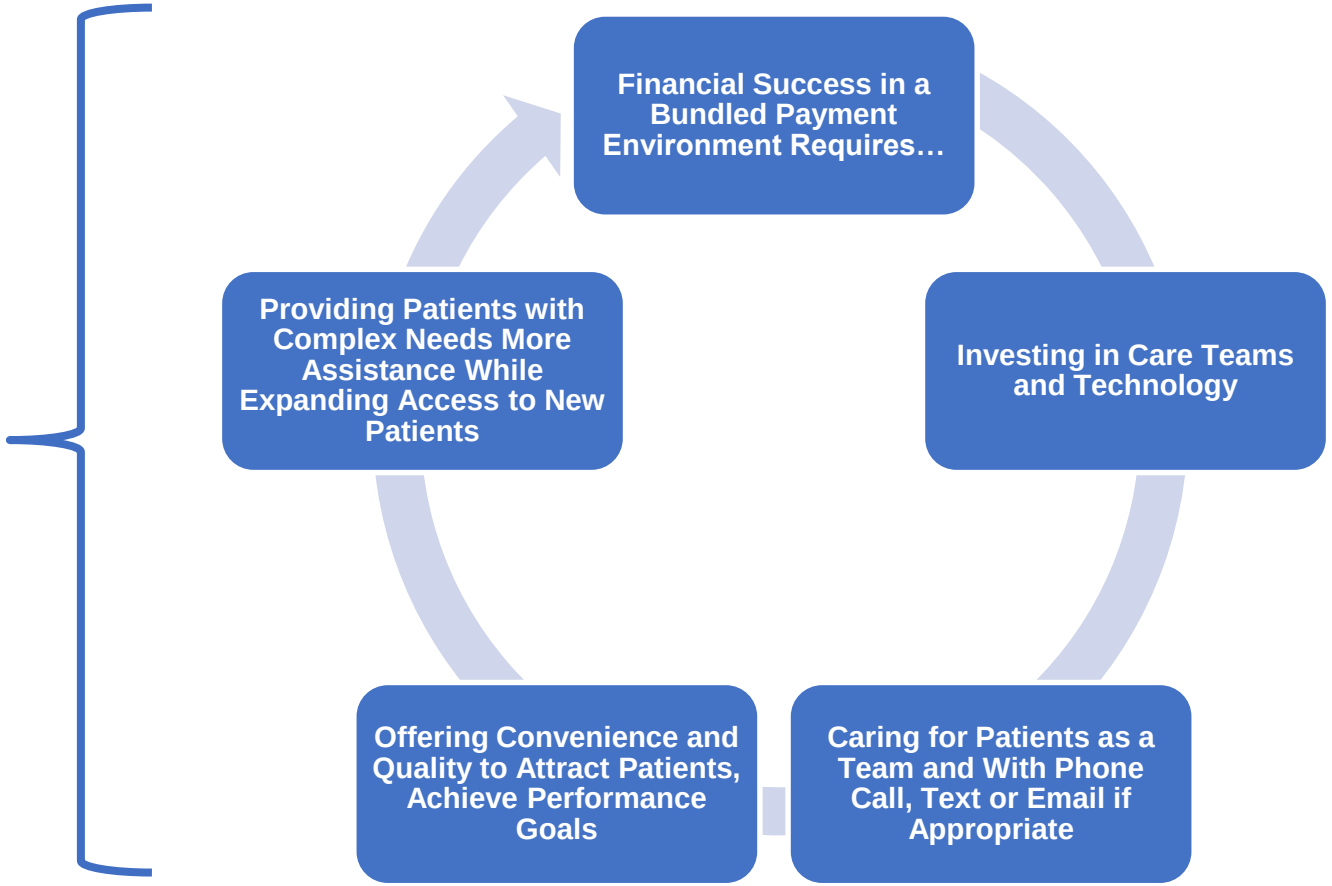
- Include services that comprise meaningful portion of patient care (CPC+ as framework).
- Increase flexibility for care delivery as clinically appropriate and preferred by the patient.

*The PRC will consider different services for FQHCs and pediatrics.

Basic Bundle Payment

Services in the bundle basic will no longer receive fee for service payments.

A full bundle model offered the best opportunity to support care delivery transformation.



Risk of Revenue Loss with Hybrid Method

Under a hybrid model, moving to non-FFS billable services will negatively impact revenue.

Fee for Service:
Dr. Smith and her team (2 MDs, 1 NP, 2 MAs) see about 80 patients a day in the office. They are paid an average of $75 per visit. Revenue for an average day $6,000.

Basic Bundle:
The practice moves about 25% of office visits to other care team members (paid via the supplemental bundle) and/or phone, text or email.

Full: The bundle payment is 100% of historical costs or $6,000.

***50/50 Hybrid*:** The basic bundle payment is 50% historical costs or $3,000. Each office visit brings in half the historical FFS rate or $37.50 per visit. However, with only 60 office visits per day, FFS revenue drops to $2,250. Total revenue for an average day decreases to $5,250.

Payment Approach	FFS Revenue	Bundle Revenue	Total Revenue
FFS	$6,000 (80 office visits)	N/A	$6,000
Full Basic Bundle	N/A (60 office visits)	$6,000	$6,000
Hybrid Basic Bundle	$2,250 (60 office visits)	$3,000	$5,250

Supplemental Bundle

- Advance payment to support activities and investments ***not typically*** billed fee for service. Supports compensation for new care team members, new technology investments, and other expenses to fulfill capabilities requirements, such as:
  - Community Health Workers, Integrated Behavioral Health Clinicians, Pharmacists
  - Partnerships with community based organizations
  - Technology for telemedicine and phone, text and email encounters
- Will be standardized across providers participating in a payer's program and adjusted based on the needs of the population, likely including social determinants of health needs.
- PRC will recommend funds only be used to support primary care transformation and are limited to specific allowable uses (TBD) based on PTTF's capabilities recommendations.
- The PRC is still discussing whether these funds will flow or be paid to ANs and FQHCs or to individual providers or practices.

Provider Compensation

- ANs and FQHCs continue to determine internal compensation structure within their organizations.
- Individual provider compensation will not be directly related to a provider's contribution to total cost of care in a way that incents underservice or patient selection (i.e. cherry picking).

Rationale:

  - AN/FQHC compensation structures need to fit within existing contracts, employment arrangements, organizational culture and priorities.
  - Strong support for language that protects consumers against underservice and cherry-picking
  - ANs and FQHCs need to compensate providers for providing high-quality, efficient care, which often lowers total cost of care.

PRC Next Steps

- Develop framework for performance and accountability measurement, including consumer protections against underservice and cherry-picking patients.
- Determine how model design and services included in the basic bundle will differ for FQHCs and pediatrics.
- Define allowable uses of supplemental bundle funds based on Task Force recommendations for capabilities.
- Define approaches to adjusting the supplemental bundle based on patient characteristics.
- Define payment model options that offer ANs and FQHCs different levels of supplemental bundle funding and risk depending on their infrastructure and culture.

Questions?

- Do these recommendations align with your expectations?
- Do any give you heartburn?

Next Steps

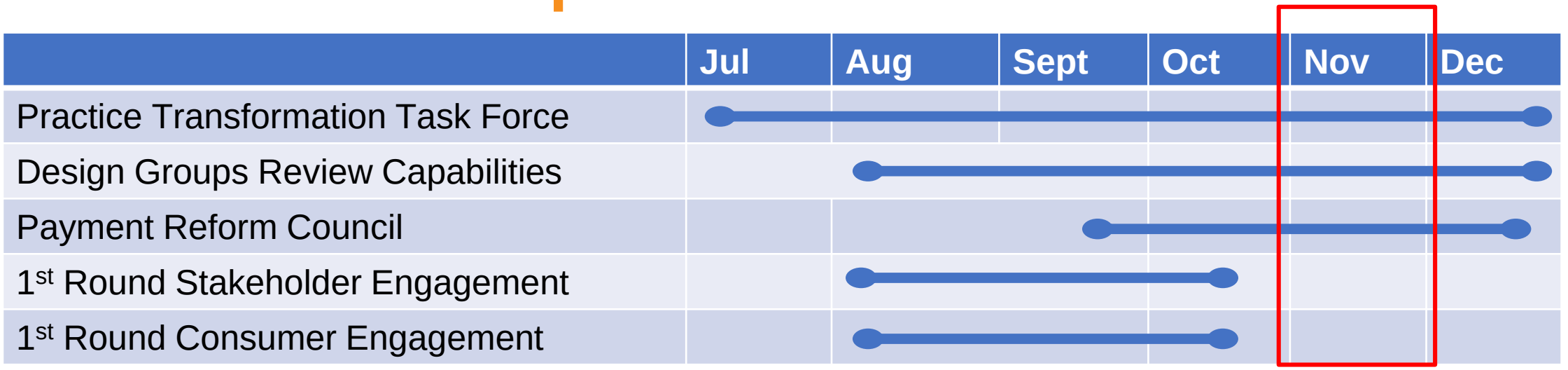
Next Steps

- Next PTTF Meeting: December 18th
- **New PTTF Meeting: January 8th**
- Pediatrics, disabilities, integrative medicine design groups ongoing
- Payment Reform Council meetings through early January

Adjourn

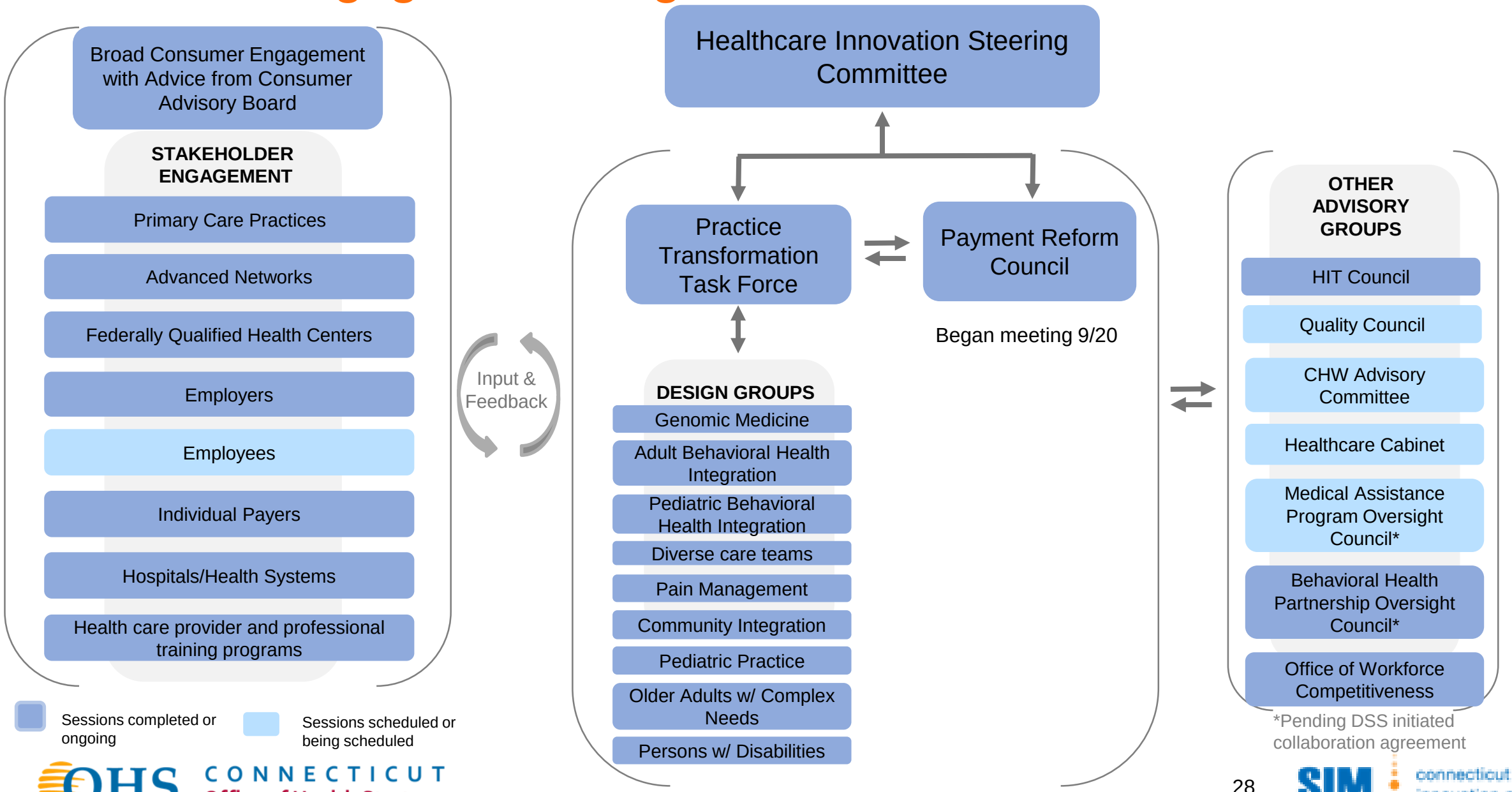
Appendix

PCM Work Plan Update



- Practice Transformation Task Force: Complete review of capabilities by January
- Design Groups: Complete design groups in December
- Payment Reform Council: Meeting October – early January

Stakeholder Engagement Progress



OHS CONNECTICUT Office of Health Strategy

DRAFT FOR DISCUSSION ONLY

SIM connecticut state innovation model

Task Force Recommendations to Date

Capability	Included in Model	Core or Elective	Deployed in All Practices or Subset
Phone/text/email	Yes	Core	All
Telehealth	Yes	Core	All
Remote Patient Monitoring	Yes for certain conditions	Core for conditions w/ efficacy & cost savings	
eConsults	Yes	Core	All
Oral Health Integration	Yes	Core	Maybe only pediatrics
Home Visits	Yes	Elective	For certain populations
Shared Medical Appointments	Yes	Elective	
Infectious Diseases	No	N/A	
Genomic Screening	Tabled until further evidence	N/A	
Functional Medicine	No but explore integrative medicine	N/A	
Diverse Care Teams	Yes	Core	All
Pain Management and Medication Assisted Treatment	Yes with revisions	Core	Basic training for all, subset specialize
Adult Behavioral Health Integration	Yes but continue development		All
Pediatric Behavioral Health Integration			
Community Integration	Yes	Elective	
Older Adults	Yes	Core	Subset specialize
Persons with Disabilities			
Implications of Capabilities for Pediatric Practices			

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