Payment Reform Council

October 25th 2018

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of Minutes	5 min
4. House Rules Review	5 min
5. Purpose of Today's Meeting	5 min
6. Basic Bundle	70 min
8. Introduce Supplemental Bundle	15 min
9. Next Steps and Adjourn	5 min

Introductions/ Call to Order

Public Comment

Approval of the Minutes

House Rules

House Rules for PTTF Participation

1. Please identify yourself and speak through the chair during discussions
2. Be patient when listening to others speak and do not interrupt a speaker
3. 'Keep comments short (under 2 minutes if possible) and to the point/agenda item (*the chair may interrupt if the speaker strays off topic or talks longer than 2 minutes*)
4. *Members should avoid speaking a second time on a specific issue until every PRC member who wishes to speak has had the opportunity*
5. *Members should take care to minimize interference (please mute all phones, turn off cell phones, limit side conversations or loud comments)*
6. Please read all materials before the meeting and be prepared to discuss agenda/issues
7. Please participate in the discussion—ALL voices/opinions need to be heard
8. *Participation in the meetings is limited to Task Force members and invited guests; all others may comment only during the initial public comment period*
9. After the meeting, please raise any concerns with meeting process/content with the co-chairs

Discussion of Basic Bundle

Discussion of Payment Model Options

Confirm Services to Include in Basic Bundle:

- Sent in advance for review. Confirm provisional recommendation.

Continue Conversation of Hybrid v. Full Basic Bundle:

- Determine whether the basic bundle will be the sole reimbursement for most primary care services.

Discuss Adjusting Basic Bundle Payments Over Time:

- Determine approach for adjusting basic bundle payments account for changes in population risk and the use and cost of primary care services.

Begin Discussion of the Supplemental Bundle:

- Gain input on the questions the PRC will consider with regard to the supplemental bundle.

Attributes of Basic and Supplemental Bundles

Basic Bundle

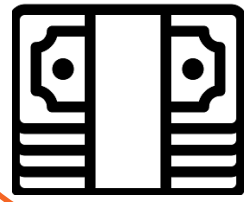
- An advance payment for primary care services, such as office visits.
- It can represent all the payment for services in the bundle definition OR partial payment.
- It will be calculated using historical claims data and adjusted over time.
- The basic bundle is a mechanism to purchase the time PCPs historically billed for office visits, and in turn, offer PCPs and patients more flexibility.
- PCP time remains focused on patient care. Other activities may include managing team members, learning and collaboration opportunities.

Supplemental Bundle

- An advance payment to support activities and investments not ***typically*** billed fee for service.
- It will be based on a standardized target for all providers in a specific carrier's program, which aims to introduce more equity in payments.
- Payments will differ based on patient characteristics and provider capabilities or performance. Risk adjustment strategy will be aligned with patients' care management needs.
- Providers accepting greater levels of risk will be eligible for higher payments than those who do not.

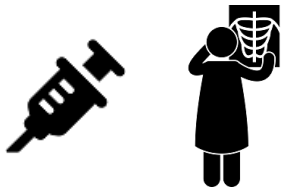
Payment Model Options: Let's revisit the hybrid question

Basic Bundle



Supplemental Bundle

Fee for Service Payments



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

Tonight's Payment Reform Council Focus

Should the basic bundle methodology include an option where providers continue to receive a reduced fee for service payment for services included in the bundle?

Learnings from CPC+ and Others

- Hybrid models can impede care transformation.
- During informal conversations, some CPC+ providers in Oregon shared primary care bundles are not very meaningful when they represent a small about of revenue.
- Too many hybrid options creates unnecessary complexity. Hybrid ratios in CPC+ range from 10% to 65% of revenue bundled.

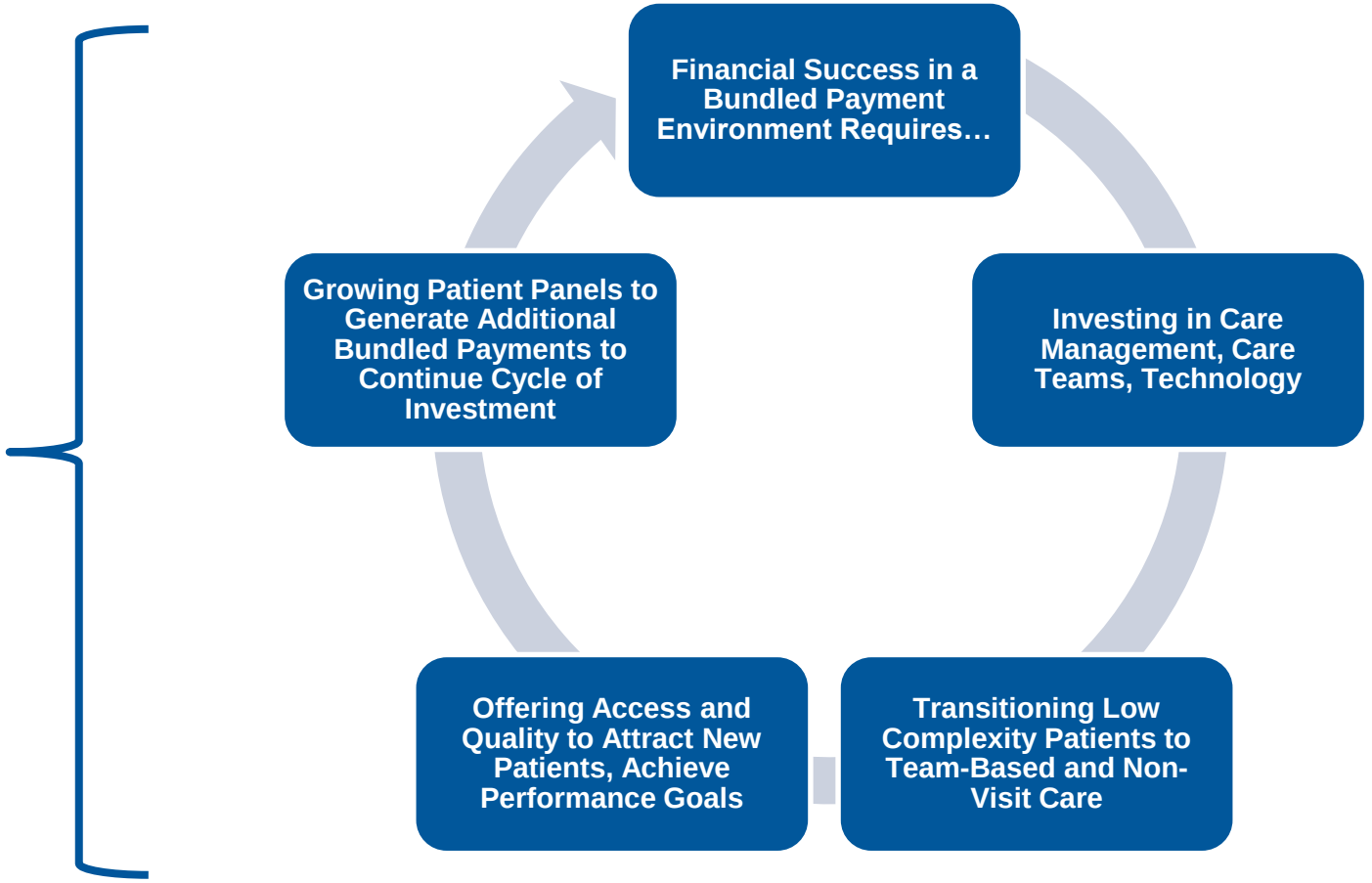
Should the basic bundle be the sole reimbursement mechanism for included services?

What We've Heard from Connecticut Stakeholders:

- Providers and payers are split. Some said care delivery changes will occur more quickly if the move to bundled primary care payments is 'all in.' Others said a "glide path" would be preferable for advanced networks with less experience in value-based payment.
- Some consumer advocates expressed concern that a move toward bundled payment could incent underservice. A model option that maintains partial fee-for-service payment could be another way to address this concern.
- Employers had no specific recommendation on this point but expressed strong support for model options that result in meaningful gains in care delivery and reductions in total cost of care.
- Across stakeholders, there was a strong preference for model options that support broad participation and position all for success.

Some stakeholders said a hybrid model felt “safer.” Here’s why it may be riskier.

A hybrid model, *particularly one with too little revenue coming through bundles*, may hinder care delivery transformation.



Risk of Revenue Loss with Hybrid Method

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

Fee for Service:
Dr. Smith and her team (2 MDs, 1 NP, 2 MAs) see about 80 patients a day in the office. They are paid an average of $75 per visit. Revenue for an average day $6,000. Dr. Smith returns patient phone calls and emails after hours. She is not paid for this time.

Bundle:
Using supplemental bundle revenue, Dr. Smith's practice adds a care coordinator and a social worker. It taps into community health workers, pharmacists and e-consult services from its AN. The practice moves about 25% of office visits to other care team members and/or phone, text or email. With the time saved, Dr. Smith participates in Project Echo, the practice begins pre-visit huddles and it accepts new patients again. Dr. Smith also gets her evenings back.

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

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

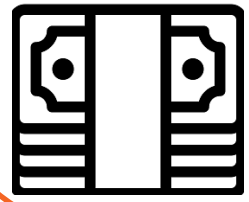
Payment Approach	FFS Revenue	Bundle Revenue	Total Revenue
FFS	$6,000 (80 office visits)	N/A	$6,000
Full Basic Bundle	N/A (60 office visits)	$6,000	$6,000
Hybrid Basic Bundle	$2,250 (60 office visits)	$3,000	$5,250

Decision Point

Should the basic bundle methodology include an option where providers continue to receive a reduced fee for service payment for services included in the bundle, recognizing this option might jeopardize revenue stability as more care moves away from office visits and other FFS services?

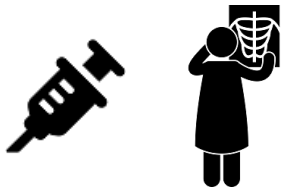
Payment Model Options: Adjusting the Basic Bundle Over Time

Basic Bundle



Supplemental Bundle

Fee for Service Payments



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

Tonight's Payment Reform Council Focus

How should the basic bundle be adjusted over time?

Basic Bundle – Possible Adjusters

The basic bundle will require adjustments over time to ensure it represents current trends and population characteristics.

- Addition or Deletion of Services Included in the Bundle
- Population Risk
- Use Trend for Primary Care Services Included in the Bundle
- Unit Cost Trends
- Benefit Changes Impacting Use and Cost of the Bundle

Not all of these adjustments may be necessary.
Those that are recommended for consideration may be determined to be immaterial for a specific payment period (i.e. benefit adjustment when no changes in benefit design).

Adjusting for Changes in Population Risk

What methodology could be used?

- At this time, our research finds there is not sufficient benefit to developing a risk adjustment methodology specific to expected primary care costs.
- Therefore, each payer's existing, preferred prospective total cost of care risk adjustment methodology could be used, such as hierarchical condition category (HCC) for Medicare.

If we're moving away from fee-for-service payment and claims, where would the data come from?

- Option 1: Claims data, including shadow claims as needed – most likely initial solution
- Option 2: Data captured from EHRs – long-term goal

The ability to utilize data captured from EHRs requires:

1. Infrastructure to reliably capture data from EHRs, standardize it, aggregate it and share it with payers. This infrastructure might support the derivation of risk scores and utilization volume from EHRs. The models for doing so, however, will take time to develop and could not be developed and tested by 2021, when we expect PCM to launch.
2. The willingness of providers and payers to ***trust*** using EHR data for this purpose.

Adjusting for Changes in Use of Primary Care Services

Over time, particularly with a new payment model, we expect to see changes in the number of primary care services used and the type of services used. Further, as care evolves new services could be added to the basic bundle.

Changes Might Include:

- Reduction in office visits
- Increase in other touches (phone, email, text, telemedicine, home)
- Increased PCP ability to supervise care teams
- Increased PCP ability to address more complex conditions (e-consult, Project Echo)
- Addition of rounding on patients in the hospital or skilled nursing facilities

Adjusting the Basic Bundle: A possible equation

The Payment Reform Council may want to recommend an equation to adjust the basic bundle. Payers would determine the specific methodologies used to complete the equation.

(Base Period Claims (+/-) Addition or Deletion of Services Included) * Population Risk Adjustment * Use Trend * Unit Cost Trend * Benefit Adjustment Factor

Where:

- Base period claims represents a calculation of historical use of basic bundle services and price.
- Addition or deletion of services included represents the value of services added or subtracted from the bundle. These could be valued based on history or expert projections (for a new service where history is not applicable).
- Population risk adjustment represents the change in the risk of the population served by the bundle normalized to the overall population.
- Use trend represents the projected change in primary care services for the period covered by the bundle. These projections may leverage historical changes in use, assumptions about the overall population morbidity (ex, very bad flu season projected), and assumptions about service availability.
- Unit cost trend is the change in provider rates from the base period to the bundle period.
- Benefit adjustment factor is leveraged to reflect changes in coverage that impact costs (i.e. VBID).

Decision Points

1) Should the Payment Reform Council recommend the basic bundle be adjusted for the factors below?

Base Period Claims adjusted by:

- Addition or Deletion to Services Included
- Population Risk
- Use Trend
- Unit Cost Trend
- Benefit Adjustment Factor

2) Should the Payment Reform Council recommend an equation and payers determine the specific methodologies to populate the equation?

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Differentiating Among Basic, Supplemental and FFS

Basic: Bob visits his doctor complaining of increased thirst and lethargy. He is diagnosed with diabetes.

Supplemental: Bob's PCP recommends a phone call with a dietician employed by the AN.

Fee for Service: Three months later Bob has some additional lab tests.

Some Services Will Have Components of More than One Type of Payment

Basic and Supplemental: Bob has a telemedicine check up with his PCP. His PCP's time is paid via the ***basic*** bundle but the new technology investment is paid via the ***supplemental*** bundle.

Basic and Supplemental: Bob's diabetes is complicated by heart disease so his PCP offers an e-consult with a cardiologist. His PCP's time is included in the ***basic*** bundle. The e-consult service provided by the subspecialist is paid via the ***supplemental*** bundle.

What We've Heard from Connecticut stakeholders

The supplemental bundle should be…

- Reasonable relative to the capabilities requested
- Accountable
- Non-duplicative
- Affordable

We will approach supplemental funding through an evaluation of the costs associated capabilities identified as important to primary care modernization and compare those costs to reasonable total medical expense savings projections.

Future Questions for the Payment Reform Council

- What can the supplemental bundle be used to fund?
- How should the supplemental bundle be adjusted?
- Should the supplemental bundle be subject to performance risk?

QUESTIONS?

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