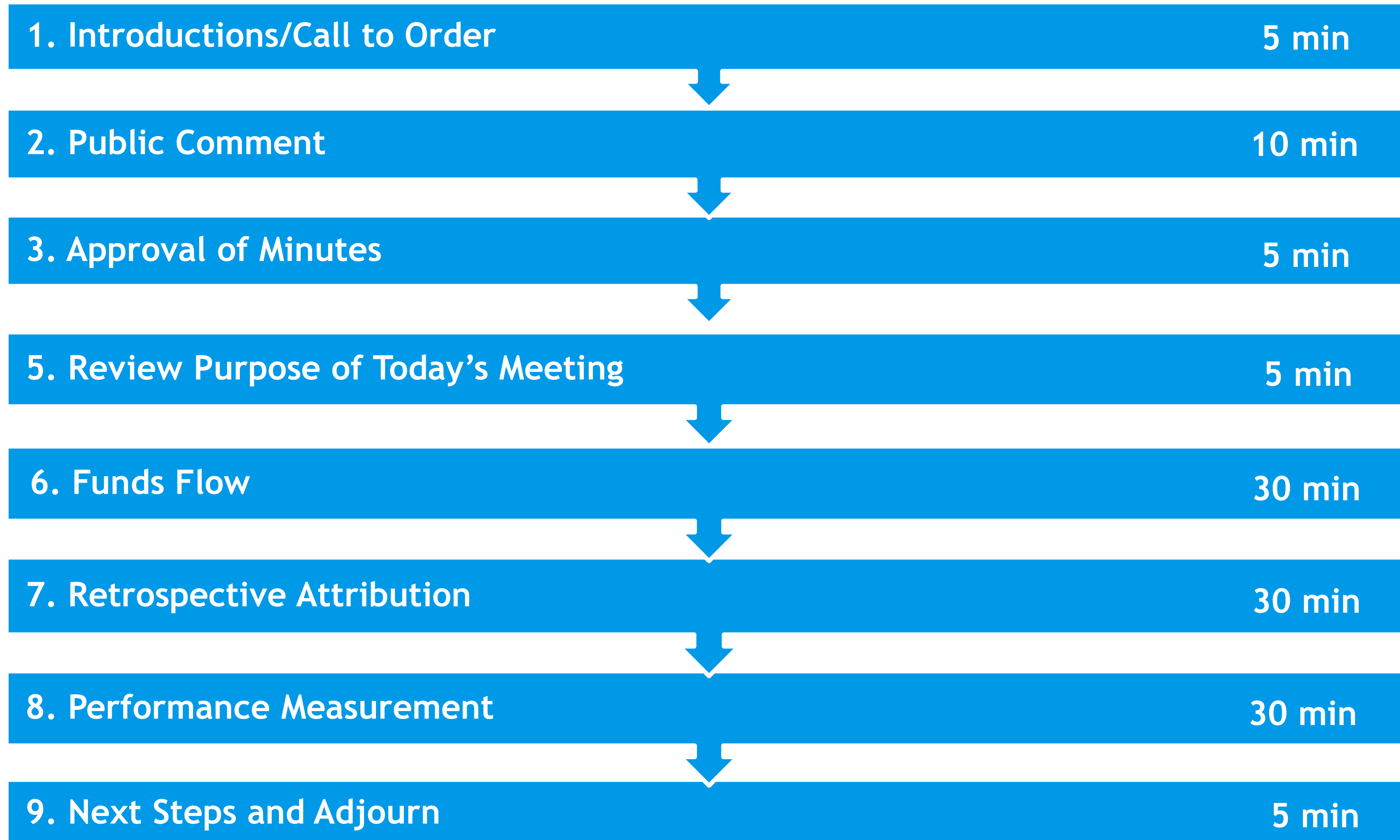
CONNECTICUT
Office of Health Strategy

Payment Reform Council

November 1st 2018

Meeting Agenda



OHS CONNECTICUT Office of Health Strategy

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Introductions/ Call to Order

Public Comment

Approval of the Minutes

Funds Flow

Discussion of Payment Model Options

Discuss Funds Flow:

Determine how basic and supplemental payments will be distributed to providers.

Continue Discussion of Attribution:

Determine whether attribution will be reconciled retrospectively.

Begin Discussion of Performance Measurement:

Begin conversation of how performance will be measured and reported.

Funds Flow

Tonight's Payment Reform Council Focus:

- How will basic and supplemental payments be distributed to providers?
- Will PRC weigh in on provider compensation or funds flow issues related to ASO clients or Medicare Advantage

Funds Flow Tradeoffs - Basic Bundle

Options	Benefits	Risks
1: Basic Bundle funds flow follows current FFS path	• Less operational complexity, "change" for CMS, ANs, Providers • Even if calculated by Provider or TIN, providers could elect dollars be deposited in AN account	• Does not provide another motivator for greater integration
2: Basic Bundle paid to AN/ACO	• May smooth out differences in historical utilization trends	• Difficult for some ANs to administer • Requires additional "ask" of CMS • Some providers might object to AN capturing dollars first

Funds Flow - Supplemental Bundle

Recommendation: Calculate supplemental bundle by AN and pay to AN

- In our conversations with stakeholders, there was broad agreement that the supplemental bundle should be paid to AN, even if this meant some additional administrative complexity.
- Supplemental payments will leveraged to support networkwide investments in care teams and new technology, some of which will be deployed at the practice.

Funds Flow - Provider Compensation

Recommendation: PRC does not weigh in on provider compensation.

- ANs compensation structures are complicated and have many moving parts including contracts with providers and employment agreements.
- Even without including a recommendation from the PRC, we expect compensation policies will evolve over time to be better aligned with the payment methodology.

Decision Point:

Does the PRC support the recommendation below?

Medicare FFS:

- Basic bundle payments follow current path for FFS payments.
- Supplemental bundle is calculated for each AN and paid to the AN.
- ANs determine internal compensation structure within their organizations.

Other Payers:

- Same as for Medicare FFS unless existing contracts suggest another approach would be preferable.

Attribution

<u>Tonight's Payment Reform Council Focus:</u>

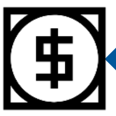
- Determine whether attribution should be reconciled retrospectively.

Proposed PCM Attribution for Medicare FFS

Patient Self Report = Patient Assigned

Gold standard but not always available (MSSP, Next Gen)

OR



Majority PCP Charges = Patient Assigned

If patient does not self-report, then patient behavior (charges) dictates (MSSP, Next Gen).

Prospective Patient List Provided to ACO

Prospective list supports AN care management and budgeting (MSSP, Next Gen)

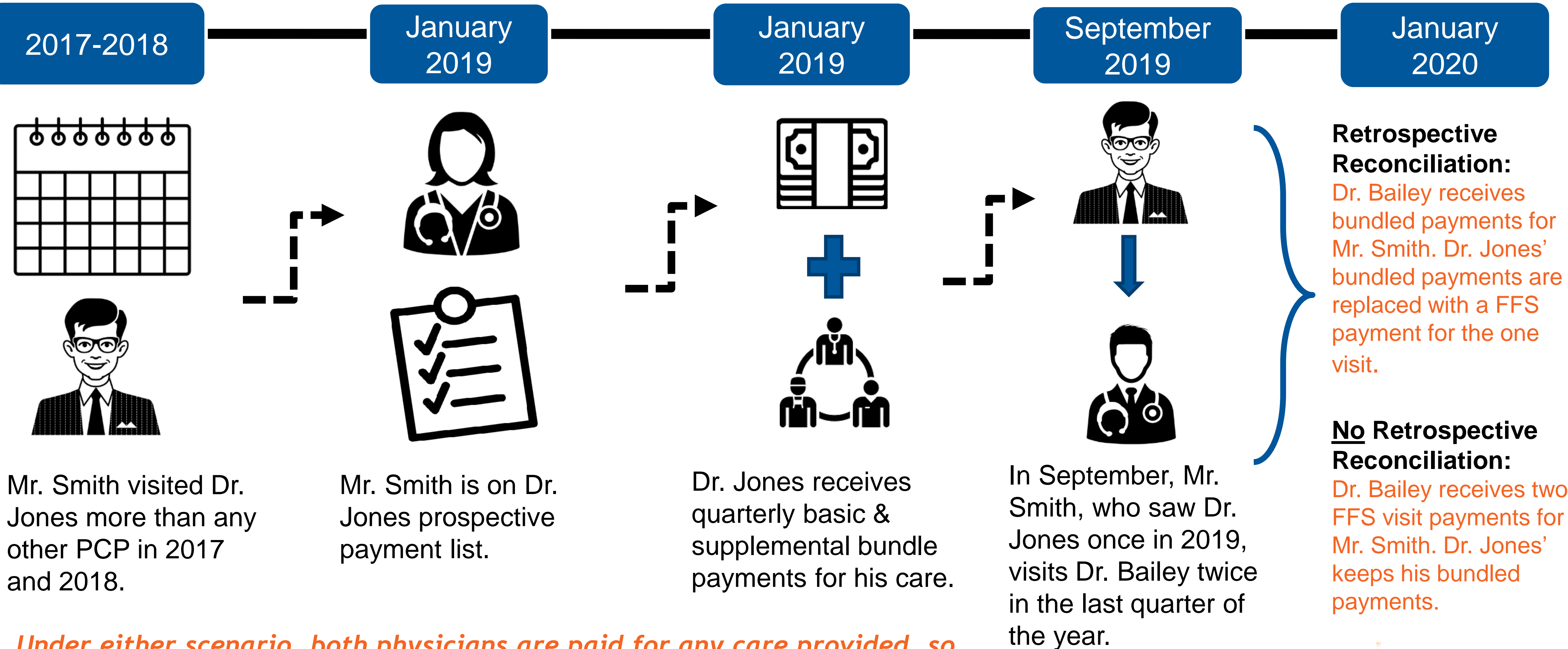
Quarterly Updates

Process would vary by program (MSSP, Next Gen)

Final Retrospective Reconciliation

Subject to review by providers as part of the settlement process (MSSP)

Retrospective Reconciliation: How it Works



Under either scenario, both physicians are paid for any care provided, so there is no incentive not to see Mr. Smith.

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Quick Recap: Tradeoffs of Retrospective Reconciliation

Benefits

- Ability to get “credit” for additional patients gained.
- Better reflects care delivery during the period.
- Providers may have more incentive to keep beneficiaries engaged throughout the year.

Challenges

- Risk of having fewer attributed patients than expected.
- Managing beneficiary/patient churn can be an efficiency and revenue challenge for practices.
- Administrative burden for payers and providers.
- When assignment changes frequently, communications to beneficiaries can become confusing.

Quick Recap: Tradeoffs of No Retrospective Reconciliation

Benefits

- Less administrative burden
- No declines in attributed patients (i.e. less revenue than expected at the end of the period)

Challenges

- Risk of having fewer attributed patients than with retrospective reconciliation.

Decision Point:

Should attribution be reconciled retrospectively?

Begin Discussion of Performance Measurement and Monitoring

<u>Tonight's Payment Reform Council Focus:</u>

- Share consumer priorities for PCM model design and how recommended capabilities and provisional recommendations respond to consumer needs.
- Begin discussion of approach to performance measurement and monitoring

Consumer PCM Priorities

What are consumers looking for in PCM model options?

- Providers have experience with population health management, know attributed patients in advance and are well-positioned for success
- Patients choose their providers
- Reduced cost-sharing
- Improved access, longer visits for complex needs, more convenient options.
- Protections against underservice and patient selection (i.e., cherry picking)
- Transportation barriers addressed
- Care teams value patients' preferences and cultures
- Additional support for patients with unmet medical, behavioral and social needs

Addressing Consumer PCM Priorities

Providers are well-positioned for success and outreach to patients

- Provider qualifications require experience in population health management and shared savings
- Prospective attribution

Patients choose their providers

- Patient choice of providers maintained
- Attribution prioritizes when patient affirmatively chooses provider

Reduced cost-sharing

- Value-based insurance design likely to be recommended with waiver of cost-chare for the PCP to whom you're attributed

Improved access

- Phone, text, email, telemedicine offer fast access for minor needs and frees up PCPs to spend more time on complex medical needs
- Expanded care teams offer additional support between visits
- e-Consult offers quicker access to a specialist's opinion of a treatment plan and whether a visit is needed
- Pressure on total cost of care puts focus on keeping patients well and out of the hospital
- Home visits, telemedicine and remote patient monitoring support patients with transportation needs

Addressing Consumer PCM Priorities (continued)

Protections against underservice (i.e., seeing patients less than they need or in different ways than they prefer)

- ***Require that providers submit periodic reports that demonstrate how new funds are being invested (e.g., CPC+)***
- ***Measure volume of patient contacts by the PCP and by members of the Care Team***
  - ***Include office and telemedicine visits; phone, text, email interactions;***
  - ***Urgent care and ED visits; hospitalizations***
- ***Measure Care Experience (specific questions/items to be considered) and link care experience performance to financial rewards***
- Ensure that patients are given the option of an in-office visit when appointments are scheduled
- Ensure that patients are given information about who they can contact if they feel they are not getting needed services

Protections against patient selection (i.e. avoiding patients that are more challenging to serve

- Adjusting the basic and supplemental bundle based on clinical need or complexity (risk adjustment)
- Potentially adjusting the supplemental bundle to include social determinant risks
- ***Mystery shopper function, which is currently used in PCMH+ to test whether practices are not attempting to avoid some patients over others***

Bolded, italicized items related to performance measurement and monitoring

Addressing Consumer PCM Priorities (continued)

Care teams value patients' preferences and cultures

- Training in cultural sensitivity and awareness
- Increased access to community health workers, who should represent the communities they serve.
- Medical interpretation services always available.

Additional support for patients with unmet medical, behavioral and social needs

- Integrated behavioral health care team member on site or available via telehealth
- Integration with community resources
- Screening for social determinant of health needs
- Care coordination functions to connect to SDOH community supports

Bolded, italicized items related to performance measurement and monitoring

QUESTIONS?

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