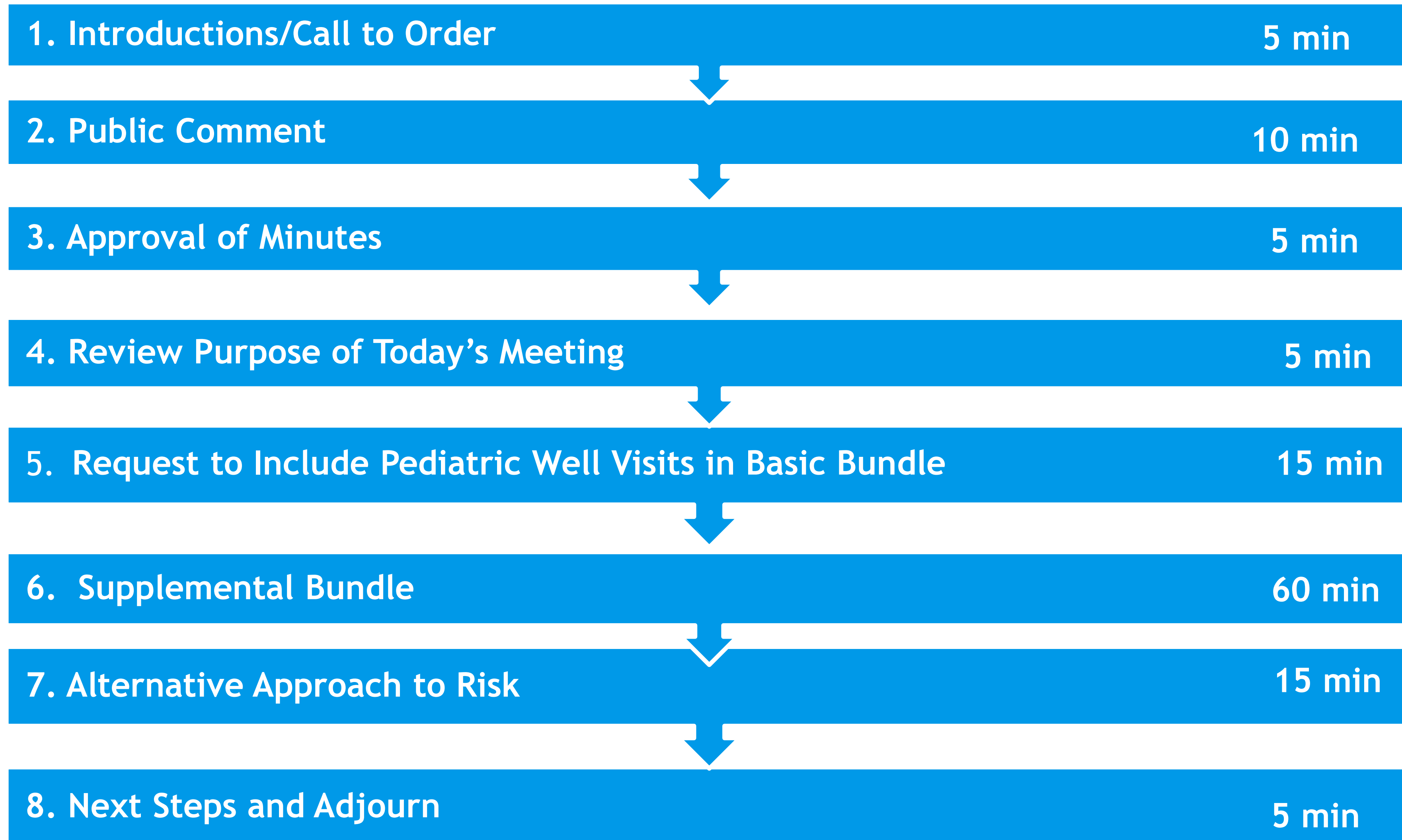
CONNECTICUT
Office of Health Strategy

Payment Reform Council

December 6th 2018

Meeting Agenda



Introductions/ Call to Order

Public Comment

Approval of the Minutes

Revisiting Pediatric Well Visits in the Basic Bundle

The PRC provisional recommendations currently exclude preventive and wellness visits from the basic bundle. These visits will continue to be paid fee for service.

Concern: Some pediatrics advocates have expressed concern that excluding these services for children will make the basic bundle less robust for pediatric practices and in turn, not provide the same opportunity to transform care delivery. (*See public comment from CHDI and CT Health Foundation*).

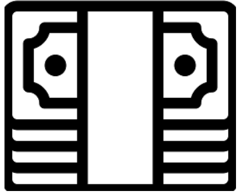
Rationale: Advocates note that flexible funding through bundling preventive services is necessary to support the clinical, developmental, social and behavioral needs of children and their families in a way that promotes long-term health and well-being into adulthood and reduces disparities.

For an adult PCP practice, less than one in five visits is a preventive or wellness visit. For pediatrics, it's more than one in three. If pediatric well visits are excluded, much of the pediatrics practices' revenue would not be paid via the basic bundle.

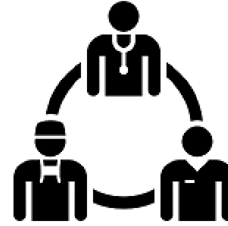
Recommendation: Include preventive and wellness visits in the basic bundle for pediatric patients.

The Supplemental Bundle

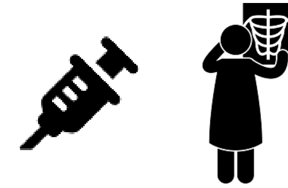
Basic Bundle



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

- Continue discussion of the supplemental bundle and how it should be adjusted to account for differences in populations.
- Determine approach for how these payments should flow to providers.
- Determine whether these payments can be recouped if not used for approved purposes.

Quick Review:
Supplemental Bundle Conversation To Date

Basic and Supplemental Bundles

Basic Bundle

PCP's Time

(MD, DO, APRN, PA)

- **Office visits, phone, text, email, telemedicine, home visits, shared visits.**
- Leading care teams.
- Participation in technical assistance to offer more specialized care.
- Supporting e-Consult.

Both adjusted to reflect differences in patient needs and expected costs.

Supplemental Bundle

New Expenses Necessary to Achieve Capabilities

- **Expanded, diversified care teams that connect with patients through office visits, phone, text, email, telemedicine, home visits, shared visits.**
- Primary care integration with behavioral health services and community-placed resources.
- New investments in technology and infrastructure to support achieving the capabilities.
- Specialist payments for e-Consult.
- Patient-specific expenses to address social determinants of health needs such as food security/food as medicine, housing instability and transportation.

What We've Heard from You:

Agreement with Proposed Uses:

- Compensation of care team members to meet capabilities requirements.
- New, direct investments in HIT and infrastructure to meet capabilities requirements.
- Expenses associated with behavioral health integration and community integration.
- Training and technical assistance.

Agreement with Risk Adjustment Approach, But Need to Know More:

- Since supplemental bundle funds will largely go toward supporting care management, behavioral health integration and community integration, ideally these payments should be adjusted to align with the patients' needs in those areas.

What We've Heard from You:

Cautions:

- Offer options to meet the needs of ANs/FQHCs at different points in evolution to population health, value-based payment.
- Encourage "scaling up" over time. Consider requiring some demonstration of success before allowing provider organizations to advance to the highest tiers of the program.
- Develop a glidepath to build the supplemental bundle payment into the total medical expense calculation. This approach could demonstrate ANs/FQHCs commitment to reducing total cost while offering some protection against losses in the early years before investments show full savings.
- Strong accountability needed to make sure dollars flow to the primary care practices and are spent to achieve the capabilities.

Calculating the Supplemental Bundle

What is sufficient investment in care transformation?

To determine the supplemental bundle payments, we looked to others and the specific capabilities under consideration for PCM.

Our Approach:

1. Review literature to gain better understanding of other models. Last Time
2. Estimate the cost of specific capabilities proposed by the PCM Design Groups and Practice Transformation Task Force. Today
3. Use cost estimates and publicly available data on Connecticut ACOs to model scenarios. Today
4. Model possible impact on total medical expense, percent investment in primary care. Next Time

Context for Reviewing Capabilities Cost Estimates

1. Estimates based on the literature, not actuarial assessments reflecting the specific needs of Connecticut residents. Actuarial assessments will come later.

2. PCM assumes some foundational investments in HIT. The supplemental bundle may not cover all costs for some capabilities for some provider organizations and may cover more than the cost for others. Organizations have made different historical investment decisions.

3. PCM supplemental bundle payments intend to cover the cost of new care team members, new investments in technology directly related to achieving the capabilities and the training and technical assistance necessary to position providers for success.

4. Investments in new care teams will look different for different provider organizations depending on the patient needs, practice type (adult v. pediatric), organizational culture and budget.

Calculating the supplemental bundle:

Hypothetical Cost Estimates for Core Capabilities

Core Capabilities	Estimated Cost PMPM	Assumptions (*all cost estimates based on an "average" multi-payer, 1500/per FTE MD panel*)
Phone, Text, Email	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Telemedicine	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Remote Monitoring ***(For conditions where there is proven benefit)***	$.50-$1.50	**One-time Fixed Cost** $20,000 Implementation; $15,000 Integration Fee; $15,000 Training Fee **Annual Fixed Cost** - $175,000 Platform fee **Annual Variable Cost** - $7 Transaction cost per patient Assumes 80,000 covered lives. Costs would vary depending vendor, AN size and the targeted conditions.
eConsult	$2.94	Assumes 12 eConsults per week per PCP ($85 each including specialist time and technology platform)
Expanded Care Teams	$10.00-$15.00	Using CPCI, "fully-enabled" PCM estimates
BH Integration	$0	Assumes AN/FQHC has necessary technology. Care team members included in basic bundle and expanded care teams estimates.
Specialized Practices	$2.00-$6.00	Technical assistance, equipment, access to support networks like Project Echo. May include some additional care team members specific to the need of the specialized practice. Recognizes panel sizes may need to be smaller than a standard practice.
Training and Technical Assistance	$3.00	Training in collaboration and leadership for expanded care teams.

Supplemental Bundle Target Ranges – Medicare Model Options

	TIER ONE		TIER TWO		TIER THREE
Core Capabilities	$19	Core Capabilities	$24	Core Capabilities	$35
Elective Capabilities	$0	Elective Capabilities	$3	Elective Capabilities	$5
Target Supplemental Bundle*	$18-$20	Target Supplemental Bundle*	$25-$28	Target Supplemental Bundle*	$35-$40

TIER ONE

Description:
Expanded Care Teams, BH Integration, Training and Technical Assistance, Few Specialized Practices

Availability:
Years 1-2

TIER TWO

Description:
Expanded Care Teams, BH Integration, Training and Technical Assistance, Additional Specialized Practices, Some Investment in Elective Capabilities

Availability:
Years 1-5

TIER THREE

Description:
Maximizes Care Team Potential, BH Integration, Training and Technical Assistance, Strong Cadre of Specialized Practices, Greater Investment in Elective Capabilities

Availability:
Years 2-5

* Please note these targets are not risk adjusted and these numbers will be further adjusted subject to a Medicare claims-level analysis.

Discussion Break:

- Do these costs and targets align with your expectations?
- Thoughts on the phased in approach to including the supplemental bundle funds into the total medical expense calculation?
- Other thoughts or concerns?

Supplemental Bundle Funds Flow:

Proposed Approach:
Supplemental bundle is calculated for each AN and paid to the AN. Funds will be used to support primary care transformation and limited to the allowable uses identified by the primary care modernization design process.

Rationale:
Maximizing the supplemental bundle investments (care teams, targeted HIT, training) require they be spread over a larger population than one practice. A strong accountability framework can ensure they are used only for approved purposes.

Recouping supplemental bundle payments not used for approved purposes

Proposed Approach:

- Allow payers to recoup supplemental bundle payments not used for approved purposes.
- Require practices to report to the state and payers (CMS, Medicaid, commercial) how funds were used. Consider making elements of these reports available to the public.
- If funding was not used or was not used for approved purposes, the AN would have the option to pay back the funds or propose to use them in the following year (rollover) for an approved purpose, subject to payer approval.
- Supplemental bundle funds not used for an approved purpose or approved for rollover will be recouped.
- Supplemental bundle payment for purposes of total medical expense = Funding for current program year not rolled over + funds rolled over from prior period - recoupment.

Decision Point:

Is there agreement with the recommendations on supplemental bundle funds flow and recoupment of supplemental bundle payments?

Funds Flow: Supplemental bundle is calculated for each AN and paid to the AN. Funds will be used to support primary care transformation and limited to the allowable uses identified by the primary care modernization design process.

Recoupment: Payers should recoup supplemental bundle payments not used for approved purposes, per the conditions outlined.

Risk Adjusting the Supplemental Bundle

Risk Adjusting the Supplemental Bundle

Proposed Approach

- Since supplemental bundle funds will largely go toward supporting care management and coordination, behavioral health integration and community integration, ideally these payments should be adjusted to align with the patients' needs in those areas.
- To achieve this, supplemental payments would be adjusted using an approach similar to CPC+.
- All beneficiaries are assigned to tiers based on their risk score **but** some beneficiaries default to higher tiers if they have certain conditions or characteristics. We will call this "secondary adjustment."
- Secondary adjustment conditions and characteristics should be meaningful to primary care, able to be defined using available data, and reasonable to isolate despite increased administrative burden.

Why start with risk scores?

- Scores and underlying data are widely available
- Risk adjustment methodologies are well established and the resulting scores are meaningful representations of population risk
- Stakeholders are generally familiar with risk adjustment methodologies and they are part of the framework for much of value based payment

Example: MassHealth Social Determinants of Care Risk Adjustment Model

- Risk adjustment methodology was augmented to capture the impact of social determinants of health on medical expense.
- The model predicts costs from DxCG relative risk score and age-sex indicators (leveraging commercially available model).
- Then, it adds markers for unstable housing (3 or more addresses/yr or v-code), disability, agency relationships, severe mental illness and substance use disorders.
- The final component is a summary measure of "neighborhood stress" based upon residence in a census block group. It is defined on the next slide.

Source: EOHHS
Model is not commercially available

Neighborhood Stress Score

A measure of “economic stress” summarizing 7 census variables identified in a principal components analysis:

% of families with incomes < 100% of FPL
% < 200% of FPL
% of adults who are unemployed
% of households receiving public assistance
% of households with no car
% of households with children and a single parent
% of people age 25 or older who have no HS degree

Source: EOHHS
Model is not commercially available

Key questions to consider for PCM:

1. What criteria should be considered as we develop risk adjustment tiers for primary care modernization?

2. What process or method will be used to apply the secondary adjustment?

3. What characteristics should trigger secondary adjustment?

What’s the right number of risk adjustment tiers?

Recommendation:

Supplemental Payments should leverage no more than 5 tiers. This is what CPC+ uses.

Rationale:

- Sufficient number of tiers to adequately adjust for differences in populations.
- Accounting and operations are simplified.
- Allows for a meaningful difference in payment between tiers.

Which method(s) should be used to apply secondary adjustment?

Approach 1:Tier jumping

- Patient's risk score falls in the tier 2 score range.
- Patient has a diagnosis of dementia.
- Patient is placed in tier 3.

Approach 2: Patients with certain needs assigned to specific supplemental bundle categories, regardless of underlying risk score.

- All patients with a diagnosis of dementia would be assigned to the highest risk adjustment category, regardless of other clinical, social or behavioral health needs.

Both approaches may be leveraged depending on the characteristic or condition.

Which populations should receive a secondary adjustment?

During stakeholder meetings, several populations were identified whose clinical, behavioral and social needs may not be fully reflected in a traditional risk adjustment methodology.

Examples included:

- Individuals with unmet social needs such as lack of stable housing.
- Individuals with behavioral health conditions and substance use disorder conditions.
- Children
- Individuals with dementia

How would providers identify these populations?

Population: Individuals with unmet social needs such as lack of stable housing.
Possible Approach: Massachusetts used zip code. The zip code links to a look up table that captures the community attributes included in the neighborhood stressor score. Therefore the individual's secondary adjusted reflected their community, not themselves.

Population: Individuals with behavioral health conditions and substance use disorder conditions.
Possible Approach: Diagnoses found in claims. This would also provide more incentive for providers to fully implement screening.

Population: Children
Possible Approach: Different tiers based on risk adjustment, diagnosis, and age. All information found in claims.

Population: Individuals with dementia
Possible Approach: In CPC+, dementia diagnoses will be determined using information from CMS's Chronic Condition Warehouse (CCW), which is based on diagnoses codes found in the claims. The designation is updated annually.

Discussion Break:

- Are we on the right track?
- What do you feel is most important as we develop a more well-defined strawman for supplemental bundle risk adjustment?
- Other thoughts or concerns?

Potential Alternative Risk-lite Approach

Potential Alternative Risk-lite Approach:

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

Potential Alternative Risk-lite Approach:

Strawman is based on CPC+ Track 2, which is similar in design and aims to PCM.

CPC Plus Track 2	Care Management Fees	Performance-Based Incentive Payment	Medicare Physician Fee Schedule
	$28 average per beneficiary per month (PBPM) including $100 PBPM to support patients with complex needs	$4 PBIP tied to quality, patient experience and utilization performance	Hybrid bundled payment for office visits: Reduced FFS w/ primary care bundle
Potential PCM Adaptation	**Tier 1 Supplemental Bundle Payment**	**Performance-Based Incentive Payment**	**Full Basic Bundle**
	$18-$20 average target, with increased payments for high-needs populations	$4 PBIP tied to quality/patient experience and utilization performance	Full basic bundle payment. Same as other PCM AN/FQHCs.

Potential Alternative Risk-lite Approach:

- Providers receive PBIP at the beginning of each year.
- Only the PBIP is returned at the end of the performance years if quality and utilization targets have not been met; risk cautious provider can simply bank the PBIP for the year.
- Elimination of total cost of care accountability addresses concerns about incentives to reduce necessary specialty referrals, diagnostic tests and procedures.
- Purchasers may be concerned that reduced pressure on cost accountability reduces the likelihood that return on investment will be achieved in excess of supplemental payment.

QUESTIONS?

Contact:

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Appendix

Learning from Others: CPC+

Track 1 has 4 risk tiers and Track 2 had 5 risk tiers. Each risk tier corresponds to a specific monthly CMF payment:

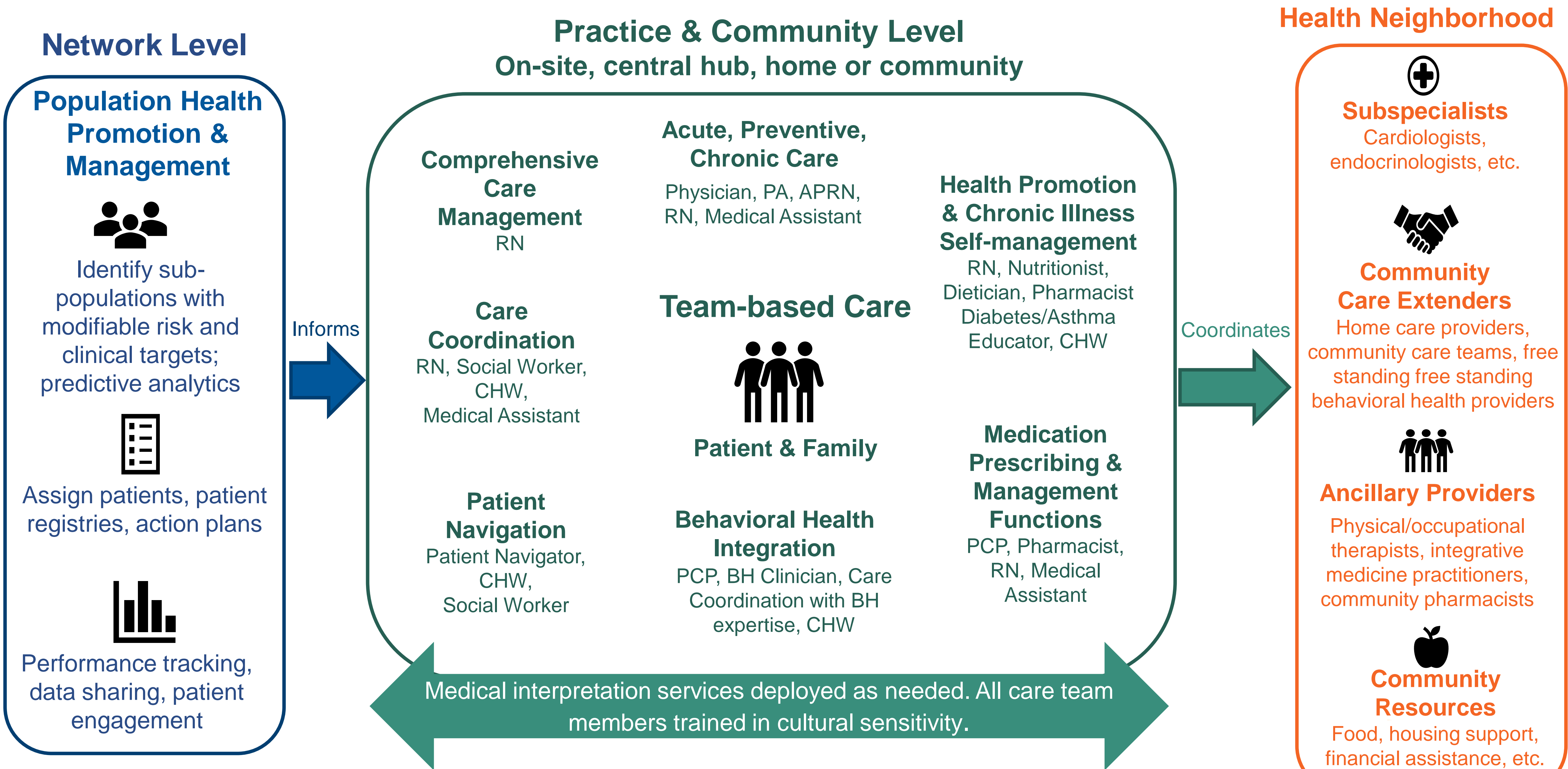
Risk Tier	Track 1	Track 2
Tier 1: Risk Score <25th percentile	$6 PMPM	$9 PMPM
Tier 2: Risk Score 25th percentile ≤ risk score < 50th percentile	$8 PMPM	$11 PMPM
Tier 3: 50th percentile ≤ risk score < 75th percentile	$16 PMPM	$19 PMPM
Tier 4: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30 PMPM	$33 PMPM
Tier 5: Risk score ≥ 90th percentile or Dementia diagnosis	NA	$100 PMPM

Care Delivery Goal: Increase the Ability of Primary Care to Meet Consumers’ Needs

PTTF Capabilities' Provisional Recommendations – IN PROGRESS

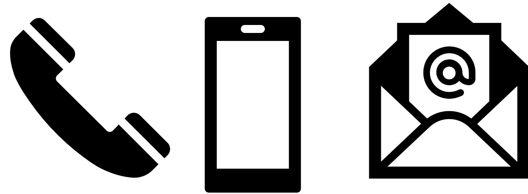
Capability	Included in Model	Core or Elective	Deployed in All Practices or Subset	Basic	Supplemental	State Supports
Phone/text/email	Yes	Core	All	PCP time	Other care team members' time	
Telemedicine	Yes	Core	All	PCP time	Coverage for training, other care team members' time	
Remote Patient Monitoring	Yes for certain conditions	Core for conditions w/ efficacy & cost savings		PCP time	Other care team members' time	
eConsults	Yes	Core	All	PCP time Phone and internet	Specialist's time	
Oral Health Integration	Yes but revisiting		Maybe only pediatrics	PCP team	Training for staff	
Home Visits	Yes	Elective	For certain populations		Staff time other than PCP	
Shared Medical Appointments	Yes	Elective		Outreach, space set up, RN/NP at visit	Facilitator BH/Coach	
Infectious Diseases	No	N/A				
Genomic Screening	Tabled until further evidence	N/A				
Functional Medicine	Explore integrative medicine	N/A				
Diverse Care Teams	Yes	Core	All		Care team members' compensation	
Pain Management, MAT	Yes	Core	Basic training for all, subset specialize			
Adult Behavioral Health Integration	Yes but continue development	Core	All			
Pediatric BHI						
Community Integration	Yes	Elective			Payment to partner orgs	
Older Adults						
Persons with Disabilities						
Pediatric Practices						

Expand Primary Care Team Functions and Roles



Support and Engage Patients in Alternative Ways

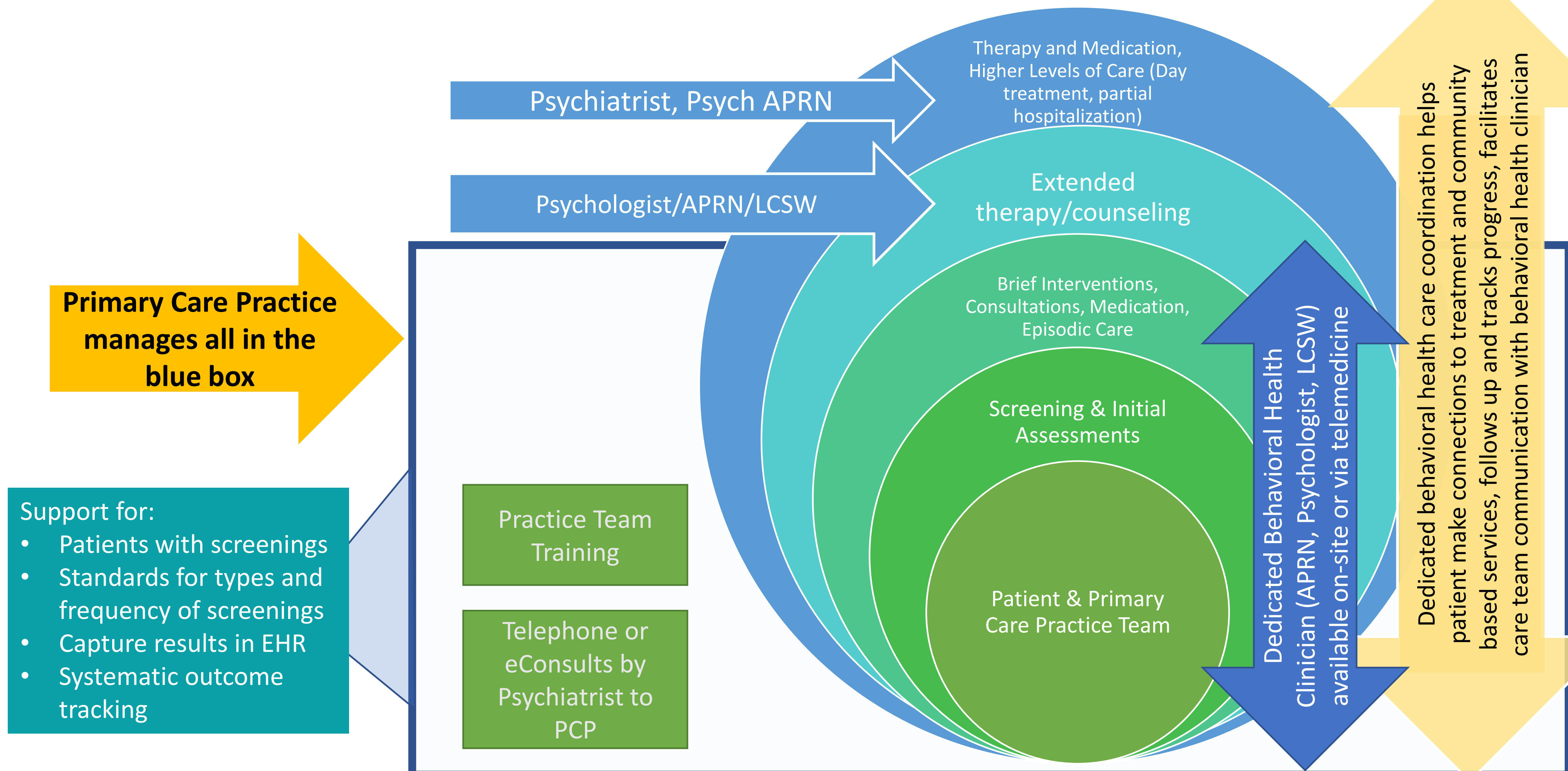
Telehealth and other non-visit based technologies help address access to care barriers like transportation, especially for populations experiencing health disparities.



Phone, Text, Email Encounters give patients and care team members expanded opportunities to establish contact outside of an office setting for non-urgent care needs.

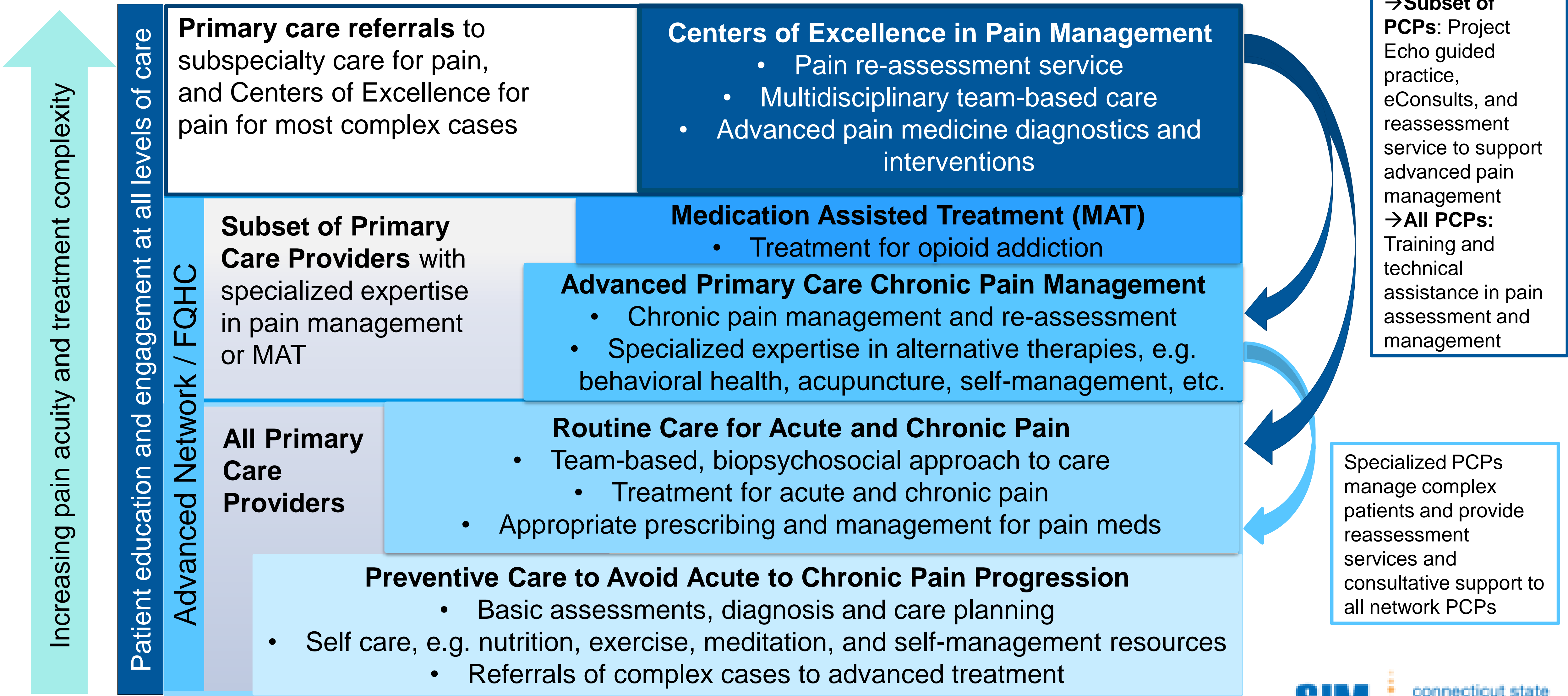
Telemedicine Visits between clinicians and patients through video conference increases access to primary care for routine care, non-urgent acute needs and behavioral health needs that do not require an office visit.

Integrate Behavioral Health into Primary Care

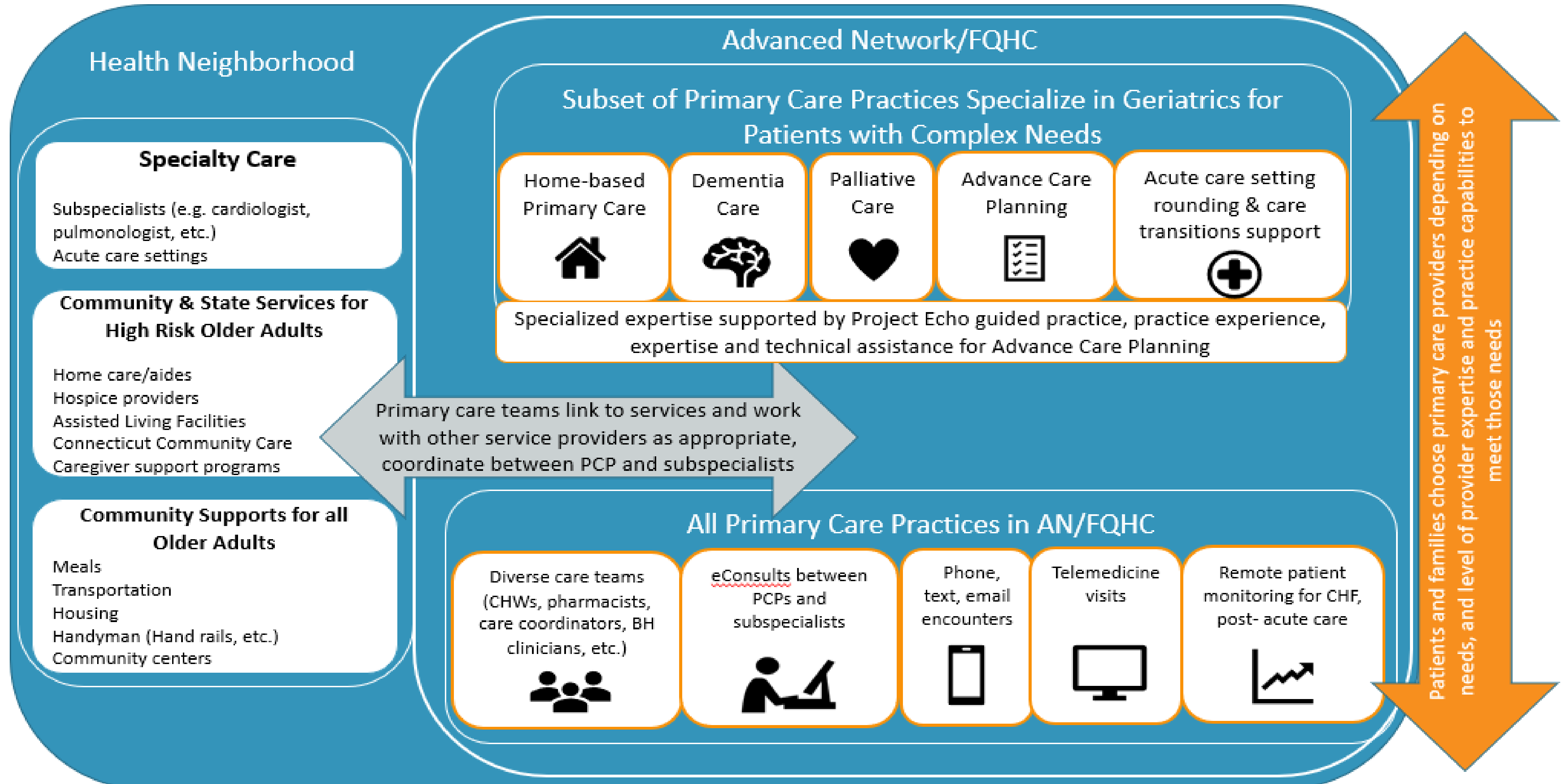


Based on feedback prior to September 25, 2018

Increase Expertise in Pain Management



DRAFT Offer Specialized Care for Older Adults with Complex Needs (under review by PTTF)



Learning from Others: Vermont OneCare ACO

Vermont leverages multiple sources of supplemental funding:

- A level per member per month payment for each high-risk patient.
- An additional per member, per month payment for every high-risk patient that identifies the provider as their 'Lead' in the management of their care.

Vermont divided patients into four cohorts based on care needs leveraging Johns Hopkins ACG:

1) Healthy/Well,
2) Early Onset or Stable Chronic Illness,
3) Complex/High-Cost with Acute Catastrophic Conditions, and
4) Full Onset Chronic Illness and Rising Risk

Learning from Others: CPC+

- CPC+ includes a care management fee (CMF), which is similar to a supplemental bundle, to improve care coordination, implement data-driven quality improvement, and enhance targeted support to patients identified as high risk.

- CMFs vary based on the level of provider engagement in the CPC+ program and the patient's risk of incurring medical costs as predicted by the HCC methodology.

- Most beneficiaries are placed in risk categories based on their HCC score. However, in recognition of the significant care management needs of patients with dementia, those patients are automatically included in the highest risk tier.*

PCM could employ a similar approach for a broader range of conditions.

** More information on the tiers is available in the appendix.*

Pediatric Preventative Care Categories

Category	Codes	Qualification
Immunization Administration	90460, 90461, 90471-90474, G0008, G0009	Primary Care Specialty Only
Initial Preventative Medicine infant	99381	Primary Care Specialty Only
Initial Preventative Medicine 1-4	99382	Primary Care Specialty Only
Preventative Medicine Est Pt Infant	99391	Primary Care Specialty Only
Preventative Medicine Visit age 1-4	99392	Primary Care Specialty Only
Preventative Medicine Visit age 5-11	99393	Primary Care Specialty Only
Preventative Medicine Visit age 12-17	99394	Primary Care Specialty Only

*T1015 is also used for preventative care. PRC previously recommended that T1015 services should be included in the basic bundle.