Primary Care Payment Model FAQs

Benefits of Primary Care Payment Reform

1. What are the benefits to consumers when considering payment reform?

Response: The proposed primary care payment reforms would have many benefits to consumers. Consumers may find they have more "touches" with their primary care team between office visits; these touches may be with coaches and navigators recruited from their own community; they will find it easier to communicate with their clinician by phone, e-mail and video; they may be able to engage their clinician from home or work and thus miss less work and avoid transportation and childcare barriers; they may require fewer office visits (because they could access care using non-visit methods), which means lower out of pocket costs; the clinician or a member of the team will be able to do home visits when needed; a consumer may find it easier to find a new PCP because the PCP is paid simply to have you as part of her/his panel; sicker patients do not have to worry about being accepted into care because CMF payments are risk-adjusted; they may also find the practice can better support them with a care coordinator, especially when there are care transitions.

2. Why would we even consider reverting back to capitation? What are the benefits of this?

Response: Connecticut's experience with capitation was primarily with managed care organizations. The capitation models generally included all health care services (hospital, home health, pharmacy, behavioral health, etc.). We are not proposing to revert to a managed care model or a full capitation model. Instead, we are proposing bundled payment arrangements directly with providers and including only one service area (primary care). In addition, this approach would include risk adjustment (i.e., the amount of time and resources a provider must spend on sicker patients is taken into account). Risk adjustment would act as an incentive for providers to ensure access to comprehensive care for patients with greater healthcare needs. Upfront, bundled payments provide the flexibility to do this. The primary reason we are proposing this is to enable practices to achieve the full promise of medical home…more flexibility in how practices and serve consumers and more diverse care teams.

3. How could the new Comprehensive Primary Care Plus (CPC+) opportunity support primary care payment reform?

Response: Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model administered by the Center for Medicare and Medicaid Innovation (CMMI), which aims to strengthen primary care through multi-payer primary care payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with different care delivery requirements and payment options, both of which provide up front funding for care delivery transformation.

The CPC+ opportunity is limited to markets (i.e., states or regions) that are selected to participate based on a competitive procurement. CMMI selects markets based on the level of public and private payer participation. CMMI reopened its solicitation of markets on February

17th; applications are due April 3rd. Once the markets are selected, CMMI will invite practices to participate in these markets through another competitive solicitation for a January 1, 2018 start date. CMMI has adjusted the model to permit Medicare ACO participating practices to apply, which positions the program well for the CT market.

CPC+ is important because it enables Medicare participation in Connecticut's primary care payment reforms. CPC+ offers the potential to bring as much as $100 million in Medicare advanced payment dollars to CT providers if our market is selected. Combined with the payments of other payers, this would be an enormous investment supporting primary care practice flexibility and care team expansion.

Impact on Care Delivery

4. How can primary care bundles support bringing mental health services, which are paid for in other arrangements, into our practice to meet children's and families' needs as early as possible and in a way that is acceptable to them?

Response: Care management fees are intended to support a more diverse care team. Practices may decide that one of the most important investments to make with these dollars is to hire a behavioral health clinician to support on site screening and brief intervention, or they will have funding to support supplement services and support provided by behavioral health clinicians over and above what they can bill insurers.

5. How can a primary care bundle reflect all the primary and preventive family counseling and anticipatory guidance that we need to do in the very early years with families to ensure that children get off to a healthy start? These need to be longer visits, as do the adolescent visits, than many of the other visits that child health providers do.

Response: Two of the model options that we describe in our materials (Option 1, partial bundle for sick visits and Option 2, full bundle for sick visits) do not include bundles for preventive care, so primary care providers will continue to have the same incentives they have always had to engage in primary and preventive family counseling and anticipatory guidance. Also, the practice will have care management dollars and flexibility to change its visit protocols to allow for more services through team based care and even through group visits, which may be a more cost-efficient way to meet some preventive care goals. Care management fees that support a more diverse care team may open up new avenues for achieving the goals of primary and preventive family counseling and anticipatory guidance, without relying solely on PCPs and office visits. Note: CPC+ is not available to pediatric practices because pediatric patients are not eligible for Medicare. However, primary care payment reforms of the type that CPC+ is promoting could be undertaken by private and other public payers.

6. How can primary care bundled payment support care and services that contribute to obesity prevention, including breastfeeding support, lactation consultation, nutrition consultation? Many of these are not covered by insurance plans.

Response: As noted above, care management fees are intended to support a more diverse care team. Practices may decide to invest in community health workers or nutritionists or consultants to address these important non-billable gaps in the services they provide. The advantage of bundled care management and office visit fees is the flexibility they provide the

practice in deciding how best to meet the needs of their patients without having to worry about whether a particular individual or activity is reimbursable.

7. How would primary care payment reform affect patients with complex conditions or rare diseases?

Response: We believe that risk adjustment would account for the additional needs of patients with complex conditions or rare diseases. We will be looking further into how risk adjustment is done in these models with the hope of sharing more information in April.

8. How will primary care payment reform affect specialists and referrals?

Response: Primary care payment reforms and their Shared Savings Program counterparts may lead practices to be more selective with respect to the specialists to whom they refer. They may favor specialists that they feel provider better quality care at a lower cost. Practices may also adopt co-management and referral protocols in collaboration with specialists to bring about lower cost in care and ensure that patients who need subspecialty services have access.

Consumer Costs

9. How does the addition of a care management fee or bundled payment affect premiums?

Response: It is anticipated that any increase in payments to practices (e.g., through care management fees), will be offset by savings from reduced ED visits and hospital admissions. However, payers may wish to phase in these increases each year that practices demonstrate savings. This approach may take longer, but it may also reduce the likelihood that the new payments will increase premiums.

10. How will the payment reforms affect out of pocket costs or deductibles?

Response: The reforms may mean that patients require fewer office visits to address acute or chronic conditions. Patients would save on co-payments for visits that are avoided as a result of phone or e-mail communication, video visits, or visits with care team members whose services are not billable (e.g., health coaches). This should mean that patients will experience an overall reduction in out of pocket costs. Note: We are currently researching the likely impact on deductibles. Based on our research thus far, it appears that deductibles only applied to billed services. This means that services that are paid as a bundle (sick visits under Option 2), might not apply to the deductible.

11. How will this affect those who purchase coverage such as businesses and individuals?

Response: It is anticipated that these reforms will help reduce the rate of growth in the cost of care. This should help slow the growth of premiums paid by employers and individuals.

Provider Considerations

12. How would any of this payment reform relate to MACRA/MIPS?

Response: Under some circumstances, participation in CPC+ would enable a provider to be exempt from MIPS because they would be participating in a payment reform that meets the definition of an Advanced Alternative Payment Model (AAPM).

13. If providers are not willing to accept risk, how will these models work? Will there be some sort of provision for stop-loss coverage or reinsurance?

Response: There are several different models that we are considering. One of the models has no risk at all (Option 1, partial bundle for sick visits). Option 2 (full bundle for sick visits) has very limited risk and Option 3 (full bundle for most primary care) a bit more. Because the bundling is only for primary care services, we believe that Option 3 should be manageable for larger provider organizations without stop-loss coverage or reinsurance. We would, however, encourage provider organizations to make their own assessment of this before selecting an option.

14. What will the contracting process be for payers and providers? Will the State be more involved?

Response: We would suggest leaving the contacting process up to the payers and providers. Accordingly, the State would only be involved in contracting if it elects to undertake a primary care payment reform. The State or the federal government may be involved in providing technical assistance to support the change process.

15. Will payment change for primary care partners affect providers who participate in ACOs?

Response: The primary care payment reforms are intended to complement the ACO model by a) providing practices with more up front revenue to transform and b) enabling practices to develop alternatives to visit-based care without giving up income. Within ACOs, practices may be able to share resources (CHWs, behavioral health providers, nutritionists) across sites bringing efficiency in the spending of care management dollars.

16. If there will be items that are non-billable that will be introduced to the primary care setting (Uber rides, meals on wheels, etc.) how will docs justify additional time and costs to coordinate this care without hiring additional staff and training?

Response: We recommend that providers be given control over what additional non-billable services and activities they introduce. The additional time and costs would be covered by the Care Management Fees (CMF) and/or the flexible bundled payments.

17. How will independent practices be able to undergo this type of reform? This seems almost impossible for independent practices on top of everything else they are tasked to do.

Response: One of the main reasons for undertaking these reforms is to improve the quality of life for clinicians in practice. In our stakeholder interviews with providers we have learned that primary care providers are frustrated and dissatisfied with their inability to be flexible in their care delivery models. They would like to innovate to include more health care disciplines and to allow new modes of interacting with their patients. Payment reform would allow them to focus on providing care to the sickest patients, as they were trained to do, while meeting patients' diverse needs more efficiently and adeptly. Those practices that pursue these reforms may need

technical assistance to help with the change process. We recognize that some practices may not want to undertake these changes, so we are recommending that these reforms only be extended to practices that want them.

Transitioning to PCPM

18. What type of support will be available for providers and consumers alike with non-fee-for service?

Response: If Connecticut is selected as a market for CPC+ payment reform, CPC+ will offer participating practices a variety of learning opportunities to support their transformation needs with in-person, virtual, and on-demand events and information. National and regional learning communities will provide CPC+ practices with opportunities for in-person and web-based learning. Learning events and materials will orient practices to CPC+ program requirements and guide practices through the CPC+ corridors of work. Online collaboration tools and web-based portals will facilitate practice sharing. Regional learning communities will also offer targeted, practice-level technical assistance to support practices to enhance their capabilities. If Connecticut is not selected as a market for CPC+ payment reform, the SIM PMO will look at other opportunities to initiate and support such reforms among interested payers. The biggest challenge will be arranging for Medicare participation, which is included in the CPC+ opportunity.

19. How are primary care providers going to integrate a more comprehensive care team if they never have before (CHWs, Social Workers, etc.)? How will they be able to access these employees, have time to train, and pay them?

Response: This question is an important one that speaks to the challenge of changing practice work flows and care team processes, roles and functions. Technical assistance will be needed to support this process, whether provided by the state or federal government. Several models for embedding new types of health care providers can be applied based on the experience of other states and even some providers within Connecticut. The cost of hiring or contracting with new care team members will come from the care management fees, or billing under other arrangements, such as behavioral health services.

20. Will there be a transition period or transition process as we shift from fee for service to a different form of primary care payment? How long will this whole process take?

Response: Some providers will not require any transition at all with the basic models because FFS remains in place for most services. However, Option 1 can be implemented gradually, over a 2 to 3-year period, with the percent of visit costs that are bundled gradually increasing from 25% to 65% or so. We are not proposing one size fits all…in other words, we recommend that payers and providers negotiate terms that both parties are comfortable with and that will provide a solid foundation for success.

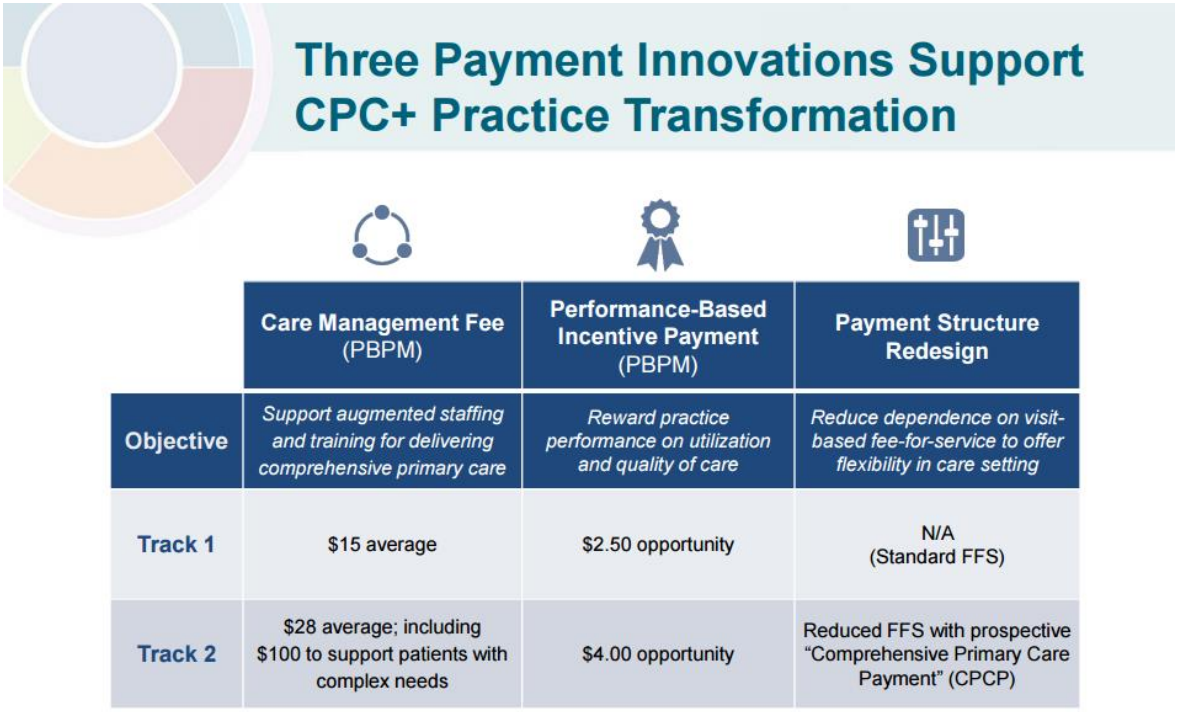
Primary Care Investment through PCPMs

21. Would practices that are PCMH's have any additional care management fee/incentive payment under any new primary care payment models?

Response: PCMH practices that successfully apply to participate in CPC+ would have access to additional care management fees for their Medicare patients. They would also have access to bundled payment for a portion of their office visit costs if they pick Track 2. Whether PCMHs have access to additional care management fees and bundles from other payers depends on a) whether the payer is participating in CPC+ and b) the model that those payers decide to adopt.

22. What additional transformation investments will be available, especially to independent practices?

Response: CPC+ participating practices will have access to the care management fees for their Medicare patients as noted in the table below, depending on which track they select. The care management fees are transformation investments. The care management fees paid by other payers would also support transformation.



	Care Management Fee (PBPM)	Performance-Based Incentive Payment (PBPM)	Payment Structure Redesign
Objective	*Support augmented staffing and training for delivering comprehensive primary care*	*Reward practice performance on utilization and quality of care*	*Reduce dependence on visit-based fee-for-service to offer flexibility in care setting*
Track 1	$15 average	$2.50 opportunity	N/A (Standard FFS)
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

Monitoring Care Delivery Reform under PCPMs

23. What care delivery reforms will CPC+ require that practices undertake and how will practices be monitored?

Response: The CPC+ care delivery requirements are intended to provide a framework for practices to deepen their capabilities throughout the five-year model. These incremental requirements will guide practices through the comprehensive primary care functions as markers for regular, measureable progress to the CPC+ model aims. Track 2 requirements are inclusive of and build upon Track 1, as the framework for delivering better care, smarter spending, and healthier people in CPC+ is the same across both tracks. Track 1 practices that participated in CPC are expected to continue their work of practice change in CPC+ in PY2017. Track 2 includes additional requirements that will aid practices to increase the depth, breadth, and scope of care offered, with particular focus on their patients with complex needs.

The care delivery requirements in each of the Functions below will evolve and deepen over the term of the model. As practices become familiar with the initial stages of the work and gain expertise, they will be ready to refine their work and will see opportunities to continue to improve the care of and outcomes for their own population of patients.

Practices will report their progress regularly through a secure web portal that will provide both the practices and CMS insight into practice capabilities. CMS will support practices in their work through the requirements with robust learning communities at the regional and national level, and with data feedback for practices to use in care coordination, quality assessment, and improvement activities.

24. How will the upfront care management fees be followed up on/tracked to ensure these payments are being used as intended?

Response: We recommend that payers require practices to provide reports that show how the money is spent. Specifically, practices should be required to report the new things they are doing to support patients and the additional people they have hired to be a part of the care team.

25. How will we know that providers are investing the additional funds in a way that supports real transformation?

Response: Practices will be responsible for reporting their Medicare spending to CMS. Practices will be required to both forecast their spending of the CPC+ Payments and, at the end of the performance year, provide an accounting of actual CPC+ expenditures. This reporting will help practices understand and optimize their use of these alternative payments and will also help CMS to understand how practices use the revenue they receive to perform the care delivery work the model requires.

26. How will the State get consumer feedback on the process? Is there concern on eliminating one care visit (4 →3) on patient care?

Response: None of the models require a reduction in the number of patient visits per patient per year and, in fact, this may not be an outcome of the reform. In addition, providers are increasingly concerned about being consumer focused and friendly in order to become their preferred provider, so providers will likely try to avoid leaving patients with a sense that they have diminished access to office visits, however, they end up deciding on the appropriate frequency and type of visit. Patient-provider interactions may become more convenient and family-centered through the use of technology, home visits, and other innovations that practices develop to meet the unique needs of patients. Of course the appropriate frequency and type of visit will vary quite a bit from patient to patient depending on health status and patient preference. We also recommend that consumer experience be surveyed and that consumer experience scores be factored into the incentive payments.

Measuring Quality

27. If quality measures have not shown any improvements in payment, why are they going to be of focus?

Response: Medical home pay for performance programs and shared savings programs that tie financial rewards to quality performance have been shown to improve quality. For this reason, we believe that that quality measures are an essential part of the model.

28. How will quality measures of potential primary care payment models align with Medicare quality measures? Will there be specific quality measures for pediatric providers?

Response: We would encourage payers to review the quality scorecards that they currently have in place and adjust the measures to better align with the Medicare measures under CPC+. The CPC+ measures are already aligned with the measures in Medicare's Merit-based Payment Incentive System (MIPS).

29. Given the unique breakdown of funding in pediatrics (mostly well visits, immunizations, etc.), are there different quality and/or accountability measures for these providers?

Response: We recommend that the primary care payment reforms be implemented as a complement to a SSP contract. As such the applicable quality measures would be those that are part of the SSP program, and these typically include measures that are specific to pediatric care processes and outcomes.

30. Do payer partners need to use the same utilization and quality measures as CMS?

Response: In CPC+, payers are encouraged to align but are not required to do so.

31. Will quality measures be used to calculate performance based incentive payments?

Response: The CPC+ model for Medicare requires that providers achieve performance targets in order to retain their performance based incentive payments.

Federal Considerations

32. What will happen if we make payment reform changes and the White House introduces new programs that make this impossible?

Response: If the national landscape changes such that these payment reforms are not possible, they would need to be adjusted or discontinued. Regardless of the national landscape, payment reforms that focus on value will continue to be needed.

PCPM Participation

33. What is the current status of Connecticut in regards to payment reform? How about in relation to the national current status?

Response: Many payers nationally have moved toward value-based payment models and especially shared savings program models. Connecticut's payers have also adopted these models on a relatively wide scale consistent with the national trend. However, there is much variability from state to state. The proposed primary care payment reform is intended to complement the shared savings program models by providing more money up front to primary

care practices and giving them more flexibility in how they serve their patients. This flexibility is not permitted in the current FFS payment environment.

34. Is the objective of payment reform recommendations to mirror the CPC+ program?

Response: Payers are encouraged to adopt a model that is similar to the CPC+ program. They are not required to mirror CPC+.

35. If the State recommends a specific payment model, would all payers implement the same model design throughout the State?

Response: Even if the SIM Practice Transformation Task Force recommends a particular primary care payment model, payers will not be *required* to implement the recommended model.

36. Will individual consumers (who purchase their insurance) have the opportunity to participate in any of the primary care payment reform programs?

Response: This depends on whether the payers that choose to participate in primary care payment reform, whether through CPC+ or otherwise, decide to include consumers that purchase coverage on the individual market. There are two commercial payers that offer products on the health insurance exchange and we do not yet know whether they will participate for any of their insurance products (individual, employer, Medicare Advantage).