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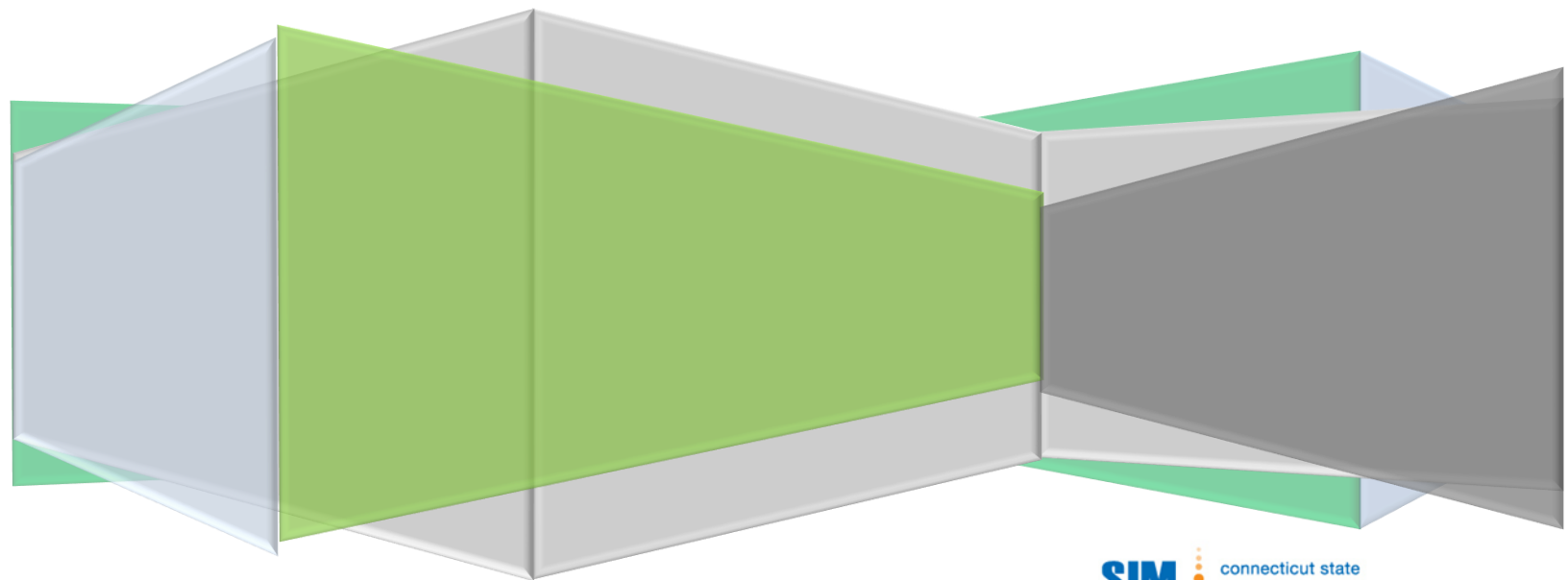
connecticut state
innovation model

Primary Care Payment Reform

Unlocking the Potential of Primary Care

XXXX, 2018

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SIM



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*This white paper was prepared for the Connecticut State Innovation Model
Practice Transformation Taskforce by Qualidigm*

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Acronyms

ACO	Accountable Care Organization	HHS	Department of Health and Human Services
APM	Alternative payment model	HISC	Healthcare Innovation Steering Committee
AMH	Advanced Medical Home	LAN	Healthcare Payment Learning & Action Network
AN	Advanced Network	MSSP	Medicare Shared Savings Program
APCD	All-Payers Claims Database	NCQA	National Committee for Quality Assurance
ASO	Administrative Services Organization	NQF	National Quality Forum
CAB	Consumer Advisory Board	OSC	Office of the State Comptroller
CCIP	Clinical & Community Integration Program	PCMH	Patient Centered Medical Home
CHW	Community Health Worker	PCMH+	Person Centered Medical Home +
CMMI	Center for Medicare & Medicaid Innovations	PCP	Primary care provider
CMS	Centers for Medicare and Medicaid Services	PCPM	Primary care payment model
DMHAS	Department of Mental Health and Addiction Services (CT)	PMO	Program Management Office (SIM)
DPH	Department of Public Health (CT)	Task Force	Practice Transformation Task Force
DSS	Department of Social Services	RFP	Request for Proposals
EHR	Electronic Health Record	SIM	State Innovation Model
FFS	Fee for service	SSP	Shared Savings Program
FQHC	Federally Qualified Health Center	TA	Technical Assistance
GDP	Gross domestic product	VBP	Value-based payment

Executive Summary

Introduction

The Connecticut State Innovation Model (SIM) initiative develops and implements state-led, multi-payer healthcare payment and service delivery reforms that promote healthier people, better care and smarter spending. SIM makes investments in programs designed to improve how care is delivered, including the Advanced Medical Home Program (AMH) and the Community and Clinical Integration Program (CCIP).

AMH helps primary care practices become patient-centered medical homes (PCMH), focusing on whole-person, team-based care. CCIP builds on AMH by helping providers develop new organization-wide capabilities to improve primary care. CCIP focuses on the integration of new care team members, such as community health workers and pharmacists, comprehensive assessments of patients with complex health needs including personal goals and social determinant risks, linkage to community resources, integration of behavioral health and strategies to improve health equity.

The SIM initiative promotes the alignment of payers around an Alternative Payment Model (APM) that rewards better care. The APM that SIM promotes is called a shared savings program model, which rewards providers for meeting quality targets and reducing the rate of growth in the total cost of care. Shared savings program arrangements are intended to incentivize provider investments in SIM-related care delivery reforms—such as diverse care teams, care coordination, community linkages, analytics, and consumer engagement.

To date, healthcare organizations appear to be having trouble achieving the AMH and CCIP goals because they are being asked to provide care differently, with added staff and resources, while still being paid fee-for-service (FFS). Moreover, it has become apparent that there may be limitations in the shared savings program model that prevent providers from undertaking transformative change, especially in primary care. To change this, we must evolve our payment models in ways that allow providers to develop care delivery capabilities that benefit patients.

The SIM Program Management Office (PMO) invited the Practice Transformation Task Force (Task Force) to examine the limitations of Connecticut's shared savings reforms and make recommendations to address these limitations, **with a focus on transforming primary care**. The PMO contracted with Qualidigm to provide subject matter expertise and consultative support to the PMO and the Task Force. This is a report of the Task Force's recommendations and the Qualidigm findings based on key informant interviews across the State of Connecticut.

Primary Care Payment Models: Background

Primary care payment reforms began in the 1980s. Well before the emergence of today's shared savings program models, there were payment innovations that bundled all or a portion of the cost of primary care in payments to providers to enable flexibility in primary and team-

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based care.¹² Most of these models placed less emphasis on office visits and more emphasis on innovative methods of patient engagement, such as the use of diverse care team members like health coaches.

More recently, the number and variety of APMs has increased, including those focusing on primary care. As part of this project, we examined alternative care and payment models including those of Evergreen Health, Iora Health, and Kaiser Permanente. We also examined CMMI's Comprehensive Primary Care Plus (CPC+) initiative which aims to transform primary care by providing population-based payments to incentivize improvements in nearly 4,000 primary care offices nationally.

These models bundle some portion of primary care reimbursement, enabling alternatives to visit-based care. They also allocate more of the healthcare dollar for primary care, rather than other service lines such as hospital, pharmacy, and specialty care.

In 2015, the Department of Health and Human Services (HHS) established the Health Care Payment Learning & Action Network (LAN). This collaborative network of public and private stakeholders is committed to advancing payment reform by establishing a common framework, aligning approaches to payment innovation, and encouraging use of best practices. The LAN developed recommendations for primary care payment reform based on their payment framework comprised of the following four categories:

- *Category 1:* FFS - No link to quality and value
- *Category 2:* FFS - Link to quality and value
- *Category 3:* Alternative Payment Models built on a FFS architecture
- *Category 4:* Population-based payments

Connecticut's shared savings programs align with Category 3. Most primary care payment reforms enabling team-based care and non-visit-based patient incorporate some elements of Category 4. They include population-based payments, typically in the form of risk-adjusted care management fees and partial or full bundling of primary care services.

Primary Care Payment Model Options (PCPM)

The Task Force examined three PCPM options that might address the limitations of Category 3 shared savings models. The three options included:

- Care management fees and partial bundled payment for sick visits
- Care management fees and full bundled payment for sick visits
- Comprehensive bundled payment for most primary care services

They also examined important considerations for pediatric patients.

Stakeholder Feedback

¹ Porter, Michael E. & Baron, Jennifer F. (May 7, 2008). *Commonwealth Care Alliance: Elderly and Disabled Care*. Harvard Business School, 9-708-502.

² Arnold Milstein and Elizabeth Gilbertson, *American Medical Home Runs*, *Health Affairs*, 28, no.5 (2009):1317-1326; doi: 10.1377/hlthaff.28.5.1317

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As part of this project, the Qualidigm team completed an extensive series of stakeholder interviews to discuss potential limitations of the current reimbursement environment and solicited feedback on the three model options. Qualidigm met with provider organizations representing over 4,000 healthcare providers—a majority of the state’s providers. Payer interviews represented over 80% of all covered lives across the state. Lastly, the Qualidigm team interviewed representative consumer advocates, including the Connecticut SIM Consumer Advisory Board, a 17-member group representing patients from culturally and linguistically diverse backgrounds across the state.

What We Learned

- Providers:
 - are dissatisfied with the lack of flexibility in existing FFS payment models;
 - are willing to accept limited risk, in exchange for flexibility;
 - prefer payment options that fit with their current capabilities, allowing for greater flexibility and risk as they evolve;
 - need access to advanced payments to support investments in new services and care team members (e.g., community health workers); and
 - need access to social determinant-related public health databases to help improve care coordination, access to care and improved outcomes.
- Payers:
 - want to move away from traditional FFS payment models;
 - need support for investments in primary care and the shared savings models;
 - feel reluctant to make advanced payments without demonstrated savings; and,
 - recommend that any reforms providing for advanced payments be tied to provider accountability.
- Consumer Advocates:
 - appreciate the benefits of diverse care teams to support patients, including a greater number of touches between office visits, help navigating the health system or help from a community health worker to access community services.
 - acknowledge the benefits of avoiding visits (and associated transportation challenges) for needs that could be handled through telehealth visits, phone or e-mail,
 - concluded that Connecticut’s current FFS payment models contribute to unsustainable healthcare costs, which does not support the goal of affordability;
 - acknowledged there were risks in transitioning away from FFS, such as the possibility of under-service; and,
 - advocated a move toward models supporting best practices for care, provided that risks are mitigated and performance is monitored closely.

Task Force Recommendations

The Task Force concluded that primary care payment reform is an essential means to enable primary care transformation, including non-billable innovations in consumer engagement and team-based care. They urged the state to engage Medicare and convene the State’s public and private payers to examine how primary care payment reform can become an essential component of Connecticut’s care delivery and payment reform strategy. If well-designed,

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primary care payment reform can address a number of the challenges facing practices today. To this end, the Task Force had the following recommendations:

- **Recommendation 1:** Connecticut’s payers should implement primary care payment reform to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.
- **Recommendation 2:** Payers and providers are encouraged to use prospective bundled payments that reduce or eliminate reliance on visit-based care. Payers should offer entry-level options that limit the risk associated with bundling and an incremental strategy that enables practices to build their capabilities over time.
- **Recommendation 3:** Primary care payment models should use prospective primary care bundles or care management fees to increase by at least double the funding dedicated to primary care as a percentage of the total cost of care.
- **Recommendation 4:** Primary care payment models should be coupled with an alternative payment model, such as a SSP, that rewards practices for controlling the total cost of care.
- **Recommendation 5:** Primary care payment models should include the cost of new services in prospective primary care bundled payments or care management fees, which should be exempt from cost-sharing.
- **Recommendation 6:** Primary care payment models should use risk adjustment to adjust payments to account for underlying clinical and social-determinant differences in the patient populations served by different primary care practices.
- **Recommendation 7:** Fee-for-service (FFS) payment may play a limited role as part of a blended primary care payment model to incentivize certain services and protect against under-service.
- **Recommendation 8:** Primary care payment models should include a bundled payment option in which primary care practices receive resources to manage mental health and substance use conditions and assume accountability for associated outcomes.
- **Recommendation 9:** Primary care payment models should maximize the flexibility that primary care teams have to expend resources on health-the promotion of health and health equity and coordination with community services, including the use of community health workers.
- **Recommendation 10:** Payers that utilize primary care payment models should ensure that quality of care is measured and rewarded and that practices demonstrate that they are investing in and have implemented transformational change that results in appropriate level of service and equitable access.
- **Recommendation 11:** Primary care payment models should be multi-payer, cover the majority of a practice’s patient population, and provide practices with external coaching support and technical assistance.

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- **Recommendation 12:** Primary care training programs (residencies and medical schools) should be engaged early on in the development of model because of the role they play in training the next generation of clinical primary care leaders.

The Task Force further advised on an advisory process for the design of a Primary Care Modernization program model that will advance the above recommendations. The goal of this design process is to detail: 1) new care delivery capabilities for Connecticut's primary care practices and 2) payment model options that support those capabilities. The program model is intended to double primary care spending over a period of five years so that doctors can provide patients with more support. It will also introduce new payment methods that increase flexibility to make care more convenient, community-based and responsive to the needs of patients, while also ensuring that flexible funds are wisely invested and that patients are protected from the risk of under-service (e.g., loss of access to office-visits) and patient selection. Together, these changes must improve outcomes and health equity while reducing the total cost of care and increasing the joy of practice. The program model will be an option for consideration by the governor-elect during the transition period that begins soon after the November election.

Introduction and Purpose of the Project

The State Innovation Model (SIM) and Primary Care Transformation

The Connecticut State Innovation Model (SIM), through a \$45 million grant from the Center for Medicare and Medicaid Innovation, develops and implements state-led, multi-payer healthcare payment and service delivery reforms that promote healthier people, better care and smarter spending. To this end, the SIM supports several initiatives focused on improving population health, promoting new insurance designs and provider payment models, encouraging the alignment of healthcare quality measures, updating health information technology and implementing a Medicaid shared savings program (PCMH+). A core SIM aim is to promote transformation of care delivery services.

The Advanced Medical Home and Community and Clinical Integration Programs

SIM has two major initiatives focused on changing care delivery. The Advanced Medical Home (AMH) Program provides technical assistance to individual primary care practices to enable them to become NCQA recognized medical homes. Primary care practices enrolled in this program receive support to:

- Enhance access and continuity
- Promote team-based care
- Encourage population health management
- Plan and manage care
- Track and coordinate care
- Measure and improve performance

Building on the practice-level capabilities developed in the AMH program, the Task Force developed the [Community and Clinical Integration Program](#) (CCIP). This program provides

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technical assistance and funding to help Advanced Networks and Federally Qualified Health Centers achieve system-level care delivery standards, including:

- Improving care for individuals with complex health needs;
- Introducing new care processes to reduce health equity gaps;
- Improving access to and integration of behavioral health services; and,
- Improving the integration of oral health, complex medication management, and the use of e-Consults.

Payment Reform and Shared Savings Programs (SSP)

Though many healthcare organizations are participating in care delivery reform efforts, they have found it difficult to fully implement the needed capabilities. Traditional Fee-for-service (FFS) models are still predominant in Connecticut. FFS stimulates the provision of more services, instead of helping to fund and support new care delivery capabilities that ultimately benefit and engage patients.

Changes in healthcare delivery require alignment with changes in healthcare payment models. In recent years, payment reform in Connecticut has largely been focused on shared savings program arrangements offered by Medicare and commercial payers. SIM helped align payers around shared savings programs by funding Medicaid's first shared savings program, the Person Centered Medical Home + (PCMH+) initiative. Shared savings program arrangements are intended to incentivize providers to meet quality targets and reduce growth in total care costs. Shared savings programs are intended to enable and support provider investments in SIM-related care delivery reforms, such as analytics, diverse care teams, care coordination, community linkages and consumer engagement.

Despite the potential benefits of shared savings programs, there may be limitations in the model that prevent providers from undertaking transformative change, especially in primary care. For this reason, the SIM Program Management Office (PMO) invited the Practice Transformation Task Force (Task Force) to examine the limitations of Connecticut's shared savings reforms and make recommendations to address these limitations **with a focus on transforming primary care**.

The PMO contracted with Qualidigm to provide subject matter expertise and consultative support to it and the Task Force. To help these groups better understand healthcare payment reform history and the vast array of primary care payment models employed today in Connecticut and across the country, the Qualidigm team:

- Conducted a review of the current literature on health reform in general, and on primary care payment reform specifically, which included approximately 1,000 publications, articles, papers, journals and press releases.
- Summarized best practice themes resulting from the scan.
- Identified and summarized organizational models and primary care best practices.
- Created an interview guide to help gather information during stakeholder meetings.
- Identified and interviewed leading Connecticut-based provider and payer organizations.
- Used the information gathered to assess the level of transformation in progress in Connecticut, against identified best practices.

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- Shared the themes and progress against stated organizational goals with the Task Force so the team could use the information to create its recommendations.

Qualidigm and the PMO convened and engaged the Task Force to examine and evaluate primary care payment model (PCPM) options that could address the limitations of ~~and move beyond~~ shared savings program models in order to pay for and support primary care transformation. As a result of this process, the Task Force issued 11 key recommendations for the adoption of PCPMs in Connecticut (See **Acknowledgements** for list of Task Force members).

Background

Early Payment Reform

Extensive payment reform experimentation began in the 1980s and 1990s, driven partly by the unchecked increase in healthcare spending as a percentage of Gross Domestic Product (Figure 3-1).

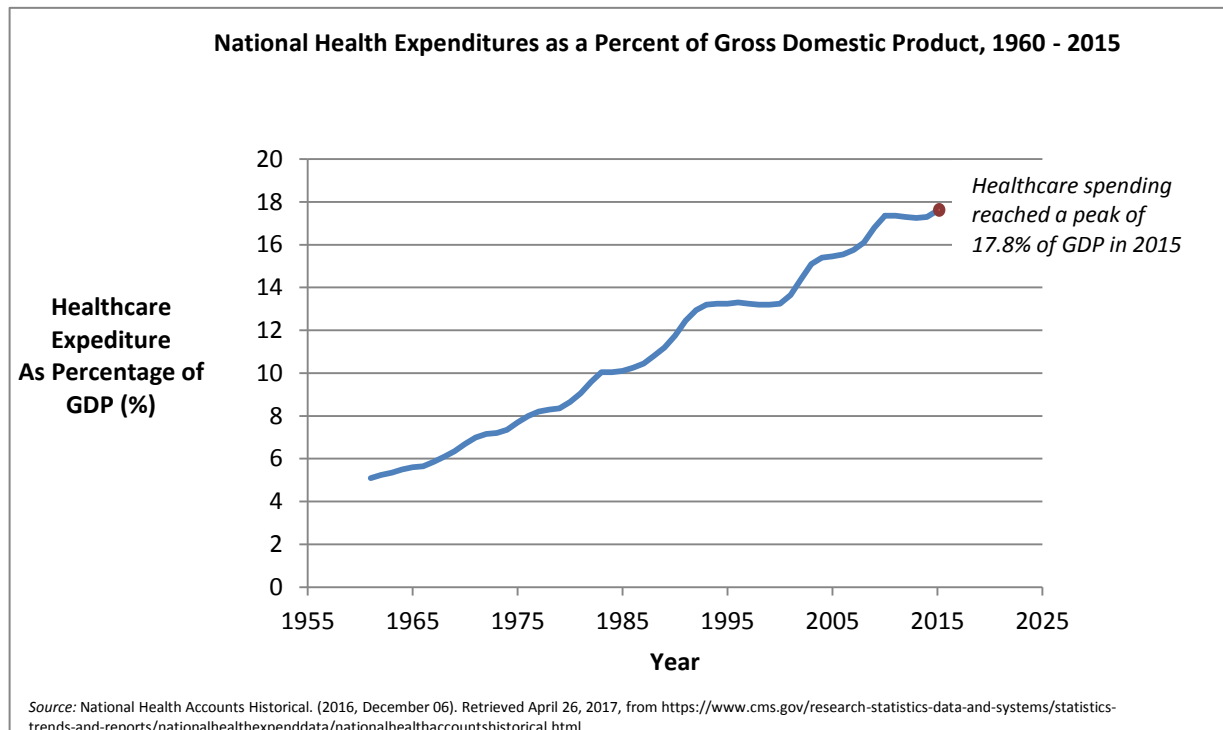


Figure 3-1: National healthcare expenditures as a percentage of GDP, 1960-2015

Health insurers aggressively pursued new payment models, including “capitation,” to rein in soaring costs and bend the healthcare cost curve. Capitation, in healthcare insurance, is a generic term for a fixed payment per person for access to a set of services, usually per-member-per-month (PMPM). Providers receive a set payment per patient in the provider’s panel, and services included can be narrowly defined; e.g., a subset of services delivered by a primary care physician, or more broadly defined; e.g., global capitation for all health care services. Provider capitation models have been around for many years and have been used successfully and beneficially in a variety of situations and locations across the country.^{3, 4, 5, 6, 7}

³The Advisory Board Company. (2016, May 16). *Maryland’s All-Payer Global Budget Cap Model and Its Implications for Providers*. Retrieved from <https://www.advisory.com/-/media/Advisory-com/Health-Policy/2016/Maryland-All-Payer-Model-White-Paper.pdf>

⁴Song, Z., MD, PhD, & Rose, S., PhD. (2014, October 30). Changes in Health Care Spending and Quality 4 Years into Global Payment — NEJM. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMs1404026-t=article>

⁵Pearson, W. S., PhD, MHA, King, D. E., MD, MS, & Richards, C., MD, MPH. (2013, July & Aug.). Capitated Payments to Primary Care Providers and the Delivery of Patient Education. Retrieved from <http://www.jabfm.org/content/26/4/350.full>

⁶Porter, Michael E. & Baron, Jennifer F. (May 7, 2008). Commonwealth Care Alliance: Elderly and Disabled Care. Harvard Business School, 9-708-502

⁷Arnold Milstein and Elizabeth Gilbertson, American Medical Home Runs, *Health Affairs*, 28, no.5 (2009):1317-1326; doi: 10.1377/hlthaff.28.5.1317

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Capitation was not well-received in Connecticut where early models focused on cost rather than improved patient care and emphasized primary care providers as gatekeepers. By the end of the 1990's, all payers had discontinued the practice of capitated provider contracts in Connecticut.

Early Payment Reform and Clinical Innovation

Although these early payment reform attempts did not bring about the desired improvements in practice, some of the more innovative clinical models introduced in this era are still important and desirable for today's enhanced primary care models. Among them:

- Disease management
- Clinical practice guidelines
- Informal specialty consultations
- Best practices implementation
- Care delivery team coordination that includes case managers, discharge planning and social workers
- Development of alternative care settings
- Creation of links to community services
- Development of treatment plans
- Establishment of family and social evaluations
- Creation of health risk assessments
- Development of provider decision support systems

Clinical innovation has driven change in care delivery, practice staffing and resource allocation. Today's primary care practices rely more on advance care providers, such as physician assistants and advanced practice registered nurses, to deliver and coordinate patient care. Practices also have had to bear the administrative burden and cost associated with these innovations – often at the expense of patients and staff.

In recent years, primary care providers participating in new payment models have been held accountable for achieving the “Triple Aim”, a standard developed by the Institute for Healthcare Improvement (IHI) that focuses on improving population health, improving health care quality, and controlling growth in the cost of care. To address issues that are making providers leave, or not choose primary care, the IHI has added a fourth aim to the original goals of improving population health and the patient care experience while reducing costs. The “Quadruple Aim” seeks to improve the primary care provider's experience and reduce burnout, as do the new clinical and payment models that enable innovation in care delivery while supporting the Quadruple Aim.

Practice transformation is a lofty goal but success stories suggest that it is attainable. One example includes four primary care sites in the United States cited as “medical home runs” by Mercer Health and Benefits Medical Director Arnold Milstein and Elizabeth Gilbertson, president of the Hotel Employees and Restaurant Employees International.⁸ According to the

⁸Milstein, Arnold and Gilbertson, Elizabeth. (November 12, 2012). American Medical Home Runs, Four real-life examples of primary care practices that show a better way to substantial savings. HealthAffairs, Volume 28, Number 5.

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authors, patients in these practices incur 15 to 20 percent less in total (risk-adjusted) health care spending because they have been given the opportunity and responsibility to improve outcomes and lower cost. The success factors cited by the authors included “exceptional individualized caring” for chronically ill patients, efficiencies in service provision and a careful selection of the specialists they referred patients to. They further suggested that savings like these, when returned to providers, will drive both short and long-term results.

The Medical Home Model

Medical home was introduced by the American Academy of Pediatrics in 1967 with their first policy statement calling for centralization of pediatric medical records to ensure continuous care published in 1977.^{9,10} The medical home model evolved beyond the centralization of medical records to a care delivery model that focused on addressing the need of the total child. Since then, the concept has moved beyond pediatrics concept into adult primary care.

The medical home model was further developed and connected to payment reform in 2006, when the American College of Physicians (ACP) published the advanced medical home model. ACP called for reimbursement reform to further evolve care delivery according to medical home principles. The Patient-Centered Primary Care Collaborative (PCPCC) was established that same year. A leading national multi-stakeholder coalition, the PCPCC is dedicated to advancing the medical home concept.

Another milestone in the advancement of care delivery and payment transformation occurred in 2008, when the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Council (URAC), The Joint Commission (TJC), and the Accreditation Association for Ambulatory Health Care (AAAHC) launched medical home accreditation or recognition programs. NCQA Patient-Centered Medical Home (PCMH) standards are by far the most widely used medical home standards in Connecticut today.

Adding to the body of knowledge supporting transformation, the PCPCC has produced annual reports since 2012. These reports highlight published successes and lessons learned from pilots, demonstration projects, and private and government payers, including¹¹:

- **Quality improvements:** diabetic control, diabetic eye exams, cholesterol control, BP control, pediatric well visits, access to care, heart disease care, breast, cervical, and colorectal cancer screening, asthma management, flu shots, decreased inappropriate antibiotic use, and reduction in missed work days
- **Utilization improvements:** Emergency Department use, ambulatory care, urgent care, hospital admissions, hospital readmissions, specialist utilization, hospital days, high tech imaging, and increased generic drug use

⁹ American Academy of Pediatrics, Council on Pediatric Practice. Pediatric Records and a “medical home.” In: Standards of Child Care. Evanston, IL: American Academy of Pediatrics; 1967: 77–79

¹⁰ American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Advocating for ems-c on a broader scale. In: Emergency Medical Services for Children: The Role of the Primary Care Provider. Elk Grove Village, IL: American Academy of Pediatrics; 1992:117–123

¹¹ PCPCC “The Patient-Centered Medical Home’s Impact on Cost and Quality: An Annual Update of Evidence, 2012-2013 published January 2014”; 2013-2014 published January 2015; and 2014-2015 published February 2016.

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- **Cost reductions:** savings on diabetic care, total medical expense savings, pediatric cost reductions, and lower outpatient care costs
- **Satisfaction increases:** increases in likelihood of recommending to family and friends; increases in patient satisfaction measures; and reduced staff emotional exhaustion

While some studies have demonstrated the introduction of PCMH can lead to an initial increase in healthcare utilization and expenditures¹², the track record of successful medical home performance, whether measured by quality improvement, utilization and cost reductions, or improved patient satisfaction and access, is well established.^{13, 14}

The medical model addresses payment and care delivery issues that many felt were contributing to an emerging primary care practitioner shortage, at a time when an aging population and those with chronic conditions require broader access to primary care.

Payment reform can increase primary care income, support care delivery improvements, and contribute to patient and provider satisfaction. The following key principles have been identified as important components of primary care reform:^{15, 16}

- Reallocation of funding to primary care.
- Enhanced and diverse care delivery teams.
- Alternative services, which are not reimbursable under FFS arrangements.
- Alternative financial models that support primary care innovation, facilitate a reduction in unnecessary office-based care, and leverage technology and diversified care teams to promote better care.
- Uniformity by payers in financial models to help increase primary care practice efficiencies in quality measurement and practice operations.
- A total cost of care incentive such as a shared savings program within the overall design of a payer / provider arrangement.

The Healthcare Payment Learning & Action Network (LAN)

In 2015, the Centers for Medicare and Medicaid Services (CMS) launched the Healthcare Payment Learning & Action Network (LAN). A collaborative network of public and private stakeholders, it includes health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care ecosystem. The alliance provides specialized expertise, health capabilities, and innovative solutions to transform delivery of the nation's health care services. Its workgroups also developed recommendations to support primary care transformation.

¹² Timbie, J.W. PhD, et al. (2017 July). Implementation of Medical Homes in Federally Qualified Health Centers. *New England Journal of Medicine*. 377: 246-256. Retrieved from: <http://www.nejm.org/doi/full/10.1056/NEJMsa1616041>

¹³Nielsen, M., PhD, MPH, Buelt, L., MPH, Patel, K., MD, MS, & Nichols, L. M., PhD, MS, MA. (2016, February). The Patient-Centered Medical Home's Impact on Cost and Quality. Retrieved from [https://www.pcpcc.org/sites/default/files/resources/The Patient-Centered Medical Home's Impact on Cost and Quality, Annual Review of Evidence, 2014-2015.pdf](https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality,%20Annual%20Review%20of%20Evidence,%202014-2015.pdf)

¹⁴DeVries, A., Li, C. H., Sridhar, G., Hummel, J. R., Breidbart, S., & Barron, J. J. (2012). Impact of medical homes on quality, healthcare utilization, and costs. *The American Journal of Managed Care*, 18(9), 534-544

¹⁵ Cross, M. (June 2007). What the Primary Care Physician Shortage Means for Health Plans. *Managed Care*. Retrieved from <https://www.managedcaremag.com/archives/2007/6/what-primary-care-physician-shortage-means-health-plans>

¹⁶ American Academy of Family Practice 2016 FP Comprehensive™ Practice Improvement, Part II, November 2013: Collaborative Practice and Team-Based Care. Retrieved from http://www.aafp.org/test/fpcomp/FP-E_414/pt1.html

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In January 2016, a LAN workgroup published *Alternative Payment Model Framework*, describing key principles of payment reform necessary to:

“Offer providers the flexibility to strategically invest delivery system resources in areas with the greatest return, enable providers to treat patients holistically, and encourage care coordination. Because these and other attributes are very well suited to support the delivery of high valued health care, the workgroup and the HCP-LAN as a whole believe that the health care system should transition towards shared risk and population based payments. Financial incentives to increase the volume of services provided are inherent in FFS payments, and certain types of services are systematically undervalued. This is not conducive to the delivery of person centered care because it does not reward high quality, cost effective care.”¹⁷

The authors added that payment reform is in keeping with the U.S. Department of Health and Human Services’ (HHS) goal “to have 30% of U.S. health care payments [i.e., Medicare and Medicaid] in alternative payment models (APMs) by 2016 and 50 percent by 2018. HHS has also set the goal of having 85 percent of all Medicare FFS payments to quality or value by 2016 and 90 percent by 2018.”¹⁸ To this end, HHS has designed many programs, including the SIM program, to build locally supported alternative payment models to help meet these federal targets.

The LAN introduced a four category framework for conceptualizing payment models. This framework is useful for examining payment models for any type of health care service including primary care (Figure 3-2).

¹⁷ Health Care Payment Learning & Action Network, *Alternative Payment Model Framework*. Retrieved from <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

¹⁸ Health Care Payment Learning and Action Network. (n.d.). Retrieved April 26, 2017, from <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>

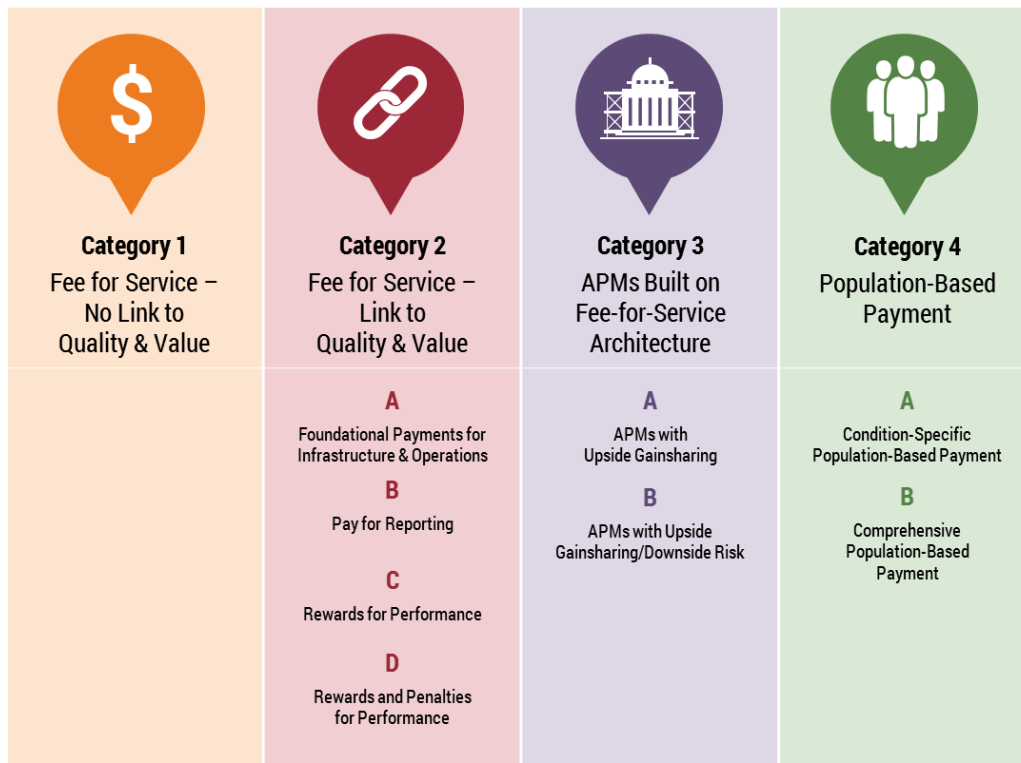


Figure 3-2: LAN's Updated Alternative Payment Model Framework

- **Category 1:** FFS payment, “which remains the dominant method of primary care payment... contributes to the challenges of delivering high-value primary care.”¹⁹
- **Category 2:** Includes many of the models seen over the past 20 years, including pay-for-performance, pay-for-quality, pay-for-care management, and various versions of PCMH.
- **Category 3:** Crosses the threshold into an Alternative Payment Model (APM) primarily by combining much of the primary care models in Category 2 on a FFS architecture with a budget and upside shared savings opportunity. It may also include downside risk, when appropriate. Commonly known as a shared savings program, it is in widespread use with Medicare, commercial payers (including Medicare Advantage), and recently with Medicaid in Connecticut.
- **Category 4:** Replaces components of FFS with prospective payment and has upside and downside risk, where appropriate.

In 2016, the LAN convened a Primary Care Payment Model Work Group charged with establishing consensus on the best way to pay for primary care using Category 3 or Category 4 population-based alternative payment models and to make practice recommendations for

¹⁹ Health Care Payment Learning & Action Network. (2017). *Accelerating and Aligning Primary Care Payment Models*. Retrieved from <https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf>, page 5.

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accelerating the adoption of these models.²⁰ The Work Group released a white paper in 2017, [Accelerating and Aligning Primary Care Payment Models](#), which summarized where the primary care model of care is poised to go and how PCPMs need to evolve to support the new, expanded care model. Unlike the early, financially-driven payment models designed to reduce the growth of health care spending as a percentage of GDP, today's PCPMs need to catch up with the maturation of today's more clinically and public health driven model of care. The authors of this paper clearly delineate the *Dual Role of Primary Care*; to:

- Establish trusting partnerships between patients and clinicians, enabling the delivery of readily accessible, high-quality patient- and family-centered care, and;
- Serve as effective stewards of health care resources through planned care, population health management, and care coordination with specialty and other services, including social services.

The LAN PCPM report identified 19 recommendations, several of which focus on payment methods:

- The preferred form of payment for primary care employs risk-adjusted, comprehensive prospective payment.
- PCPMs should be multi-payer and cover the majority of a practice's patient population.
- Prospective payments should exceed historic primary care payment amounts to support the infrastructure of the clinical team.
- FFS payment should still play a limited role as part of a blended PCPM; it provides an incentive for PCP's to perform certain services during face-to-face encounters and it promotes more efficient, comprehensive primary care.

The Work Group further recommended that primary care practices be held accountable for:

- Investing in the staff, technology, and other infrastructure needed to fulfill the dual role.
- Demonstrating success on metrics of patient access, quality of care, comprehensive provisions of services, responsiveness to patients, effective stewardship of resources.
- Measuring and achieving high patient satisfaction levels.
- Including behavioral health integration and the management of mental health and substance use services.

Finally, the LAN recommended strongly that, "to the greatest extent possible, value based incentives should reach providers across the care team that directly delivers care."²¹ Although the primary care payment model and the individual provider compensation model are not the same, they need to be aligned such that individual providers and care teams have the opportunity to share in the savings that their organization generates proportional to their own quality performance and the number of attributed lives on their panel.

²⁰ Health Care Payment Learning & Action Network. (2016) *Primary Care Payment Models Draft White Paper*. Retrieved from <https://hcp-lan.org/workproducts/pccpm-whitepaper-draft.pdf>

²¹ Alternative Payment Model (APM) Framework. (Page 9.) (2016, December 1). Retrieved from <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

A Closer Look at Primary Care Payment Using the HCP-LAN Framework

Primary care payment reform can be incrementally achieved as one progresses along the continuum of payment categories. As will be seen from the review that follows, more advanced payment categories more fully support primary care transformation.

Category 1: FFS Model – No Link to Quality and Value

The FFS model is based on payment for the delivery of a face-to-face encounter (Figure 3-4). The patient sees the doctor. The doctor bills for the service and is paid - based on very clear definitions for what a provider can and cannot do to get paid.

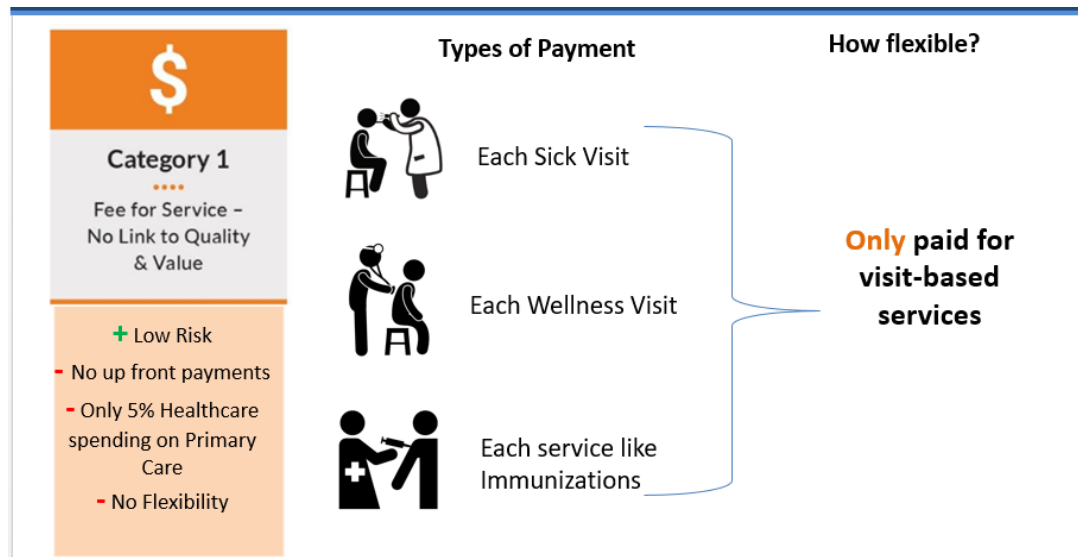


Figure 3-4: FFS Model – No Link to Quality & Value

The FFS model does not give providers flexibility to implement new processes that would help their patients if the process or service is not payable on the provider's fee schedule. More important, the only way physicians can increase revenue is by scheduling more patient visits, negotiating higher fees with payers, and/or ordering more tests.

Forced to schedule as many appointments as possible in a day, primary care providers do not have time to engage with other members of the care team, such as Community Health Workers (CHW), or take advantage of patient engagement and support services. The provider also may not have the time they want to spend with their patients. Since the provider is paid only for visits and services, there is little incentive to focus on improving their patients' overall health or in engaging additional care team members to assist in coordinating care. Ironically, providers benefit financially when patients are sick and need more visits.

According to the LAN, "Financial incentives to increase the volume of services provided are inherent in FFS payments, and certain types of services are systematically undervalued. This is

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not conducive to the delivery of person centered care because it does not reward high quality, cost effective care.”²²

Category 2: FFS – Link to Quality and Value

Pay-for-performance models address some of the disadvantages of the FFS-only model by combining traditional FFS with a bonus payment linked to quality outcomes. (Figure 3-5).

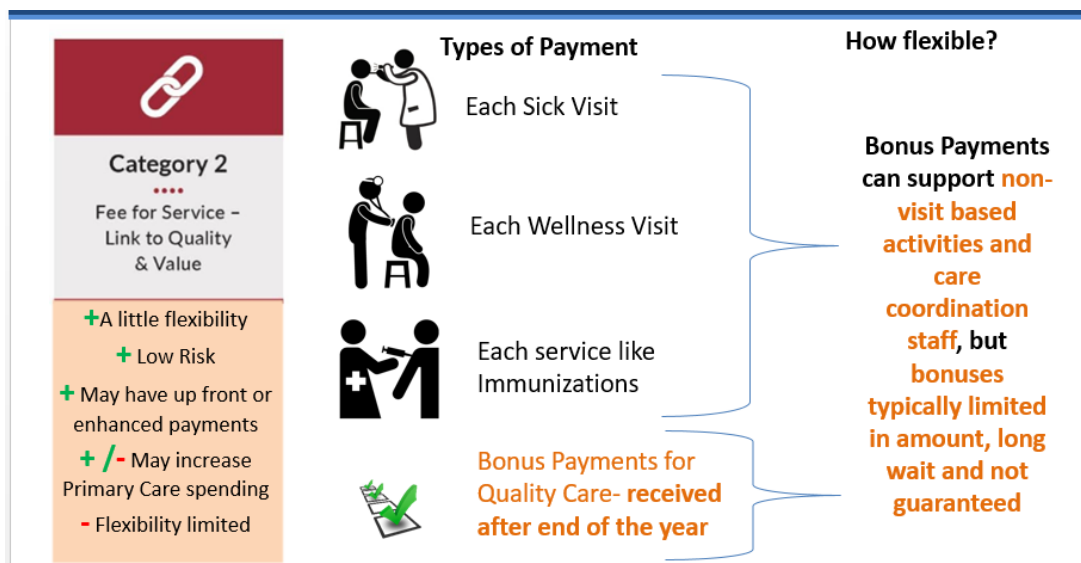


Figure 3-5: FFS Model – Link to Quality & Value

Providers receive bonus payments retrospectively based on whether they meet quality targets that result in patient health improvements. Pay-for-performance models also offer some potential for cost savings if the improvements in patient care result in reduced reliance on EDs and hospitals.

Despite the benefits of pay-for-performance models, they tend to focus on a narrow, pre-defined set of quality improvement opportunities. They are also limited in their ability to generate substantial improvements in cost of care and typically do not provide for a substantial increase in overall primary care funding to support innovation.

Providers that are successful in achieving quality targets receive bonus payments long after providing care due to the time required for quality outcomes evaluation and reporting. Therefore, these models make it difficult to support the hiring of alternative/diverse team members such as CHWs. This is because the bonuses are uncertain and unavailable when the practice incurs the expense of hiring. Practices must fund such services with no guarantee they will recoup their investments.

While slightly better than the FFS model, pay-for-performance models are still limited in their ability to support the addition of diverse care team members and non-visit based services.

²² Healthcare Payment and Learning Action Network. (2016). *ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK, Final White Paper*. Retrieved from <http://hcp-lan.org/workproducts/apm-whitepaper.pdf>

DRAFT FOR PUBLIC COMMENT**Category 3: Advanced Payment Models (APMs) Built on FFS Architecture**

Models in this category are most commonly shared savings program arrangements. They give primary care providers (often in a network) the chance to receive a more significant amount of money based on their performance against pre-determined quality and utilization measures, such as:

- Achieving normal range of Hemoglobin A1c for x% of attributed diabetics
- Reducing avoidable emergency department (ED) visits
- Reducing unnecessary hospitalizations
- Initiating comprehensive medication management for applicable patients
- Use of generic medications where applicable
- Use of less expensive diagnostic services that maintain a high level of quality

A provider network incentivizes its primary care providers to achieve these outcomes by entering into a shared savings program arrangement with its contracted insurance companies or government entities (e.g., Medicare and/or Medicaid). When providers achieve desired quality outcomes, and the network reaches a financial threshold of savings over the prior year's performance (or other benchmark), providers can receive a portion of that savings. The payer shares the savings with the network which, in turn, shares the savings with its providers—in line with LAN objectives²³.

The flexibility afforded by these payment arrangements can lead to improved access, higher quality and lower costs by using shared savings to expand reimbursement beyond the billable codes allowed under FFS. Providers can use the additional revenue to invest in innovative patient engagement and support services that allow them to connect with patients at any time, and in ways other than individual, face-to-face office visits (Table 3-1).

Patient Engagement and Support Services	
	Phone Contact
	E-Mail and/or Text Message Support
	<u>Language interpretation and translation services</u>
	Telemedicine Visits
	Home Visits
	E-Consults
	Remote Monitoring
	Group Visits (illness self-management, lifestyle coaching, prevention)
	Communications with Schooling and Child Care
	Direct Coordination with Community Services

Table 3-1: Additional Patient Engagement and Support Services

²³ Alternative Payment Model (APM) Framework. (Page 9.) (2016, December 1). Retrieved from <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

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Practices also can build more diverse, multi-dimensional provider teams that are better qualified to meet patients' needs. In addition to increasing patient satisfaction, these diverse teams may also increase care team satisfaction. They tend to be less hierarchical than traditional medical practices, where the physician is in the lead position (Table 3-2).

Care Team Diversity
Nurse Care Managers
Social Workers
Licensed Behavioral Health Clinicians
Pharmacists
Nutritionists/Dieticians
Care Coordinators
Patient Navigators
Patient Outreach Coordinators
Community Health Workers

Table 3-2: Diverse Care Team Members

In Connecticut today, most commercial and Medicare Advantage payers have shared savings program models in place with primary care physician networks. Connecticut's Department of Social Services (DSS) recently launched its first shared savings program, known as PCMH+. This new model includes added payments for enhanced care coordination activities, intensive care management, person-centered medical home practice transformation; and offers up-side only shared savings²⁴ (i.e., no risk of financial loss for the provider). (Figure 3-6).

Shared savings program models may also include a modest (e.g., \$2-5 PMPM), prospective payment to the provider network. This monthly care management fee (CMF) is based on the number of members assigned to the provider or practice. The CMF is intended for investment in care coordination to improve quality and performance. These investments are expected to result in lower medical expense. A more coordinated experience with the medical system has shown to be a better model both from a quality and financial perspective.²⁵

²⁴ Presentation to State of Connecticut, State Innovation Model Healthcare Innovation Steering Committee, March 9, 2017

²⁵ Mullins, A., MD, FAAFP, Mooney, J., MBA, & Fowler, R., MD, FAAFP. (2013, December 01). The Benefits of Using Care Coordinators in Primary Care: A Case Study. Retrieved April 20, 2017, from <http://www.aafp.org/fpm/2013/1100/p18.html>

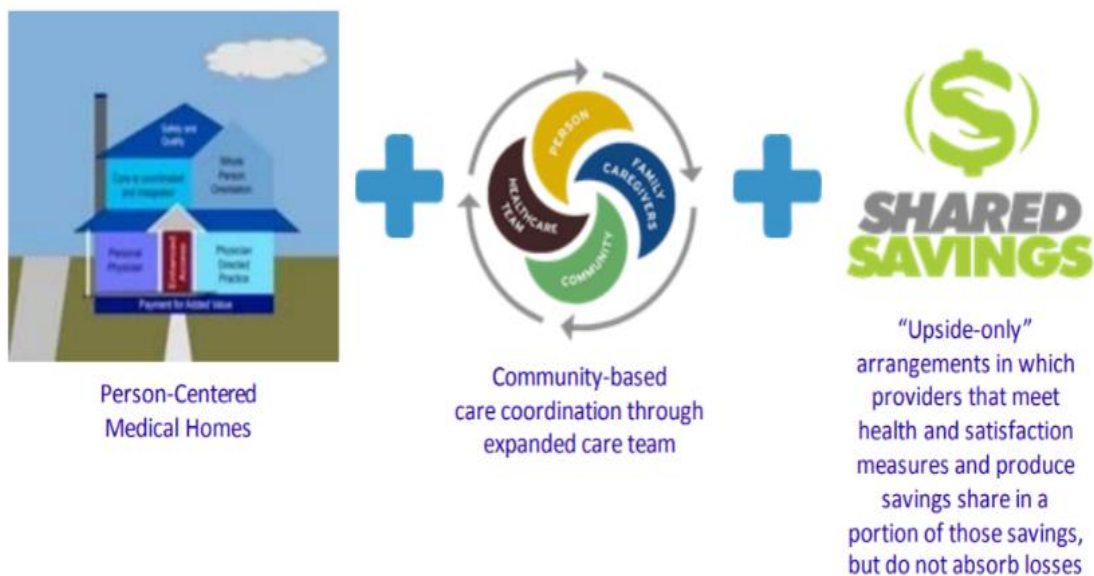


Figure 3-6: Connecticut PCMH and Shared Savings

Shared savings programs encourage primary care providers to focus on better outcomes for their patients and reduce the overall cost of care in the network. The model encourages coordination between providers in a network because they share the savings that result from better outcomes. Shared savings programs are Category 3 models because they give providers the opportunity to make investments in internal care delivery improvements in the form of PMPM payments for care coordination. (Figure 3-7).

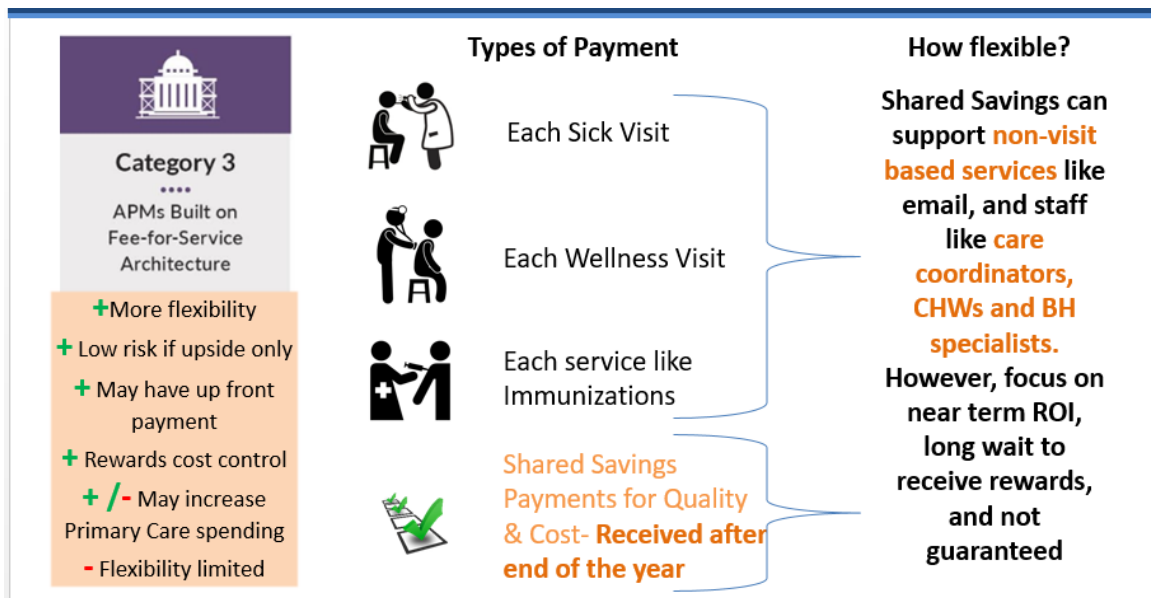


Figure 2-7: APMs Built on FFS Architecture

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There are several limitations of Category 3 models. Providers still must see more patients and they are limited in what they can do outside of traditionally billable services. This model also encourages providers to focus on opportunities for short-term, rather than long-term savings.

Another disadvantage of this model is that payers must have all of a provider's claims before they can to measure, report and reconcile quality and utilization performance metrics.

Calculation and disbursement of any savings occurs many months (>6) after the measurement period ends. For example, if the measurement period is a calendar year (January to December), then the earliest that reconciliation would occur is in June of the following year - 18 months after the measurement period started. (Figure 3-8).

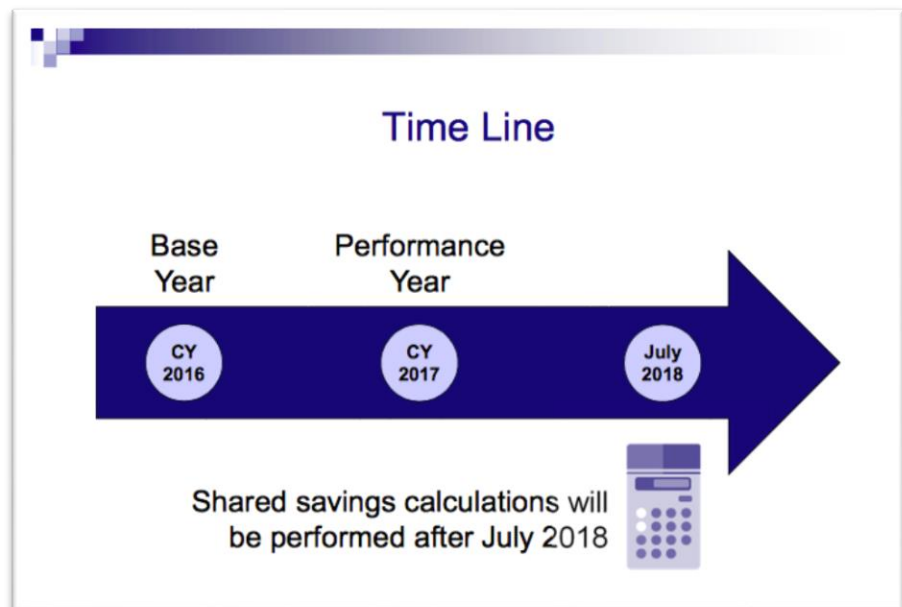


Figure 3-8: Timeline for SSP Reconciliation

This time lag makes it difficult for providers to correlate the practice's behaviors to outcomes, or to predict whether the reconciliation will result in shared savings. Though there are opportunities, providers may be reluctant to invest in care transformation because there is no assurance of a positive return on their investment.

Another significant challenge with this model is the lack of standardization among payers. Payers may offer variations on shared savings program arrangements (e.g., different quality targets), which makes it difficult for providers to undertake care delivery improvements that meet all targets. Payers may also vary with respect to the amount of their care management fees and associated care delivery requirements. In adopting care processes uniformly *across all patients*, a provider may not have the resources to offer a service at the level expected by the highest payer because this level is not supported by other payers with lower fees.

Consumers have also expressed concern that this model may increase the possibility of a practice withholding services to patients in order to maximize its savings opportunity. Known as 'under service', this concern has been expressed with other risk and capitation models.²⁶ While under service is a frequently cited risk, the literature review found no evidence to support that it occurs. Practices managing patients' overall medical care recognize that the most efficient

²⁶ CMS – CPC Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule. Retrieved February 17, 2017, from <https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf>

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way to reduce overall medical costs (and thus achieve the desired shared savings) is to engage the patient and caregivers in a more comprehensive and coordinated medical care process.²⁷

Despite their challenges, Category 3 model offers significant benefits over their FFS and pay-for-performance predecessors. Perhaps the most significant lesson from Category 3 models that have been implemented is the time it [takes to demonstrate success](#).²⁸

Category 4: Population-Based Payment

Payment models with the most flexibility for primary care delivery are those that pay part or all of a patient's primary care fees before care is delivered. With a higher care management fee, and bundled payment for primary care services, many practices and care organizations can cover a wide range of enhanced services such as:

- 24/7 access to physicians via e-visit, phone, email, text messaging
- Services provided by CHWs and other diverse care team members
- Behavioral health services integrated into the primary care setting
- [Language interpretation and translation services](#)
- Preventive care
- Care coordination
- Disease management
- Nutritional support

Models that move past the FFS structure fall into Category 4, Population Based Payments. There are numerous models in this category but the goal of those that focus on primary care is to move more healthcare dollars into primary care and to increase the flexibility of those payments to allow for diverse primary care teams and non-visit based services. (Figure 3-10).

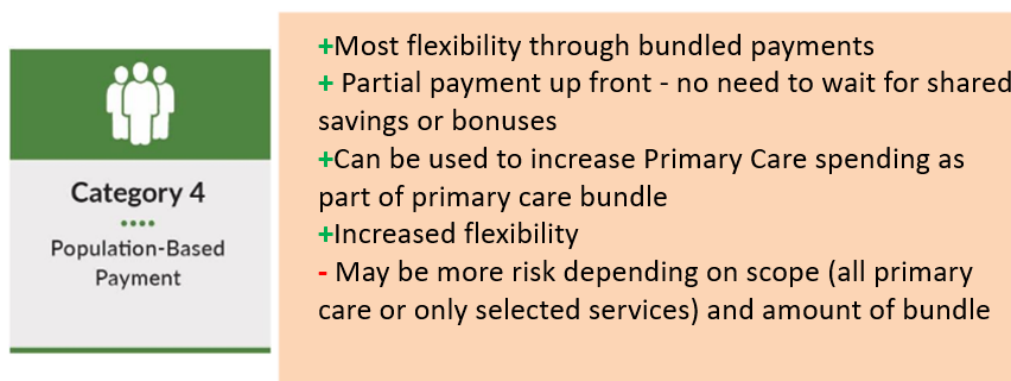


Figure 3-10: Population-Based Payment

²⁷ Oshima Lee, E., & Emanuel, E. J. (2013). Shared decision making to improve care and reduce costs. *New England Journal of Medicine*, 368(1), 6-8.

²⁸ "Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time," Health Affairs Blog, November 21, 2017. DOI: 10.1377/hblog20171120.211043

Investing in Primary Care: Promising New Models

Primary care payments represent a small percentage of the overall cost of medical care (Figure 3-1^{29, 30}). Many believe the standard payment model, fueled by a sick-care model that values quantity over quality, has resulted in a system that disproportionately rewards specialists. As primary care plays an increasingly important role in chronic care management and preventive care models, primary care providers and their support team stand to play an important role that must be rewarded.

What Percentage of Healthcare Spending Goes Into Primary Care?

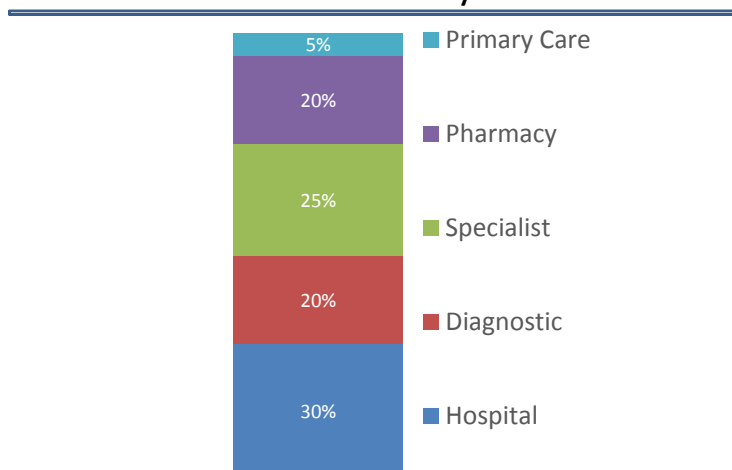


Figure 4-1: General breakdown of healthcare spending by major category

Several organizations around the country are making progress in increasing reimbursement for primary care relative to other services. Their models increase funding to primary care for patient care coordination, higher quality care delivery, improved patient satisfaction with a commensurate reduction in the use of other services and associated costs across the healthcare continuum.

Many models, described in the literature,³¹ illustrate the need to reallocate dollars so spending on primary care is at least double—from about 5% today to 10 or even 12%. This increased spending is needed to improve the infrastructure required for the desired care and practice transformation. The additional spending on primary care is expected to be offset by reduced overall health care spending.

²⁹ Patient-Centered Primary Care Collaborative. (2016). Growing the Primary Care Share of Healthcare Spending.

<https://www.pcpcc.org/event/2016/02/growing-primary-care-share-healthcare-spending>

³⁰ National Health Expenditures 2015 Highlights. (n.d.). Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>

³¹ Phillips, R. L., & Bazemore, A. W. (2010). Care and Why It Matters for U.S. Health System Reform. *Health Affairs*, 29(5), 806-810. doi:10.1377/hlthaff.2010.0020. Retrieved April 2017, from <http://content.healthaffairs.org/content/29/5/806.full.pdf+html>

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Converting a practice built on the FFS model to a highly-coordinated alternative payment model is challenging. However, there are many examples of recent attempts by health insurance companies to enhance funding for primary care by providing care management fees or care coordination fees. These models may provide additional funding, but usually not in a coordinated manner with other payers, doing little to increase the overall funding of primary care.

Three Innovative Delivery and Payment Models

Enhanced primary care funding models from around the country show great promise in transforming care and achieving the Quadruple Aim.³² Practices are building more diverse care teams, improving communications and engagement strategies, and enhancing patient care to improve outcomes, lower costs and increase both patient and staff satisfaction. The following organizations have successfully adopted PCPMs that have allowed for these types of transformation.

Evergreen Health³³ is a Health Maintenance Organization (HMO) in the Baltimore Maryland area that provides a robust complement of primary care services (see below) at their primary care practices. These practices, built on a patient centered medical home architecture, offer a wide range of health care services including extended hours, convenient appointments and a diverse team of health care providers who create a personalized health and wellness plan for each patient. The health care team includes a physician, nurse practitioner, a behavioral health specialist and a care coordinator to help with referrals and follow up care. Care is highly integrated and includes on-site behavioral health and:

- Preventive Care
- Illness Assessment, Treatment, & Disease Management
- Wellness Services
- Women’s Services
- Care Coordination
- Linkages to community resources
- After-Hours Services

Evergreen’s practices receive a risk-adjusted advanced payment (Category 4) for the majority of their primary care services. The advanced payment allocated to primary care is approximately 10% of premium. Evergreen’s goal is to help stabilize and reduce the total cost of care while achieving high scores in both quality and patient satisfaction measures.

Iora Health³⁴, based in Boston, Massachusetts, launched its first practice in 2012. Today, Iora Health has 29 practices in 11 states, including Connecticut and Massachusetts. Iora has

³² Institute for Healthcare Improvement, WIHI: Moving Upstream to Address the Quadruple Aim, Retrieved from <http://www.ihl.org/resources/Pages/AudioandVideo/WIHI-Moving-Upstream-to-Address-the-Quadruple-Aim.aspx>

³³ Evergreen Health retrieved from <http://www.evergreenmd.org/primary-care-offices/onsite-services/>

³⁴ Iora Health – retrieved from <http://www.iorahealth.com/>

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championed a patient-centered primary care approach with higher levels of funding and innovative approaches to care delivery.³⁵

Iora Health works under a unique comprehensive primary care payment model, which includes a risk-adjusted budget, incentives for meeting patient experience, quality, or utilization targets, and/or shared savings arrangements. Its care model:

- Is customized in each market to fit the patients' needs.
- Focuses on providing patients with the support they need to follow recommended treatment and improve their health.
- Relies heavily on non-physician staff, particularly health coaches (e.g., community health workers). The care team provides practical and emotional support to patients, reinforces patient education and actively participates in care delivery. This approach permits physicians to care for the sickest patients and affords the staff time to check in with patients between visits and permits home visits.
- Fully integrates behavioral health.
- Includes a daily "huddle" to review patients coming in that day and discuss patients with high "worry scores"—a measure based on both clinical data and care team's instincts.
- Is designed to achieve better outcomes: improved quality, reductions in unnecessary and downstream care and improved patient and physician satisfaction, which addresses the provider burnout issue identified in the Quadruple Aim.

Kaiser Permanente³⁶ is the nation's largest nonprofit integrated health care system, insuring and treating over 9.6 million members. It is a pre-paid integrated system consisting of three distinctly separate, but related entities: a health plan that bears insurance risk, medical groups of physicians, and a hospital system. Kaiser Permanente's care teams work together to serve their patients, and they share the financial incentive to provide high quality, affordable care and manage population health, rather than generating high volume of compensable services.

Both the health plan and the medical group are aligned and accountable for a global budget, and only contract directly with each other for the provision of medical services. All three entities share in the goal, reflected in the organization's capitated payment system, of keeping patients healthy while optimizing utilization. This alignment is crucial in Kaiser Permanente's effort to maintain affordability for their purchasers and members. Kaiser Permanente - California is often seen as a prime example of integrated care.

Key features of Kaiser Permanente's model include:

- An efficient acute care delivery system to address patients' needs across the continuum of care and maximize population health.
- Around-the-clock telephone access to nurses for clinical advice.
- Physician access to a plan-wide electronic health record (EHR) system that contains every member's complete ambulatory and hospital medical history.

³⁵ Fernandopulle, R. (2015, August 17). Breaking the Fee-For-Service Addiction: Let's Move to A Comprehensive Primary Care Payment Model. Retrieved April 2017, from <http://healthaffairs.org/blog/2015/08/17/breaking-the-fee-for-service-addiction-lets-move-to-a-comprehensive-primary-care-payment-model/>

³⁶Center for Health Policy at Brookings. (2015). Kaiser Permanente – California: A Model for Integrated Care for the Ill and Injured. Retrieved from https://www.brookings.edu/wp-content/uploads/2016/07/KaiserFormatted_150504RH-with-image.pdf

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- Acute and emergency clinical pathways and protocols that do not discourage physicians from spending more time with each patient as needed, that encourages appropriate ED use, and provides the tools and infrastructure to shift non-emergent care to more appropriate and cost-effective settings.
- Ambulatory “transitional care” programs for some common high intensity chronic medical conditions to help manage patients before they need ED care and upon hospital discharge.

Kaiser Permanente’s payment model has enabled them to provide a substantially greater portion of their care through telehealth. In fact, non-visit alternatives have been so popular with patients that Kaiser Permanente’s primary care providers provide a majority of their care through telehealth.

Comprehensive Primary Care Plus (CPC+)

National and state-level momentum for advanced primary care has continued to grow and strengthen with the introduction of Comprehensive Primary Care Plus (CPC+). CPC+ initiative is a promising advanced primary care medical home model developed by the Center for Medicare and Medicaid Innovation (CMMI). The goal of the program is to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.

The CPC+ model provides substantial funding to primary care practices to help pay for many of the services described as key to the overall improvement in health status of patients.^{37, 38} The program, undergoing expansion in 2017 and 2018, is a unique hybrid of multiple payment models. Some features of CPC+ include:

- Comprehensive prospective CMFs beyond historic primary care payment rates
- Multi-payer initiative, ideally including Medicare, commercial, and Medicaid
- Primarily non-FFS based payment including prospective bundled payment, care management fees and opportunities for quality bonuses.
- Practice investment in infrastructure, tools, processes, and non-traditional expansion of the primary care team
- Performance accountability for measurable downstream quality, utilization and cost savings

CPC+ begins to move primary care payment along the payment model continuum (Figure 4-2) by giving practices more flexibility and transformation-supporting revenue than traditional FFS and shared savings program models. Practices can improve service delivery without having to bill for additional services. In many cases, the services supporting transformation do not have assigned billing codes so they would not be eligible for FFS payment (e.g., services offered by CHWs).

In the CPC+ model design, practices must describe the services they intend to provide along with their standard practice services. The CPC+ model includes some FFS reimbursement for

³⁷ CMS (n.d.). Comprehensive Primary Care Plus: A new model for primary care in America. Retrieved from <https://innovation.cms.gov/Files/x/cpcplus-paymentbrief.pdf>

³⁸ CMS – CPC Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule. Retrieved February 17, 2017, from <https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf>

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certain services to reduce the risk of underservice to patients. To drive transformation, CMS pays practices a \$28 PMPM Care Management Fee, on average, to provide enhanced services to patients. Regular adjustments to the fee account for changes in the patient's conditions and other factors.

“It is crucial to risk-adjust payments in PCPMs to account for the disparate resources that different patients require. These adjustments should be made based on measures of disease-based medical complexity, as well as on social complexity [e.g., social determinants] and other factors affecting the intensity of care.”³⁹

CMS also provides a quarterly bundled payment based on the practices' prior year's financial experience. This payment equals a percentage of revenue generated by specific office visit Evaluation and Management (E&M) codes (generally sick visits), PLUS an additional 10% of the previous year's selected E&M financial experience. Combined, the Care Management Fee (CMF) and 10% increase equal approximately a 40% to 50% increase in primary care funding for attributed Medicare patients.

This combination payment approach, referred to as a “hybrid payment,” is described in detail in the CPC+ Payment Methodologies Manual⁴⁰. The payment provides predictable revenue and additional financial support so practices can develop and offer more innovative approaches to care delivery. Practices no longer need to depend solely on FFS for revenue. As a hybrid model, CPC+ lies somewhere between Category 3 and Category 4. It incorporates elements of Category 4 elements by partially bundling the cost of office-visits, while still using reduced FFS payment for each visit-base encounter.

To succeed, models like CPC+ are best implemented in markets where all payers participate in similar initiatives. In fact, CMMI will only consider markets where a significant number of payers are willing to participate and follow a similar financial structure (FFS + CMF + potentially some level of bundled payment). It is also important that payers' program criteria are similar, and include evaluations of emergency department visits, unnecessary inpatient admissions and other quality and utilization metrics. When all (or most) market payers implement a similar payment model and criteria, practices can adopt common work flows and quality initiatives across all patient populations. This drives efficiencies and improves patient experience.

CMMI's Comprehensive Primary Care initiative (CPCi) pilot, from which CPC+ was developed, showed substantial progress in the first two years of the four-year program. Practices engaged in transformation toward a PCMH model reported significant improvements in three patient satisfaction measures, compared to non-CPCi practices. By comparison, the CPCi practices also saw reductions in unnecessary hospitalizations and skilled nursing facility care, with savings of \$11 PMPM. Office-based primary care services dropped when they added non-FFS alternatives to face-to-face care. However, the overall savings fell short of making up for the \$18 PMPM

³⁹Health Care Payment Learning & Action Network, *Accelerating and Aligning Primary Care Payment Models* retrieved 4/17/2017 from <https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf>, page 13.

⁴⁰ CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Fee Schedule, Version 2, Feb. 17, 2017. Retrieved from <https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf>

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upfront investment by the end of the second year.^{41, 42, 43} Despite this, performance was promising enough to lead to more widespread implementation under the CPC+ program. Although a multi-payer initiative, no literature was found to assess performance for lines of business other than Medicare.⁴⁴

Table 3-1 compares the CPC+, Evergreen, Iora, and Kaiser models in terms of payment type, relationship of the organization to the PCP, care delivery model, and primary care as a percentage of total healthcare spend.

	CPC+	Evergreen	Iora	Kaiser
Payment Type	Partial E&M Bundle	Full Primary Care Bundle – Enhanced	Full Primary Care Bundle – Enhanced	Part of Global Budget
Relationship to Primary Care Provider	Independent	Employed	Employed	Employed
Care Delivery	Care coordinators, home visits, phone/e-communication, behavioral health integration	Behavioral health coaches, care coordinators, smoking cessation, telemedicine, home visits, minor procedures	Each primary care provider supported by 4 coaches and coordinators/behavioral health specialists	Diverse care team, telehealth, and other non-visit-based methods for patient engagement
Primary Care as Percentage of Total Expenditure	≈7.5%	10%	10%	N/A

Table 4-1: An overview of some current national models.

⁴¹ Ayanian, J. Z., & Hamel, M. B. (2016). Transforming Primary Care — We Get What We Pay For. *New England Journal of Medicine*, 374(24), 2390-2392. doi:10.1056/nejme1603778. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMe1603778>

⁴² Dale, S. B., Ghosh, A., Peikes, D. N., Day, T. J., Yoon, F. B., Taylor, E. F., ... & Press, M. J. (2016). Two-year costs and quality in the Comprehensive Primary Care Initiative. *New England Journal of Medicine*, 374(24), 2345-2356.

⁴³ Taylor, E. F., Dale, S., Peikes, D., Brown, R., Ghosh, A., Crosson, J., ... & Shapiro, R. (2015). Evaluation of the comprehensive primary care initiative: first annual report. *Princeton (NJ): Mathematica Policy Research*.

⁴⁴ McClellan, M., Richards, R., & Japiga, M. (2017, April 25). Evidence on Payment Reform: Where Are The Gaps? Retrieved from <http://healthaffairs.org/blog/2017/04/25/evidence-on-payment-reform-where-are-the-gaps/>

Making Transformation Happen: PCPM Options

Based on the above literature and examination of promising national models, several primary care payment model options were developed for review and discussion by the Task Force and external stakeholders. Each of the following examples defines the payment model employed, the level of flexibility afforded by each model, and a discussion of potential benefits and risks. These options range from the most conservative partial bundle approach (CPC+) to more comprehensive bundles typified by the Evergreen, Iora and Kaiser models.

PCPM Option 1

As depicted in Figure 5-1, this option includes the following:

- **A flexible, risk-adjusted care management fee:** This fee provides additional funding to the practice, supporting opportunities to expand the care delivery team, for example, to include CHWs, pharmacists, nutritionists, and navigators. This model also provides services to enhance the patient experience through additional “touches” and increases patient care plan coordination.
- **A partial bundled payment:** Prospective bundled payments, usually paid quarterly, represent a portion (e.g., 65%) of the practice’s annual payments for “sick” visits. These upfront payments can be used to invest in care delivery transformation and increase preventive services and population health initiatives. By decreasing its reliance on FFS revenue, the practice can reduce unnecessary face-to-face visits – replacing them, when appropriate, with other, more efficient services such as secure e-mail, text messaging, telemedicine, group visits and other services (see Table 3-1).
- **FFS payments:** The practice still receives FFS payments for a select group of services usually performed on a scheduled basis, such as immunizations and preventive care.

Coupled with a shared savings program, PCPM Option 1 meets most of the identified reform needs by giving the provider flexibility to invest in diverse care teams and non-visit based services. However, there is some risk that conversion to non-visit based care **could jeopardize practice revenue.**

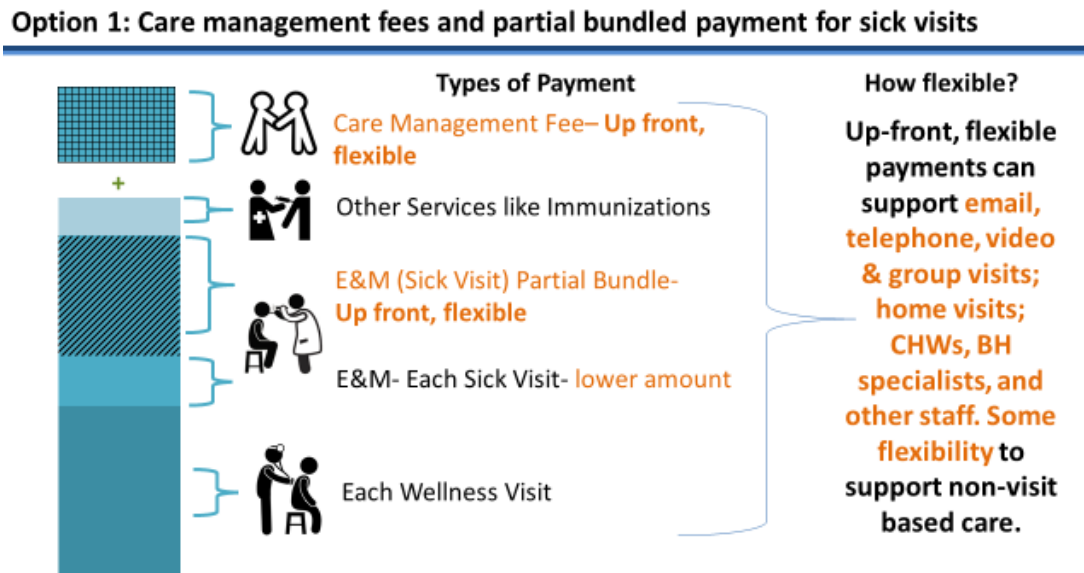


Figure 5-1: PCPM Option 1: Partial E&M (Sick Visit) Bundle

PCPM Option 2

This option (Figure 5-2) provides the same increased flexibility as Option 1. The practice receives care management fees, bundled payments and FFS payments for select, highly valued services (e.g., immunizations and preventive care). This model also offers the same opportunities to invest in non-visit based services and diverse care teams.

Option 2 differs from Option 1 only in the number of services included in the bundled payment. In Option 2, the practice's anticipated revenue for "sick" visits increases from the 65% in PCPM Option 1 to 100%. Under this model, a practice can convert a substantial portion of their patient support and engagement to non-visit based care, **without jeopardizing the practice's revenue**. Coupled with a shared savings program, PCPM Option 2 includes most elements needed to improve care delivery in the state.

Option 2: Care management fees and full bundled payment for sick visits

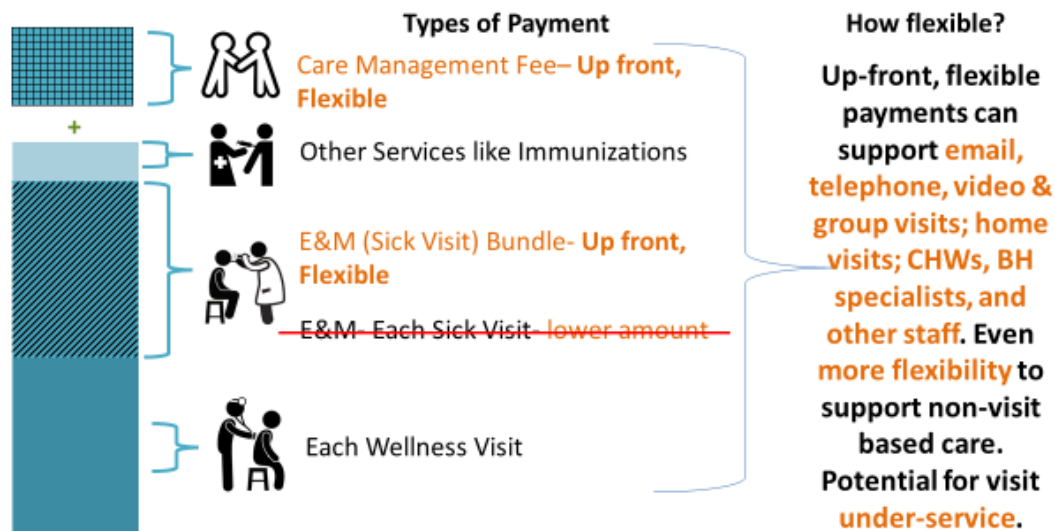


Figure 5-2: Full E&M (Sick Visit) Bundle

PCPM Option 3

For practices with advanced infrastructure and capabilities for proactive management, PCPM Option 3 provides the highest level of flexibility. This increased flexibility results from a “full bundle” of primary care services including ‘sick’ and preventive primary care services. Some services may be excluded from the bundle in order to ensure access.

This model, described in the Iora Health, Evergreen Health and Kaiser Permanente examples, also increases the practice’s level of accountability and financial risk (both - upside and downside risk). These types of arrangements also pose a risk of under service. However, a variety of patient satisfaction, quality metrics and utilization reviews are often employed to mitigate this risk.

Coupled with a shared savings program, Option 3 (see Figure 5-3) includes the majority of elements needed to improve care delivery in the state.

Option 3: Comprehensive bundled payment for most primary care services

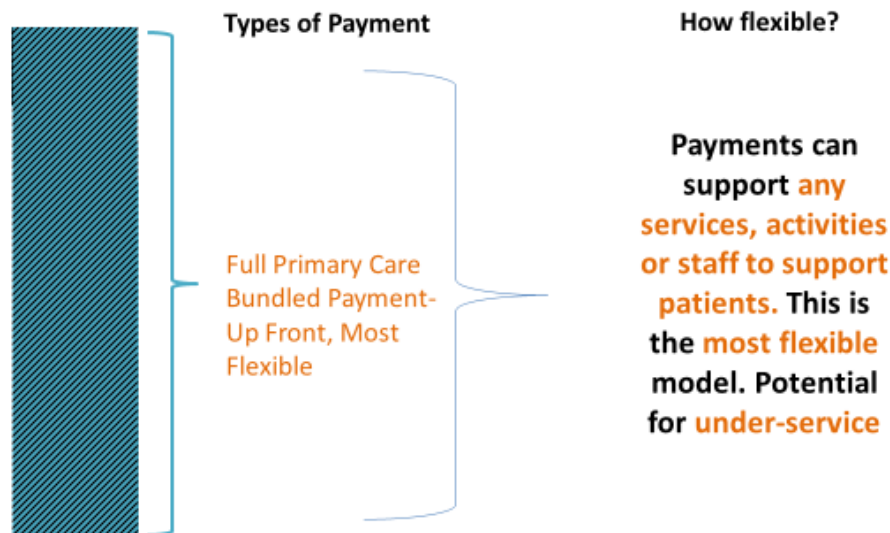


Figure 5-3: Full Primary Care Bundle

Summary of PCPM Options

The Category 4 APMs provide an alternative mechanism to help fund an expanding complement of primary care services. These services are designed to:

- **Integrate non-visit based care**, including email, telephone, video, and group visits;
- Facilitate the use of **diverse care teams**, including professionals like CHWs and Behavioral Health specialists;
- **Increase coordination** of patient care, ~~and~~ navigation services, and language services to improve the likelihood of patient engagement, compliance and health;
- Help **improve the provider's quality of life**, by reducing paperwork and increasing time available for patient visits, in support of the Quadruple Aim. Practitioners get to do what they were trained for, increasing their job satisfaction and maximizing their contribution to the care team; and
- Enhance the likelihood of stabilizing or **reducing overall cost of care**.

Special Considerations for Pediatrics

Child health services present an opportunity to improve population health over the long term, as well as a challenge to address cost savings in the short term. Children represent 24% of the United States' population,⁴⁵ but less than 12% of the health care dollars spent.⁴⁶

⁴⁵The Annie E. Casey Foundation. (2011). The Changing Child Population of the United States: Analysis of Data from the 2010 Census. Baltimore, MD: NA. Retrieved from <http://www.aecf.org/resources/the-changing-child-population-of-the-united-states/>

⁴⁶Age-and-Gender. (2016, August 09). Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Age-and-Gender.html>

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Except for children with very complex medical needs, who represent less than 5% of the population,⁴⁷ children are inexpensive in terms of health care dollars so they present few opportunities for cost savings. Yet healthy children may grow up to be unhealthy adults who require extensive and costly health services and care management. Obesity and mental health are two examples of conditions that often have their roots in early childhood and lead to lifelong health challenges that impact learning, employment, and social competency.

Primary care presents an excellent opportunity to change the life health trajectory of at risk children to a healthy one. More than 90% of children use primary care services annually⁴⁸ providing a venue to deliver health messages, identify health concerns, and connect patients to services. The primary care practice can address health risks early, before they lead to larger problems and lifelong chronic conditions that are costly to manage. The American Academy of Pediatrics (AAP), CT Medicaid, and federal early, periodic, screening, diagnosis and treatment (EPSDT) schedules outline an array of primary care services that, when fully implemented, contribute to long-term health outcomes.⁴⁹

Noteworthy in these recommendations is the abundance of preventive visits in the early years of life. The AAP and EPSDT schedules call for 12 preventive care visits before the second birthday.⁵⁰ Preventive care topics for these visits include: physical growth monitoring, immunizations, sensory screening, developmental screening, lead screening, anticipatory guidance to promote parenting skills, home and car safety, and socio-emotional development. Research has demonstrated the importance of the early years in determining lifelong outcomes, from development of resiliency to mitigate the effects of toxic stress to moving families out of poverty.⁵¹ Not only are these visits universally reimbursed by public and private payers, but data show high adherence to the schedule.⁵²

An effective pediatric primary care payment model, one that recognizes the numerous opportunities for parent and child contact in the early years, can maximize the contribution of pediatric primary care services to population health and other societal goals. Payment allowing providers to spend time with families, use innovations such as group well child visits, and generally support caretakers in parenting, can go a long way in supporting the health of future generations.

Current FFS payment forces pediatric providers to limit visit length so they can conduct enough visits in a day to sustain their practice. Pediatric primary care payment reforms need to accept that savings will be deferred until later years when children reach adolescence and adulthood, and that much of the savings will be in sectors other than health. For children with chronic illness, the savings opportunity is different than that for adults; it is long term, grounded in

⁴⁷Cohen, E., Kuo, D. Z., Agrawal, R., Berry, J. G., Bhagat, S. K., Simon, T. D., & Srivastava, R. (2011). Children With Medical Complexity: An Emerging Population for Clinical and Research Initiatives. *Pediatrics*, 127(3), 529-538. doi:10.1542/peds.2010-0910. Epub 2011 Feb 21. Review

⁴⁸Summary Health Statistics: National Health Interview Survey, 2015. (2015). Retrieved from https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_C-8.pdf

⁴⁹AAP. (2017, February). Recommendations for Preventive Pediatric Health Care. Retrieved from https://www.aap.org/en-us/documents/periodicity_schedule.pdf

⁵⁰ ibid

⁵¹ Harvard University. (n.d.). Center on the Developing Child at Harvard University. Retrieved from <http://developingchild.harvard.edu/>

⁵² AAP. (2010, April). Profile of Pediatric Visits: Annualized Estimates by Source of Payment Patient Age Physician Specialty Well vs. Sick Visit Office Setting Practice Ownership Physician Employment Status & Geographic Location 2004-2007. Retrieved from https://www.aap.org/en-us/Documents/practicet_Profile_Pediatric_Visits.pdf

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prevention, and extends beyond health services. Savings in education, social services, juvenile justice and social services are possible when children at risk for health, behavioral health and developmental problems are identified early and connected to intervention services.

A further argument for investing in pediatric primary care is that there are so many opportunities in states and communities to address child and family risks once they are identified. Families with various needs can access federally mandated and funded early intervention services under the Individuals with Disabilities Education Act,⁵³ the Children and Youth with Special Health Care Needs program,⁵⁴ Head Start and Early Head⁵⁵ and other block grant programs. Primary care can connect families to these programs, which is why a payment model supporting coordination of these services is optimal.

Connecticut Stakeholder Perspective

Primary care payment reform will impact a variety of stakeholders. For this reason, it was critically important to solicit stakeholder perspectives in considering payment model goals and options. Specifically, the project team:

- Sought affirmation from the various stakeholders that ~~they agree that~~ primary care payment needs to enable more flexibility in the delivery of primary care services and that overall primary care spending needs to increase as a percentage of our overall health care expenditures.
- Obtained input from stakeholders on how best to ensure that increases in payment and flexibility result in demonstrated benefits.

To obtain Connecticut perspectives, the independent consultants retained by Qualidigm interviewed a diverse group of stakeholders. The consultants included a Registered Nurse, a Pharmacist, and a Physician; all recent former executives in the Connecticut managed care market. The goal of the interviews was to:

- Gather information about stakeholder experiences related to the need for payment reform.
- Understand stakeholder's current and/or anticipated engagement in APMs.
- Evaluate stakeholders' interest in, and tolerance of, changes that move them away from today's FFS models.

These stakeholders included providers, payers, and consumer groups including the SIM [Consumer Advisory Board](#) (CAB) and consumer members of the Task Force. Feedback and insights from these interviews were invaluable in the development of primary care payment reform recommendations.

⁵³ 108th Congress of the United States of America. (2004, December). 108th Congress Public Law 446. Retrieved from <https://www.gpo.gov/fdsys/pkg/PLAW-108publ446/html/PLAW-108publ446.htm>

⁵⁴ HRSA. (2016, December 01). Children with Special Health Care Needs. Retrieved from <https://mchb.hrsa.gov/maternal-child-health-topics/children-and-youth-special-health-needs>

⁵⁵ U.S. Department of Health and Human Services. (n.d.). Office of Head Start. Retrieved from <https://www.acf.hhs.gov/ohs>

Provider Feedback

The team interviewed a variety of provider entities representing more than 4,000 primary care providers across Connecticut. This group represented a majority of providers in the state and spanned a wide range of sizes and organizational structures. These entities included:

- Three hospital-based integrated delivery systems
- Three solo primary care practitioners (1 Internist and 2 Pediatricians)
- Three Independent Practice Associations (IPA)

A prepared discussion guide facilitated each 1.0 to 1.5-hour in-person or telephone interview. The team obtained the following viewpoints from the interviews with the provider entities:

- There is widespread dissatisfaction across primary care providers with the current care models and resultant limitations in flexibility of care that they can deliver, due to the current FFS payment model.
- Providers support the goal of advancing care delivery to a best practice model of care (e.g., PCMH) and agree that FFS is not a sustainable payment methodology to achieve this objective.
- Providers agree that primary care is under-funded and that up-front payments and increased flexibility with respect to the amount of risk they are required to assume are highly desirable.
- In general, as the size of the primary care provider entity increased, the fewer barriers to reform they perceive (i.e., larger entities have access to more of the necessary resources to support and facilitate care delivery transformation). For smaller entities, the resource requirements necessary to support transformation are a substantial barrier.
- Category 4 payment models (e.g., CPC+) are an attractive entry into primary care payment reforms.
- Primary Care Providers and their patients would benefit from having access to coordinated databases that facilitate easy access to community and public health support services designed to address social determinants of health (e.g., access to safe and affordable housing, availability of healthy foods, transportation, etc.)

Table 6-1 depicts the results of the primary care provider canvass related to care team composition. Each check mark represents one of the provider entities interviewed. The informal survey revealed that each of the three hospital-based integrated delivery systems has at least some care teams composed of MDs, APRNs, Licensed Behavioral Health Clinicians and RN/Care Coordinators. By comparison, only one of the three solo primary care practitioners interviewed has an APRN on-staff, and none has a care team including other disciplines.

Current CT Primary Care Environment

Care Team Composition									
	MD	APRN	Licensed Behavioral Clinician	Pharmacist	RN Care Coord./ Case Manager	Social Worker	Nutritionist/Dietician	Community Health Worker	Patient Navigator
Multi-Hospital Systems	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓✓	✓			✓
IPAs/PHOs	✓✓✓	✓	✓	✓	✓✓	✓	✓		✓
Solo Practitioners	✓✓	✓							

Table 6-1: Current Connecticut Primary Care Team Composition

A theme emerged as the interviews progressed and participants addressed questions about care team composition, as well as the use of non-visit-based care. Hospital-based Integrated Delivery Systems use more diverse care teams and non-visit based care strategies than their smaller, less capitalized counterparts. These strategies include web-based, or e-consults; web and phone-based doctor visits for some services (e.g., telemedicine), tweets/chats/on-line support groups, care team huddles to discuss the best approach to patient care, etc. (Table 6-2).

But even those providers that used diverse teams and non-visit based approaches to care did so on a limited basis. They explained that their limited approach was because of the lack of funds available to sustain widespread implementation of these best practices.

Current CT Primary Care Environment

Non-Visit Based Care												
	Predictive Model	Risk Stratification	High Risk Rounds	Proactive outreach to at-risk pop.	Patient Education	Email/text support	In-home CM	E-consult/ Telemedicine	Communication w/Child Care/School	Patient/Family Advisory Council	Online Support Groups (i.e. tweet/chat)	Group Visit
Multi-Hospital Systems	✓	✓	✓✓	✓	✓✓	✓	✓✓	✓				✓✓
IPAs/PHOs		✓	✓	✓✓	✓✓		✓	✓✓				
Solo Practitioners	✓	✓	✓	✓	✓			✓				

Table 6-2: Current care services at work in Connecticut

In summary, the larger the healthcare system, the more likely it is to have implemented use of diverse care teams and to employ the use of non-visit based care strategies. However, none of the entities reported widespread use of all care team members or all non-visit based care

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strategies. Only the hospital-based integrated delivery systems include practices that have implemented more than half of the twelve innovative, non-visit approaches to care delivery discussed during the interviews. However, some smaller practices are embracing and benefitting from transformation.

Provider stakeholders were happy to share their insights and perceptions of the need for care transformation and the payment reforms necessary to enable it. (Figure 6-3).

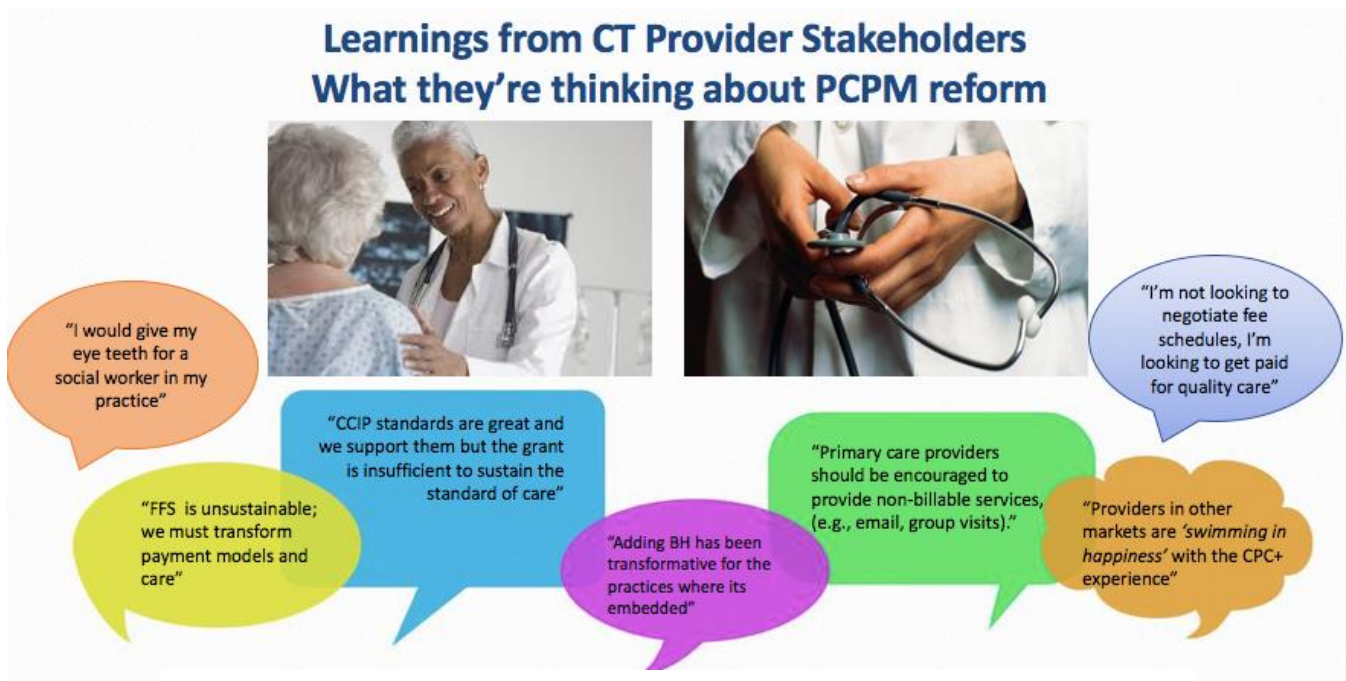


Figure 4-1: Quotations from provider interviews

Payer Feedback

The project team interviewed six payers, including local, regional and national carriers doing business in Connecticut and offering the full range of products: Medicaid, Medicare Advantage, commercial fully- and self-insured, and the health care exchanges created by the ACA. In aggregate, the payers interviewed provide health insurance estimated to cover more than 80% of the commercially insured consumers in Connecticut⁵⁶.

Representatives from the payers’ network contracting leadership and/or other executive administrators attended the 1.0 - 1.5 hours meeting conducted by phone or in person. These discussions followed the same format used with providers. Interviewers presented background information and asked a series of questions to generate discussion. However, the payer interviews were less structured than the provider interviews.

The following themes emerged from the six interviews:

⁵⁶ 2016 Consumer Report Card on Health Insurance Carriers in Connecticut, October 2016, page 9. Retrieved 4/20/2017 from <http://www.ct.gov/cid/cwp/view.asp?a=4903&Q=587026>

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- There is widespread ~~agreement about the need to support for~~ transforming payment from FFS to more innovative payment models to facilitate the transformation of primary care delivery.
- Reallocation of financial resources to primary care and reinvestment of shared savings are the most viable means to:
 - increase the percent of primary care spend,
 - fund care transformation, and
 - maintain stability in the total cost of care.
- Payers are reluctant to provide upfront payments without demonstrated cost savings/value. Reforms must include methods that ensure provider accountability for the spending of any upfront/bundled payments.

Consumer Feedback

The project team also sought the perspective of consumer stakeholders. The first group interviewed, during a regularly scheduled meeting was the Consumer Advisory Board (CAB). This 17-person group of consumers represent culturally and geographically diverse backgrounds. The Board's mission is to advocate for consumers and provide for strong public and consumer input into healthcare reform policies in Connecticut. Its purpose is to ensure significant consumer participation in the planning and implementation process.

Besides meeting with the CAB, the project team sought the consumer perspective from several consumer advocates with a special interest in health policy and Medicaid.

Each 2-hour consumer stakeholder interview included a brief presentation of the three primary care payment model options. The project team explained the payment models. They also introduced the notion that the spectrum of payment models is a continuum—with lower payments and little to no flexibility in the care delivery model at one end, and higher payments with increasing flexibility in care delivery as one moves along the continuum.

Consumer appreciate the significant benefits that PCPMs could have for consumers. They acknowledge the benefits of diverse care teams to support patients, including a greater number of touches between office visits, help navigating the health system or help from a community health worker to access community services. They also appreciated the considerable benefits in avoiding visits that could be handled through telehealth, phone or e-mail. Transportation is an identified barrier to access that could in some part be mitigated by these alternatives.

Both groups of consumer stakeholders expressed concerns related to the out-of-pocket cost impacts of payment reforms on patients (e.g., potential increased co-payments for diverse care delivery options). The consumer advocates also voiced trepidation about the risk of under service by providers who receive upfront payments and, thus, may be motivated to withhold care or care recommendations to optimize shared savings. This concern, they said, is based on their experience with Connecticut Medicaid, when capitation by insurers in the 1990s resulted in under service to covered patients.

The advocates expressed significant worry about the possibility that increasing flexibility in the new models could increase risk of underservice. They felt that the Connecticut Medicaid experience and subsequent transition to an enhanced FFS model is the direction all payers

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should pursue. They point to a February 2016 published report by the Connecticut Department of Social Services in which early evidence suggested that health outcomes and care experience are improving, provider participation in Medicaid has increased, and per member per month costs are stable⁵⁷ under the model it has adopted.

Figure 6-4 below identifies potential advantages of primary care payment reform and possible impacts that need to be considered, as reported by the interviewed consumer stakeholders.



Figure 6-4: Primary care payment reform considerations, as reported by Connecticut stakeholders.

Summary of the Interviews

Even though the interviews represented a large number and the full array of stakeholders, there was much consensus. Most interviewed stakeholders acknowledged that:

- The current, long-standing trend of cost growth and lack of affordable health care is unsustainable, and fueled by the existing pervasive FFS payment model.
- The Quadruple Aim will not be achieved under the existing FFS payment model.
- Transitioning away from today's FFS model has risks, but also significant benefits; such as the creation of a sustainable and widespread implementation of a best practice model of care.
- Development of thoughtful plans to move forward with innovative payment models should proceed, along with plans to mitigate risks and closely monitor impacts and performance.

⁵⁷ Connecticut Department of Social Services Presentation to the Medical Assistance Program Oversight Council October 14, 2016 retrieved 4/20/2017 from https://www.cga.ct.gov/med/council/2016/1014/20161014ATTACH_DSS_Presentation_and_Response_to_Bailit_Recommendations.pdf

Public Comment

The State received extensive public comment during the public comment period that closed April 9, 2018. These comments were reviewed by the Task Force and either addressed in the report or included as considerations in the design process.

Conclusions and Recommendations

How does State healthcare leadership support and sustain the kind of changes to the model of care envisioned for primary care in Connecticut? How does leadership implement PCPMs that align with the vision of an enhanced dual role of primary care and the varied payer and practice business models? Our Task Force has concluded that ~~there are~~:

- sophisticated entities in Connecticut are poised and ready for HCP-LAN Category 4 primary care payment models - with or without a FFS component.
- innovative, enhanced primary care practice models, with substantially enhanced primary care bundles and a downstream shared savings component, exist in the national market.
- ~~providers, payers and consumer advocates that agree that~~ the current FFS direction will not support the advancements in primary care needed to improve outcomes, reduce costs, and improve patient and care team satisfaction.

While this paper highlights the presence of transformational practice design, momentum for change will grow with the sharing and promotion of best practices. Payers must hold practices accountable when they receive advanced payments for infrastructure development. Investments in transformation must not be limited to the large systems. There also needs to be a **pathway to the participation of Medicare and Medicaid** to make any new approach in Connecticut a “directionally aligned” multi-payer one. Leadership must find ways to align all payers for continued sustained progress to occur.

The Task Force acknowledged the threat of reductions in coverage (e.g., uncertainty regarding CHIP re-authorization) that jeopardize the availability of quality healthcare. They affirmed that such threats underscore the importance of payment reforms that promote more efficient and effective use of available healthcare funds. The following recommendations of the Task Force are designed to help stakeholders in Connecticut achieve real transformation that delivers better value to all:

- **Recommendation 1:** Connecticut’s payers should implement primary care payment reform as a means to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.
- **Recommendation 2:** Payers and providers are encouraged to use prospective bundled payments that reduce or eliminate reliance on visit-based care. However, provider organizations vary in their level of resources and capabilities, and they may feel that one or another model will best suit the needs of their practices and patients. Accordingly, the choice of which primary care payment model to adopt for a particular provider should be determined by the payer and provider during the contracting process. The

payer should offer entry-level options that limit the risk associated with bundling and an incremental strategy that enables practices to build their capabilities over time.

- **Recommendation 3:** Prospective reimbursement for care management and other non-billable services, in combination with bundled payments for visit-based primary care services, provide practices with the resources and flexibility to achieve the goals of reform. However, these reimbursement methods should be introduced in a way that ultimately reduces the total cost of care, because increases in the total cost of care are ultimately borne by employers, consumers or taxpayers. Accordingly, primary care payment models should be coupled with an alternative payment model, such as a SSP, that rewards practices for controlling the total cost of care.
- **Recommendation 4:** The cost of providing advanced primary care is substantially greater than a typical practice earns today through FFS reimbursement. Accordingly, primary care payment models should use prospective primary care bundles or care management fees to increase by at least double the funding dedicated to primary care as a percentage of the total cost of care. In order to achieve this increase without adding to the total cost of care, the SSP arrangement should provide for the reinvestment of a portion of the savings into the prospective bundles or care management fees each year that savings targets are achieved.
- **Recommendation 5:** The design of primary care payment models should not increase out of pocket costs. As much as possible, the cost of new services should be included in the determination of the prospective primary care bundled payments and care management fees, rather than paid FFS as this will ensure that the costs of such services are not subject to the deductible. In addition, providers should not be permitted to charge co-payments for services and support that are included in bundled payments and care management fees such as phone and video communication or health coaching provided by community health workers.
- **Recommendation 6:** Primary care payment models should use risk adjustment to adjust payments to account for underlying differences in the patient populations served by different primary care practices. To the extent feasible, risk-adjustment methods should take into consideration both clinical and social-determinant risks. The risk adjustment and corresponding bundled payments should be updated frequently enough to ensure that practices have the revenue necessary to support patients whose needs and complexity are increasing.
- **Recommendation 7:** Fee-for-service (FFS) payment may play a limited role as part of a blended primary care payment model to incentivize certain services that need to be performed in a face-to-face encounter; promote more efficient, comprehensive primary care; and protect against under-service.
- **Recommendation 8:** Primary care payment models should include a bundled payment option in which primary care practices receive resources to manage mental health and substance use conditions and assume accountability for associated outcomes. This recognizes the critical role that behavioral health plays in overall health, supports better

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integration between behavioral health services and primary care, and promotes shared accountability at the organizational and clinical levels.

- **Recommendation 9:** Primary care payment models should maximize the flexibility that primary care teams have to expend resources on ~~health-the~~ promotion of health and health equity, ~~and~~ coordination with community services, including the use of community health workers as care team staff, and direct support for community-based services that support patient care and that demonstrably address social determinants of health to improve patient outcomes.
- **Recommendation 10:** Payers that utilize primary care payment models should a) ensure that quality of care is measured and rewarded, ~~and~~ b) should employ minimally burdensome methods that are aligned across payers for comparable populations (e.g., Medicaid, Medicare, commercial) to enable practices to demonstrate that they are investing in and have implemented transformational change (e.g., care team composition, engagement in non-visit-based activities), and c) should monitor to ensure that the changes result in appropriate level of service and equitable access.
- **Recommendation 11:** Primary care payment models should be multi-payer, cover the majority of a practice's patient population, and provide practices with external coaching support and technical assistance in order to effectively incent and enable practice transformation.
- **Recommendation 12:** Primary care training programs (residencies and medical schools) should be engaged early on in the development of model because of the role they play in training the next generation of clinical primary care leaders, their ability to elucidate how to carry these activities out at scale (what type of education, training, how to integrate interdisciplinary teams), and their ability to place student learners throughout the state in a variety of primary care settings and train them to be both ambassadors of the proposed changes and also to help assist in the transition to the new model of care.