FQHC Design Group

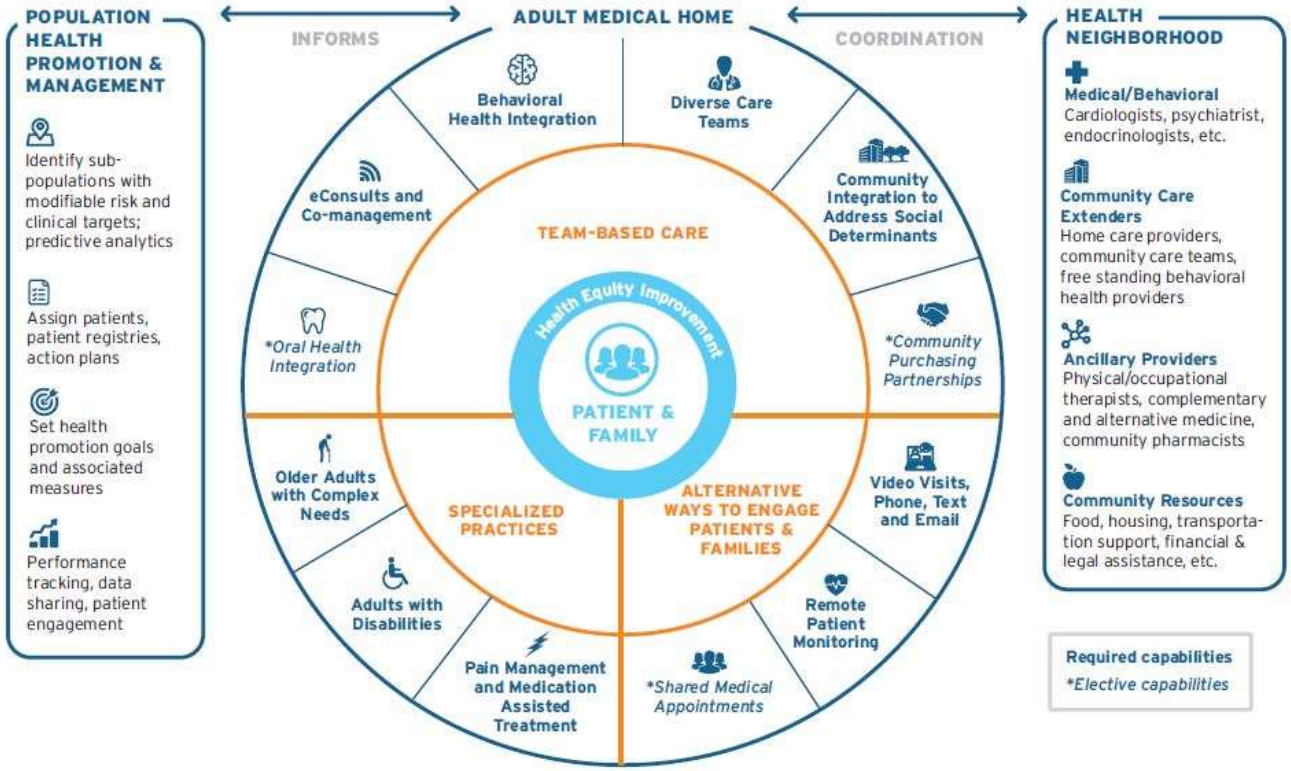
May 29, 2019

DRAFT FOR DISCUSSION ONLY

DRAW SHARED FOCUS TO PROVEN CAPABILITIES

Practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, convenient and responsive to patients' needs while improving health equity.

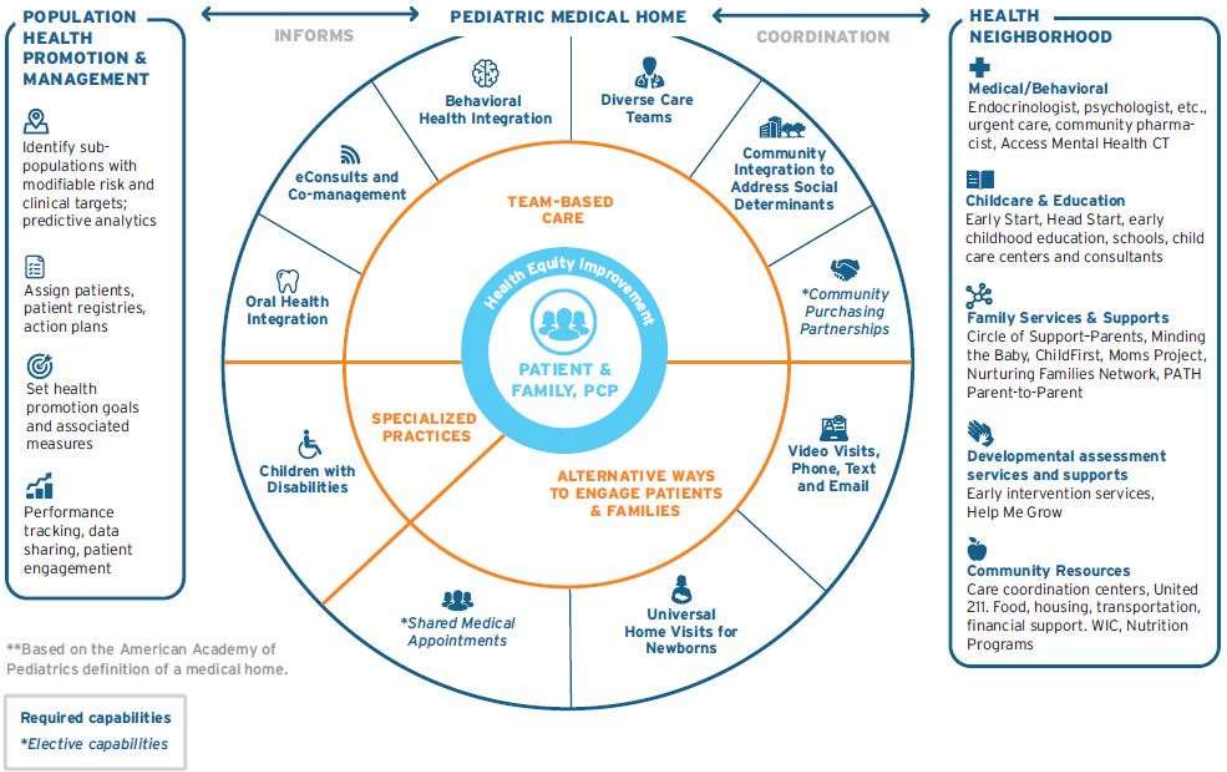
Adult Primary Care Capabilities



ADDRESS SPECIFIC NEEDS OF PEDIATRICS

Pediatric practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Pediatric Primary Care Capabilities



UPFRONT PAYMENTS OFFER FLEXIBILITY

Clinical need and patient preference drives decision-making without the financial and administrative constraints of fee-for-service payments.

Embedded within **shared savings arrangement** that rewards management of total cost of care

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Attribution

- Prospective
- Prioritize patient choice
- Not standardized across payers

Basic Bundle

Time of primary care providers

- Caring for patients
- Leading care teams
- Learning and peer support

Supplemental Bundle

Other investments to achieve the capabilities

- Care team staff
- Infrastructure and HIT
- Patient incentives
- Patient-specific expenses to address social needs

BASED ON

Historical cost of primary care services included in the bundle

% Primary care spend targets applied consistently across providers

ADJUSTED FOR

- Clinical risk
- Changes in services and use
- Unit cost trend

- Clinical risk
- Social risk
- Conditions with intensive management needs (e.g., dementia)

PAID TO

The same provider or tax ID number receiving today's fee for service payments

Advanced Networks and FQHCs participating in shared savings programs with Medicare and other payers

DEVELOPING A BASIC BUNDLE FOR FQHCs

Basic bundle payments would be based on historical or base PPS rates and utilization for attributed patients. Similar to ANs, historical experience would be converted into an advance, PMPM payment and over time adjusted for the factors described in the FQHC basic bundle equation.

PROVISIONAL MEDICARE BASIC BUNDLE EQUATION FOR FQHCs

(Base Period PPS Rate * Utilization (+/-) Addition or Deletion of Services Included) * Population Risk Adjustment * Use Trend * Unit Cost Trend (Induced Demand Factor, if needed)/Attributed Member Months for the Base Period

- Except for prenatal care and other services provided by subspecialists, all services that are currently covered by the medical PPS rate would transition to being covered by the basic bundle
- Prenatal care and other subspecialty services would be paid FFS
- Basic bundle rates could be adjusted to include primary care provider time spent on new services that are not included in today's PPS rates
- Immunizations (and other select pharmaceuticals) delivered at the FQHC site would be reimbursable outside of the PPS rate

CHANGING PAYMENT TO SUPPORT CARE TRANSFORMATION

Without flexible bundled payments, offering more convenient, patient-centered care could reduce FQHC revenue

Dr. Smith leads a small team at one of the locations of Connecticut Health Center, an FQHC. Together, three providers and two medical assistants see about 250 patients a week.

On average, about 20 of these patients have Medicare coverage.

For each of these patients, the health center is paid a PPS rate of $180 per visit. Medicare revenue averages $3600 per week ($180*20).

Dr. Smith and her team want to begin to offer more convenient, more patient-centered care through phone, text, email and video visits. They know Medicare has recently released new codes and fees to reimburse for these services.

Dr. Smith wonders how those fees compare to her current PPS rates.

CHANGING PAYMENT TO SUPPORT CARE TRANSFORMATION

Without flexible bundled payments, offering more convenient, patient-centered care could reduce FQHC revenue

Dr. Smith estimates she could care for about 5 of her Medicare patients through phone, text, email or a video visit each week. Some examples from this week are listed in the table below.

Patient Need	PPS Revenue	Service	Medicare Fee
Cold, low grade fever	$180	Virtual Check In (phone, text, email)	$14
Unusual insect bite	$180	Telehealth Visit* (video visit)	$95
Uncomplicated urinary tract infection	$180	Virtual Check In** (phone, text, email)	$14
Follow up from a recent visit for pneumonia	$180	Telehealth Visit (video visit)	$95
Discuss side effects of new medication	$180	Virtual Check In (phone, text, email)	$14

Dr. Smith's Lost Revenue:
$668 or 19%

**FQHC eligible for CMS telehealth reimbursement*
***Patient would also need urinalysis from lab*

EVALUATING THE POTENTIAL OPPORTUNITY OF NEW CODES AND FEES

FQHCs and ANs that participate in PCM will not be eligible to bill for some codes and fees as a result of their participation. We estimate providers will have significantly more opportunity to receive revenue for care transformation through PCM.

"Best Case" Revenue Opportunity Through FFS Billing Without PCM

Service	Estimated Medicare PMPM	Notes:
Remote Patient Monitoring	$0.17	Assumes 6 patients, 4 months each
Behavioral Health Integration	$1.40	Assumes ~4% of patients in practice participate
Diverse Care Team (Chronic Care Management codes)	$14.38	Assumes half of eligible patients (2 or more chronic conditions) engage
Diverse Care Team: (Transitions in Care codes)	$2.01	Assumes 75% of patients with an admission engage
Total	$17.96	

The Reality:
Providers report that overly burdensome rules around these codes result in infrequent use and little, if any, revenue.

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

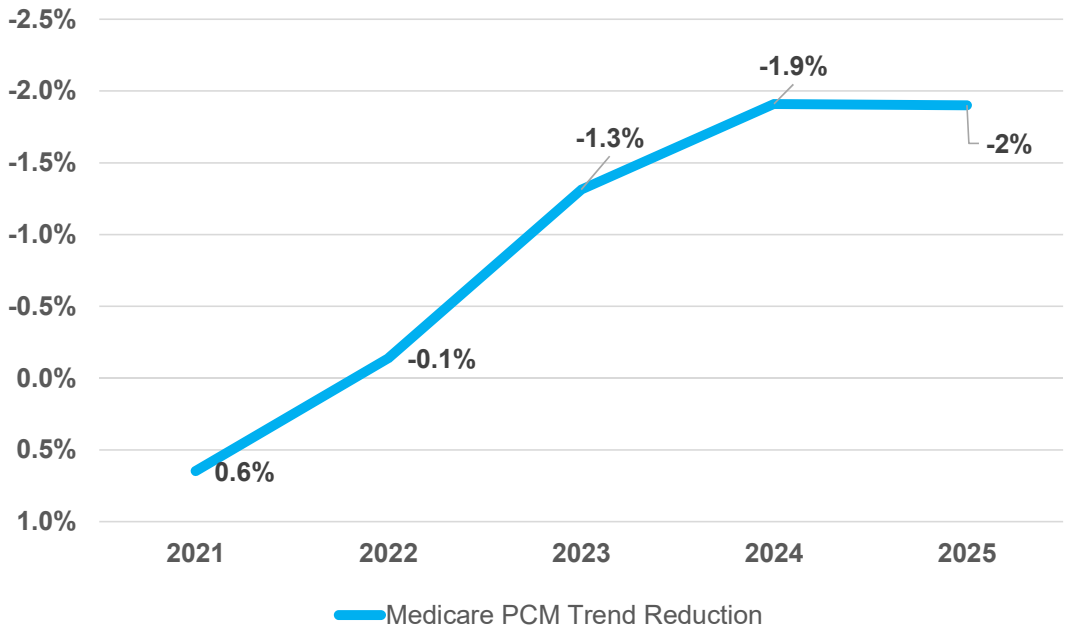
PMPM savings reflects the estimated per member, per month savings across the entire Medicare population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Medicare Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%, inpatient costs decrease 10%. *(PWC 2016)*	$32.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$4.03
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 6%. *(Strumpf, 2016; The Commonwealth Fund March 2012)*	$2.70
Specialized Practices: Pain Management/MAT	Total medical expense decreases 45%. *(Duke 2017)*	$2.10
Specialized Practices: Older Adults with Complex Needs	Skilled nursing facility utilization decreases 16%. *(Gross 2017)*	$15.03
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$2.34
Remote Patient Monitoring	Avoidable readmission costs decrease 50%. *(Broderick 2013)*	$0.33

SAVINGS INCREASE AS CAPABILITIES IMPROVE OUTCOMES

Based on an extensive review of the evidence, modeling shows PCM would drive immediate reductions in avoidable utilization and those savings would more than cover the cost of the program by year two.

PCM Impact on Medicare Total Cost of Care

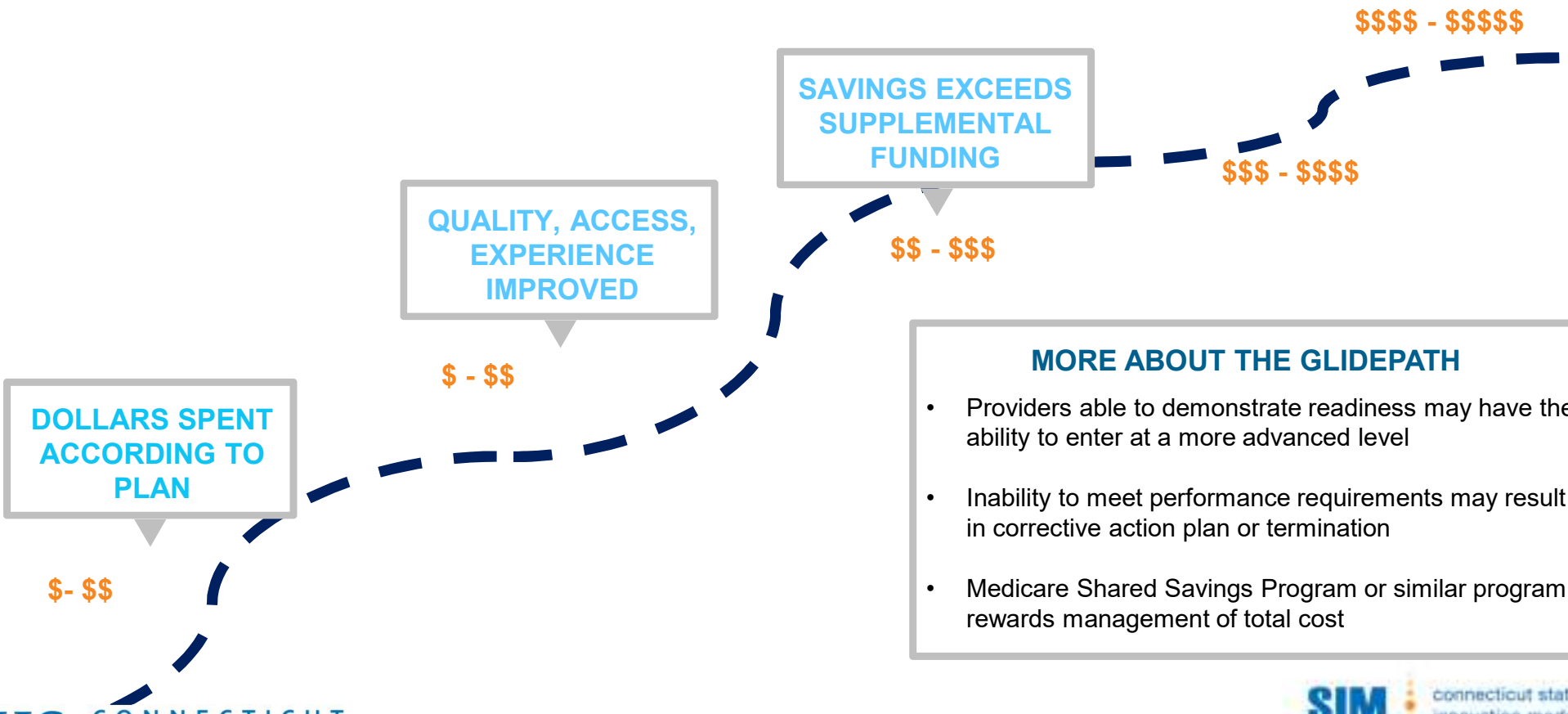


PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment in year 2 for Medicare
- Nearly 2 percent annual reduction in total cost of care by year 5
- Less spending on low value services and more spending on high value services
- Approximately 4.7% spend redeployed to primary care

GLIDEPATH ENCOURAGES SMART INVESTMENT

Supplemental payments will increase gradually and "proof of performance" will be required to advance.



MORE ABOUT THE GLIDEPATH

- Providers able to demonstrate readiness may have the ability to enter at a more advanced level
- Inability to meet performance requirements may result in corrective action plan or termination
- Medicare Shared Savings Program or similar program rewards management of total cost

OHS CONNECTICUT Office of Health Strategy

SIM connecticut state innovation model

DEVELOPING A SUPPLEMENTAL BUNDLE FOR FQHCS

The supplemental bundle approach currently being considered for FQHCs is very similar to the approach for ANs, with some differences intended to account for team-based care built into the PPS rate.

- FQHCs could seek supplemental funding up to a risk-adjusted target based on a percent of total cost of care. Goal would be to balance sustainability (achieving ROI) with receiving sufficient dollars to achieve the capabilities and transform care delivery.
- Supplemental bundle targets would be standardized across FQHCs participating at each level of the glidepath but specific to the FQHC based on the medical, behavioral and social risk of its population. This is the same as the approach for ANs.
- FQHC supplemental bundle targets may be calculated separately from the supplemental bundle targets for ANs. This is because the current PPS rates already cover some individuals and activities associated with team-based care.
- FQHCs would need to demonstrate that they are using the supplemental bundle dollars for approved purposes and similar to ANs could be subject to audit. FQHCs would utilize a documentation format similar to a cost report to show how dollars from the two payments were allocated.
- FQHCs could choose to seek less supplemental funding than the maximum target or could choose to stay on a lower level of the glidepath for up to TBD number of years.
- FQHCs would be required to achieve the same capabilities as ANs.

** For commercial only*

CAPTURING DATA ON PRIMARY CARE ACCESS

Using a standardized format, practices would document all patient touches by all practice-associated personnel.

Access Tracking Report
ABC Healthcare

Practices included: Acton, Bridgefield, Essex, Marston and Overbrook

Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).

Attributed Patients		Categories						Total
Total Number of Patients Attributed		PCP	Care Manager (RN, MSW)	Pharmacist	BH Clinician	CHW	Other (Navigator, Coach, Nutritionist)	All Clinical Encounters & Contacts
RAW TOTALS	6,149	21,390	19,262	18,137	9,827	8,201	7,230	84,047
RAW AVERAGES (PER ENROLLEE PER YEAR)		3.48	3.13	2.95	1.60	1.33	1.18	13.67
RISK ADJUSTED AVERAGES		3.34	3.01	2.84	1.54	1.28	1.13	13.14

CAPTURING DATA ON PRIMARY CARE ACCESS

Types of encounters captured for all practice-associated personnel. This would provide greater insight into care delivery than available today.

Access Tracking Report
ABC Healthcare
April 1, 2018-March 31, 2019 (rolling 12 months)

Practices included: Acton, Bridgefield, Essex, Marston and Overbrook

Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).

Attributed Patients		PCP				
Total Number of Patients Attributed		Office Visits	Telemedicine Visits	Home Visits	Phone/Text/E-mail contacts	Total Clinical Encounters
RAW TOTALS	6,149	7,230	2,987	1,172	10,001	21,390
RAW AVERAGES (PER ENROLLEE PER YEAR)		1.18	0.49	0.19	1.63	3.48
RISK ADJUSTED AVERAGES		1.13	0.47	0.18	1.56	3.34

GENERATING THE REPORT

- AN/FQHC configures EHR to capture all care team contacts, by patient and by type of contact
- PCP and care team personnel record their patient contacts in the *normal course of business* similar to other visit types
- AN/FQHC runs a quarterly summary report (de-identified) and uploads or transmits the report in a standard format to OHS and participating payers.
- Summary report includes contacts/patient by type of coverage (Medicare, Medicaid and commercial)

SHARING DATA ON PRIMARY CARE ACCESS

As part of program monitoring, the state could report both practice and system performance over time. As an example, the total encounters for one group might appear as shown below, with the vertical line representing the start of bundled payments.