

Meeting Three: FQHC Design Group Discussion Guide

For our third meeting, we've revised the list of issues below to reflect our conversations to date and added two additional topics reflecting conversations being held by the Payment Reform Council. We look forward to hearing your input. An Appendix also has been shared to provide additional information.

1. Service inclusion and basic bundle calculation for Medicare and Medicaid: unique handling of FQHCs

Revised Recommendation (changes highlighted in yellow):

- For Medicare and Medicaid, the basic bundle would include all services currently included in the Medical PPS rate including sick visits, wellness/preventive visits, nursing visits, tobacco cessation counseling and prenatal care.
- Assuming current BH services provided by a medical provider are paid under the medical PPS rate, those would be included in the basic bundle. Behavioral health services delivered by BH clinicians would be paid via the existing Behavioral Health PPS rate and left out of the basic bundle.
- Consistent with the PRC recommendation, services paid via the basic bundle would not be eligible for FFS payment.
- Assuming FQHCs can distinguish the subspecialty of the provider in historical claims, either through name or taxonomy, then services provided by subspecialists would not be included in the basic bundle.
- Dental services would be excluded from the bundle and paid via the dental PPS rate.
- For Medicare and Medicaid, registered nurses would be paid via the basic bundle when providing face-to-face visits for acute or chronic needs (consistent with today) and via the supplemental bundle when providing all other services. For commercial payers, registered nurses would be paid via the supplemental bundle, the same as ANs.

Rationale: The PPS rate is calculated using a broader range of services than the CPT codes recommended for inclusion in the basic bundle by the Payment Reform Council and it would likely be administratively burdensome and potentially impossible to “back out” those costs. However, prenatal care can be quite variable across FQHCs and even for individual patients during their pregnancies. Therefore, it likely makes sense to transition prenatal care to FFS.

Remaining Questions:

- Thoughts or questions on the care team payment spreadsheet?
- What will be the mechanism for making the PCP/subspecialist distinction to create the Basic Bundle and to separate future claims for FFS payment. Two possible solutions:
 1. The payer makes a FFS payment for any such providers unless a prenatal visit CPT code is used
 2. The payer recognizes these visits because a consultation code is used and so pays them FFS.

- What is the history of change of scope requests in Connecticut? Based on these recommendations, do you anticipate any need for changes in scope?

2. Service inclusion and calculation of the supplemental bundle, including ensuring PPS equivalency

Draft Recommendation:

- FQHCs would be required to achieve the same capabilities as Advanced Networks. More information detailing the provisional capabilities' recommendations is included in the Appendix.
- For Medicare and Medicaid, the supplemental bundled payment amounts would be calculated separately from the supplemental bundled payments to Advanced Networks. This is because the current PPS rates may already cover some individuals and activities associated with team-based care and thus do not need to be included in the supplemental bundle. More information on current cost estimates is available in the Appendix.
- Risk adjustment approaches would be the same as for Advanced Networks. More information on proposed risk adjustment approaches is included in the Appendix.
- For commercial payers, FQHCs would be treated the same as ANs being paid via the PCM supplemental bundle.
- Both the basic bundle and the supplemental bundle would be included in calculating PPS equivalency. PCM would request CMS approve a methodology in which a simple attestation by the FQHC could be used to show that PPS equivalency is met with the caveat that a full reconciliation be done only in cases where there was underpayment.

Rationale: This approach would seem to be the most efficient way to fairly compensate FQHCs without duplicative payment for certain services.

3. Developing Payment Model Options to Support PCM Participation

Strawman for Discussion:

- PCM was intended to be coupled with shared savings models (MSSP/Next Gen) that financially align providers with goals of improving care delivery and patient experience while reducing cost. Medicare has proposed that downside risk will be a requirement for participation in future programs.
- The Payment Reform Council is considering ways to mitigate risk to enable time for new investments to impact patient outcomes and cost of care.

Ideas being considered 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.
- 3) Offer an entry-level option for providers not ready to share risk.

- Consumers have voiced concerns about the introduction of downside risk in Medicaid and some providers have expressed concerns about readiness for downside risk in the early years of this initiative.
- We are sharing for discussion a potential strawman alternative for certain payers (e.g., Medicaid) or an entry level option for providers, including some FQHCs, with a low level of readiness to share risk.

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.

- Providers receive 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 providers 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.