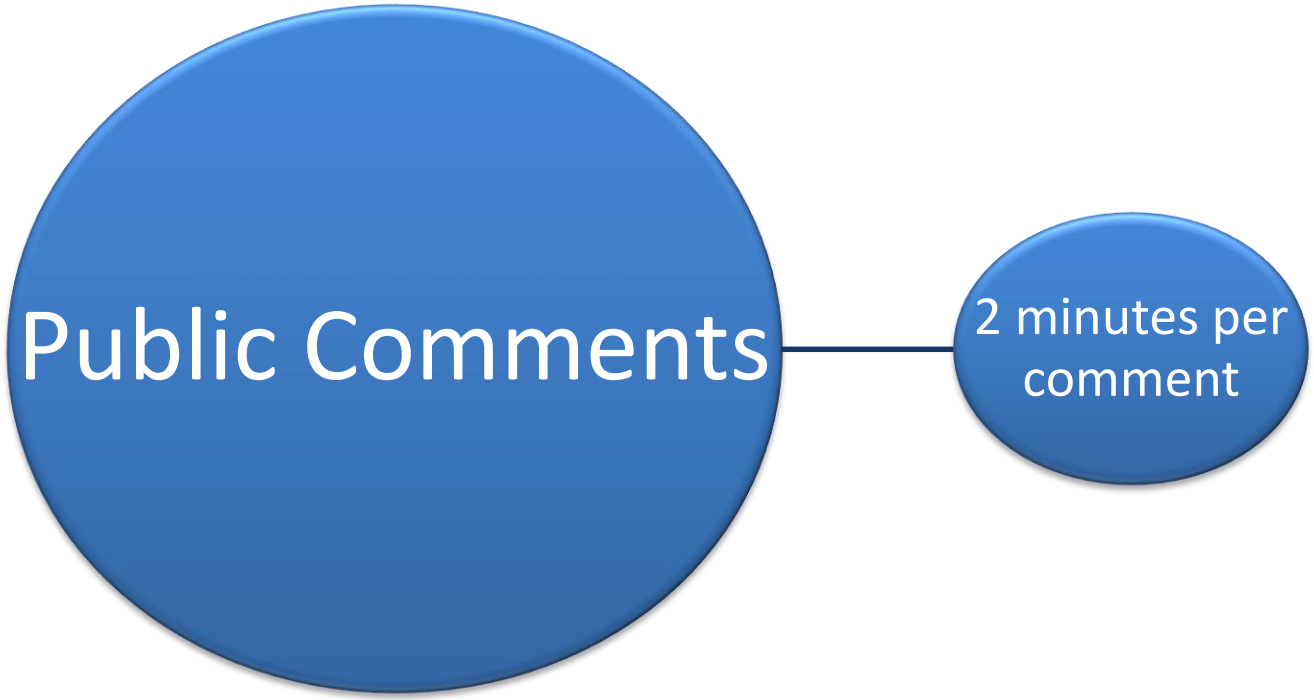
Practice Transformation Task Force

Primary Care Payment Reform

March 21, 2017

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of the Minutes	5 min
4. Primary Care Payment Reform Update and Discussion	95 min
8. Next Steps and Adjourn	5 min


Public Comments
2 minutes per comment

Approval of the Minutes

Primary Care Payment Reform Update and Discussion

Objectives of Today's Discussion

- Review Primary Care Payment Models
- Discuss Stakeholder Interview Findings
- Consider Pros and Cons of the various Payment Models
- Respond to and discuss questions about Primary Care Payment Reform

Discussion Preview

1. Should we recommend primary care payment reform?
2. Should we recommend a particular model?
3. Should we recommend that payers join CPC+? Is CPC+ the best way to get Medicare on-board?
4. Should the reform increase our investment in primary care?
5. How do we ensure that reforms don't result in higher costs for consumers, employers and taxpayers?
6. How do we ensure that consumers don't have higher out of pocket costs?
7. How do we make sure sicker patients are protected?
8. How do we make sure our investments are well spent?

Primary Care Payment Reform Review

PCPM Review- Dr. Neil's Primary Care Practice

What does Dr. Neil want to do?

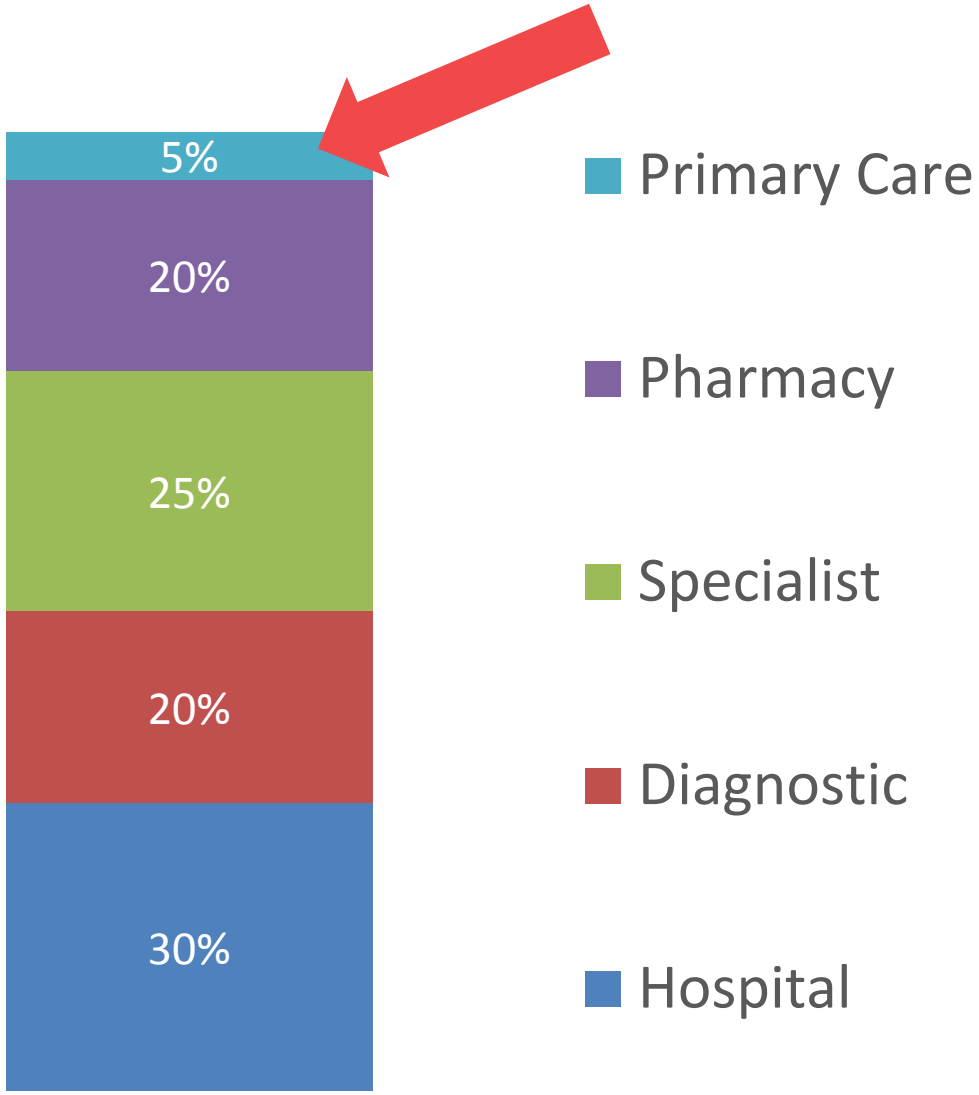
Patient Engagement and Support	Care Team Diversity
Phone contact	Nurse care manager
E-mail/text support	Social Worker
Telemedicine visits	Licensed BH clinician
Home visits	Pharmacists
E-consult	Nutritionist/dietician
Remote monitoring	Care coordinator (community health worker focus on community linkages)
Group visits (illness self-management, prevention, lifestyle enhancement)	Health coach (community health worker)
Tweet/chats/on-line support groups	Patient navigator
Patient/family advisory council	
Communication with child care/school	
Transportation	

Why can’t Dr. Neil deliver care in the way she would like?

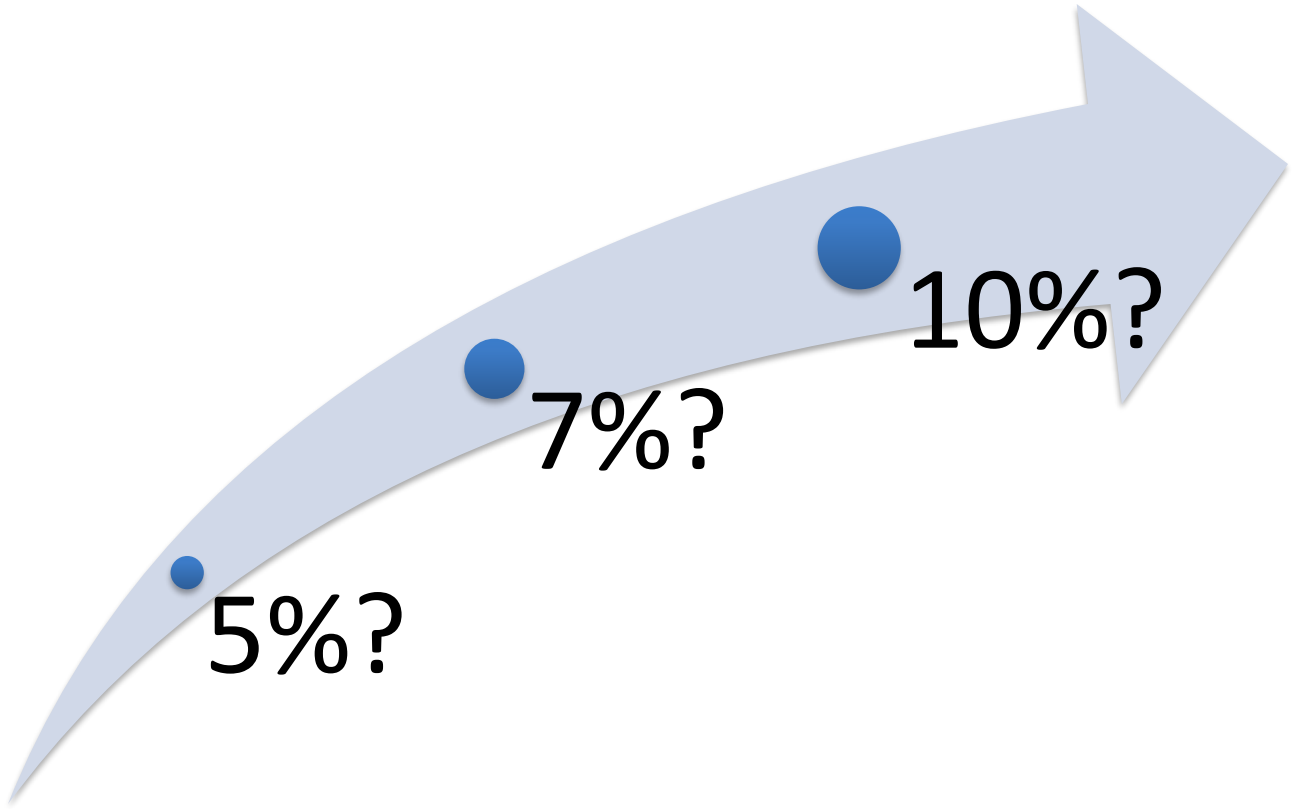
Primary Care Providers are limited in the way they can deliver care due to:

- **Low investment** compared to other areas of healthcare
- **Low flexibility** on how they can use their payments for care delivery

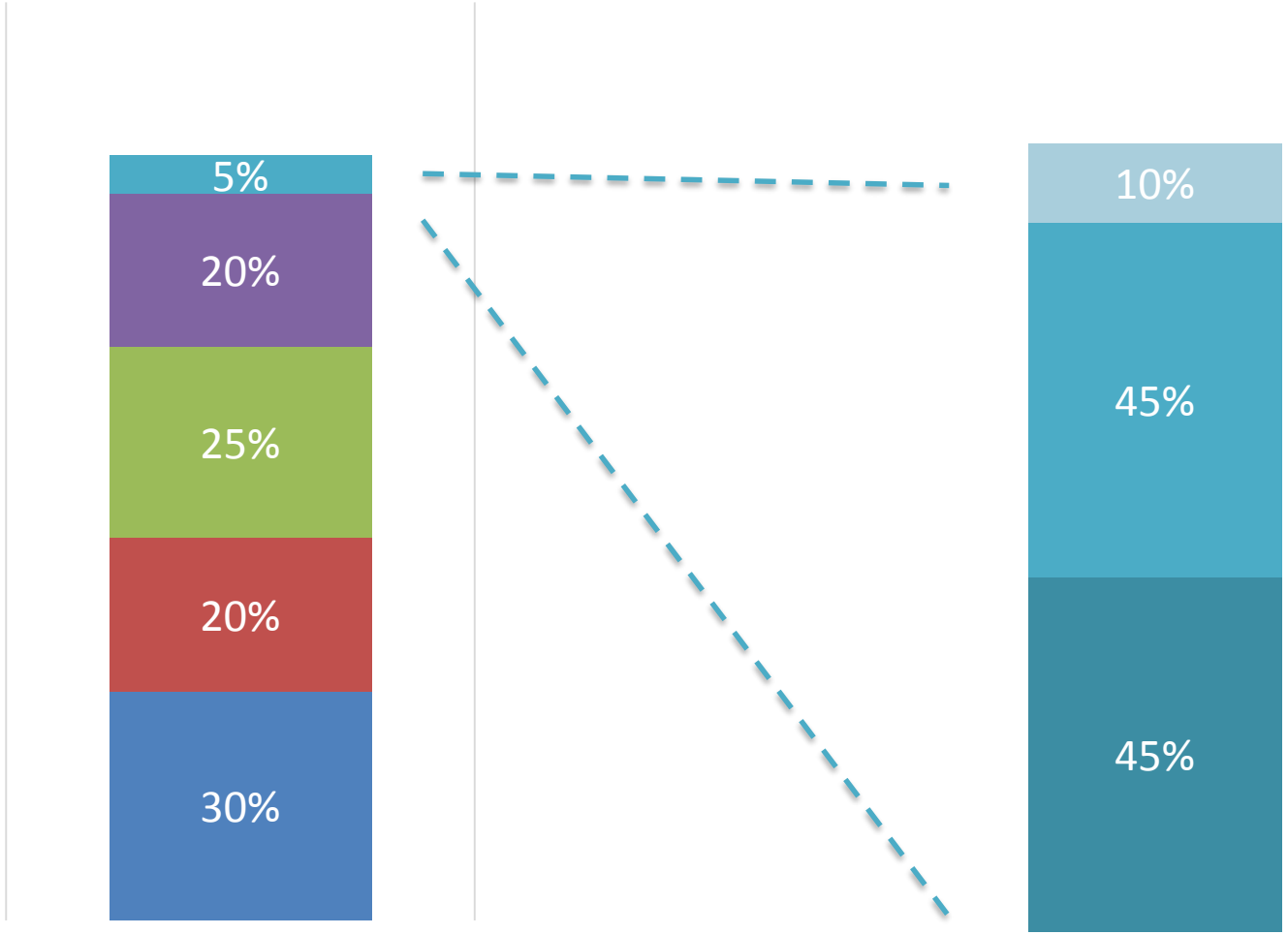
What % of healthcare spending goes into Primary Care?



How much should we be paying for primary care?

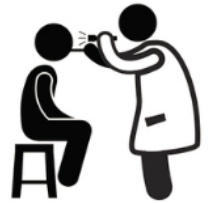


How do Primary Care Providers typically get paid?

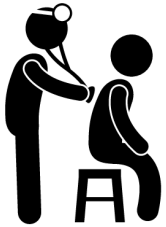


- Other Services (e.g. procedures, immunizations, labs)

- Sick Visits (Acute and Chronic Visits- E&M)



- Wellness Visits (Preventive)



QUALIDIGM

How has Dr. Neil gotten paid for most of her career?

Category 1

Fee for Service – No Link to Quality & Value

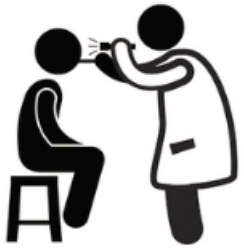
\+ Low Risk

\- No up front payments

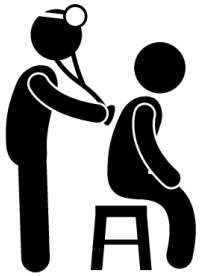
\- Only 5% Healthcare spending on Primary Care

\- No Flexibility

Types of Payment



Each Sick Visit



Each Wellness Visit

Each service like Immunizations

How flexible?

Only paid for visit-based services

How does Dr. Neil currently get paid?

Category 2

Fee for Service – Link to Quality & Value

+A little flexibility

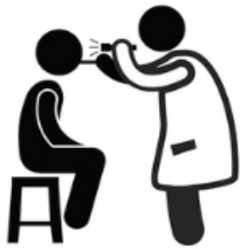
+ Low Risk

+ May have up front or enhanced payments

+ /- May increase Primary Care spending

- Flexibility limited

Types of Payment



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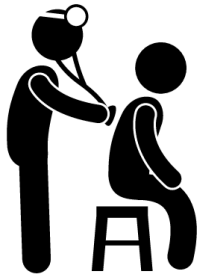


Each Wellness Visit

Each service like Immunizations

Bonus Payments for Quality Care- **received after end of the year**

How flexible?

Bonus Payments can support non-visit based activities and care coordination staff, but bonuses typically limited in amount, long wait and not guaranteed

How might Dr. Neil get paid?

Category 3

APMs Built on Fee-for-Service Architecture

+More flexibility

+ Low risk if upside only

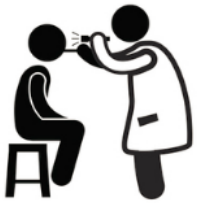
+ May have up front payment

+ Rewards cost control

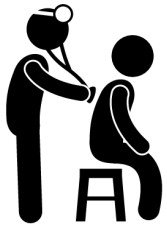
+ /- May increase Primary Care spending

- Flexibility limited

Types of Payment



Each Sick Visit



Each Wellness Visit

Each service like Immunizations

Shared Savings Payments for Quality & Cost- **Received after end of the year**

How flexible?

Shared Savings can support non-visit based services like email, and staff like care coordinators, CHWs and BH specialists. However, focus on near term ROI, long wait to receive rewards, and not guaranteed

How would Dr. Neil like to get paid?

+Most flexibility through bundled payments

+ Partial payment up front - no need to wait for shared savings or bonuses

+Can be used to increase Primary Care spending as part of primary care bundle

+Increased flexibility

- May be more risk depending on scope (all primary care or only selected services) and amount of bundle

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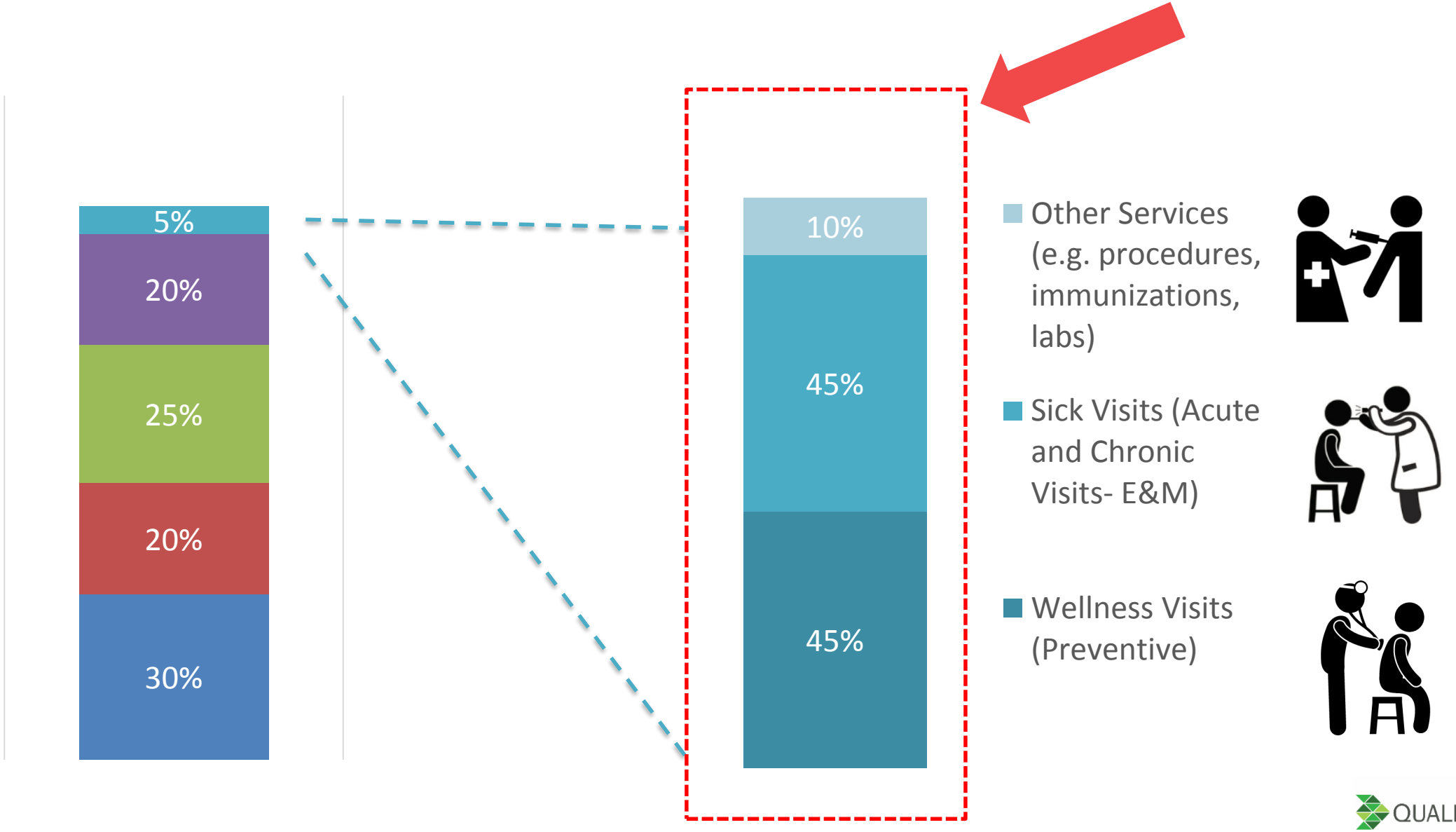

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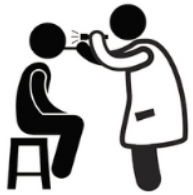
Option 1: Partial E&M (Sick Visit) Bundle

Types of Payment

Care Management Fee– **Up front, flexible**

Other Services like Immunizations



E&M (Sick Visit) Partial Bundle- **Up front, flexible**

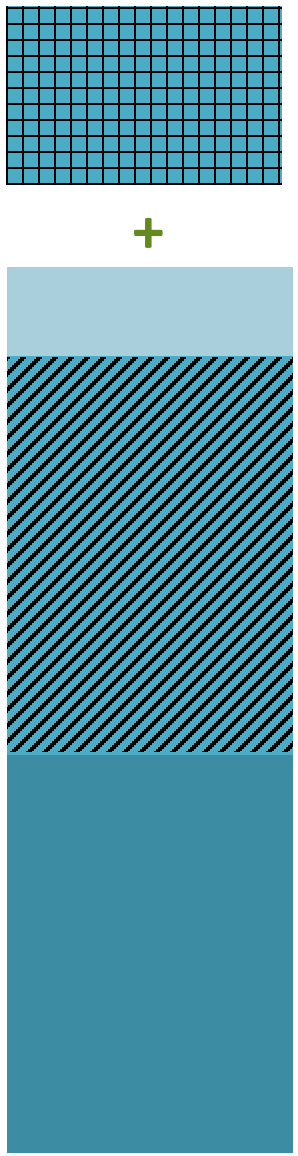
E&M- Each Sick Visit- lower amount

Each Wellness Visit

How flexible?

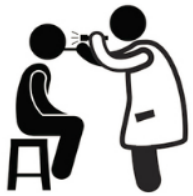
Up-front, flexible payments can support email, telephone, video & group visits; home visits; CHWs, BH specialists, and other staff. Some flexibility to support non-visit based care.

Option 2: Full E&M (Sick Visit) Bundle



Care Management Fee– **Up front, Flexible**

Other Services like Immunizations



E&M (Sick Visit) Bundle- **Up front, Flexible**

~~E&M Each Sick Visit lower amount~~

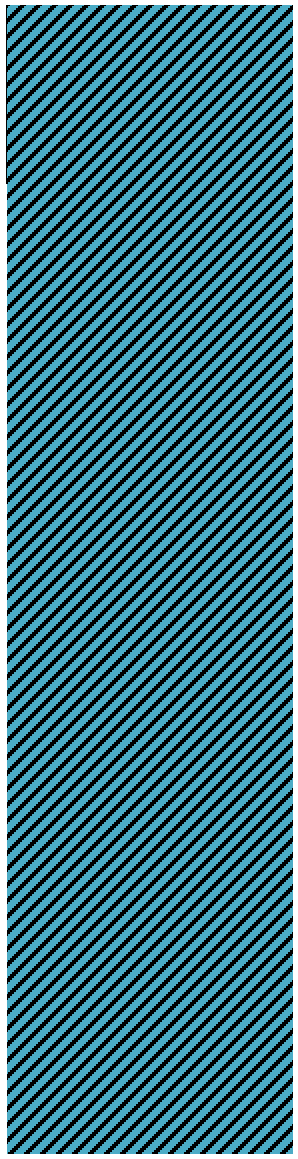
Each Wellness Visit

Types of Payment

How flexible?

Up-front, flexible payments can support email, telephone, video & group visits; home visits; CHWs, BH specialists, and other staff. Even more flexibility to support non-visit based care. Potential for visit under-service.

Option 3: Full Primary Care Bundle



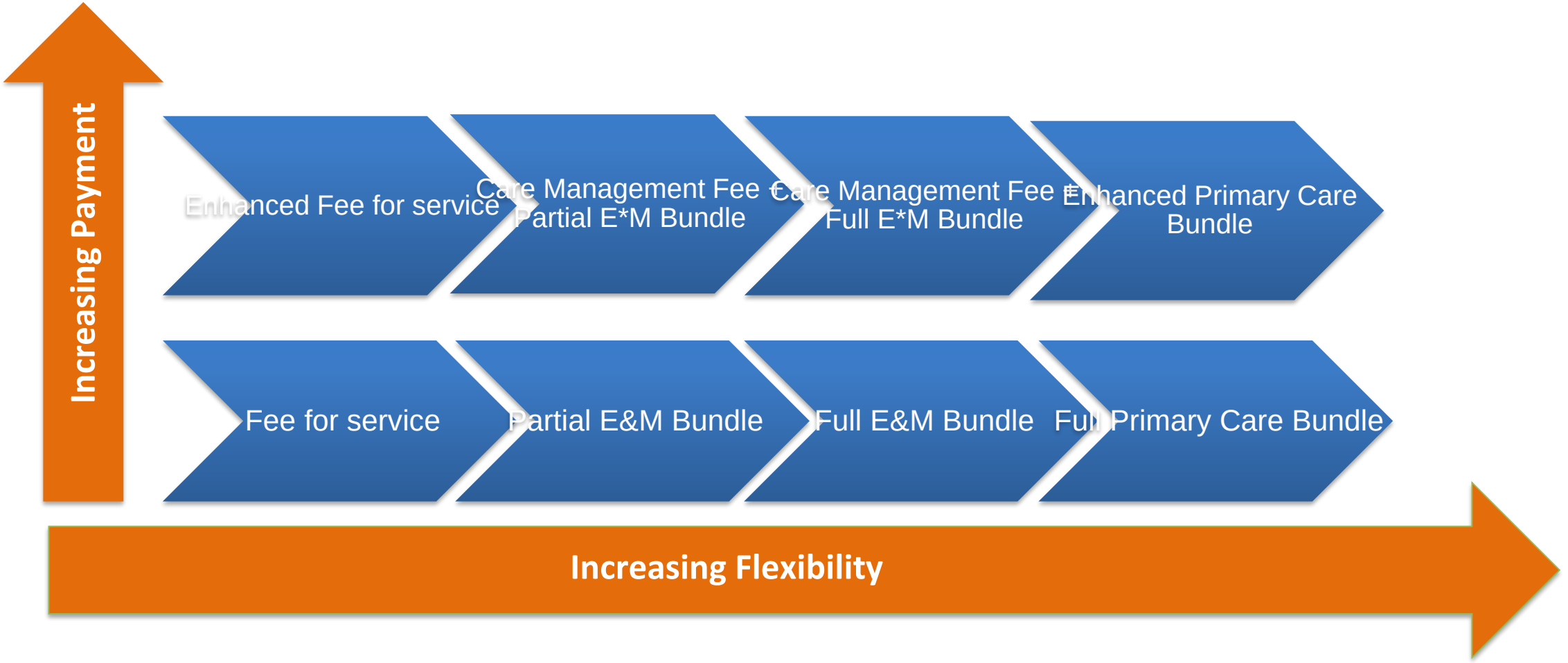
Types of Payment

Full Primary Care Bundled Payment- Up Front, Most Flexible

How flexible?

Payments can support any services, activities or staff to support patients. This is the most flexible model. Potential for under-service

The Range of Primary Care Payment Reform Models



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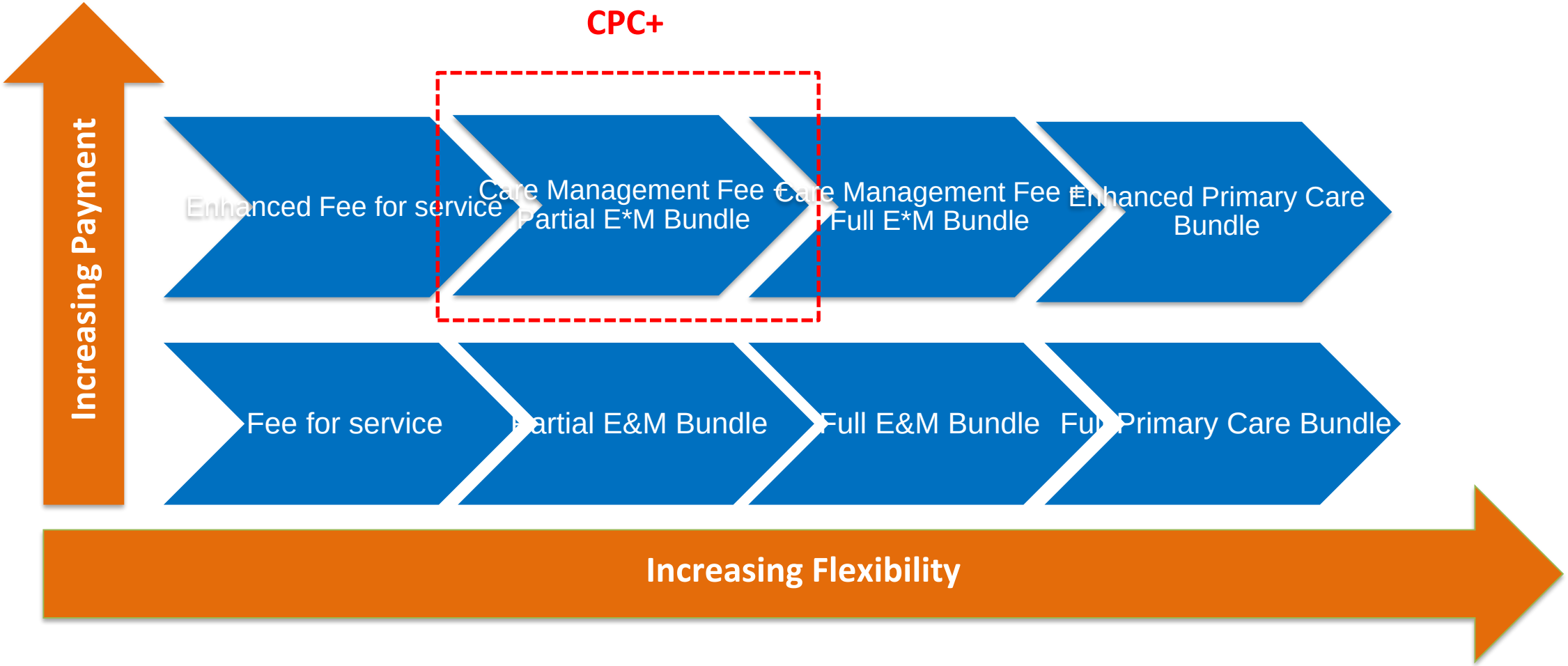
Comprehensive Primary Care Plus (CPC+)- Where does it fall?



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New Primary Care Payment Reform Opportunity- CPC+

- CPC+ is a federal opportunity for states or regions of states to participate in a Primary Care Payment Reform model
- CPC+ **includes Medicare participation** (which can often be difficult to get), and encourages **all payers to participate**:
  - Why? Because Primary Care Providers don't want to only provide telephone calls to patients with one type of insurance, or only offer a CHW to a patient with one type of insurance
- Primary Care Payment Models require up-front funding, with the idea that the system will save money over time. **CPC+ could help the state with some of that funding**.
- CPC+ is flexible in its requirements, which could enable us to make **strong recommendations** regarding the model that would **most benefit CT consumers**

Stakeholder Feedback

Current CT Primary Care Environment

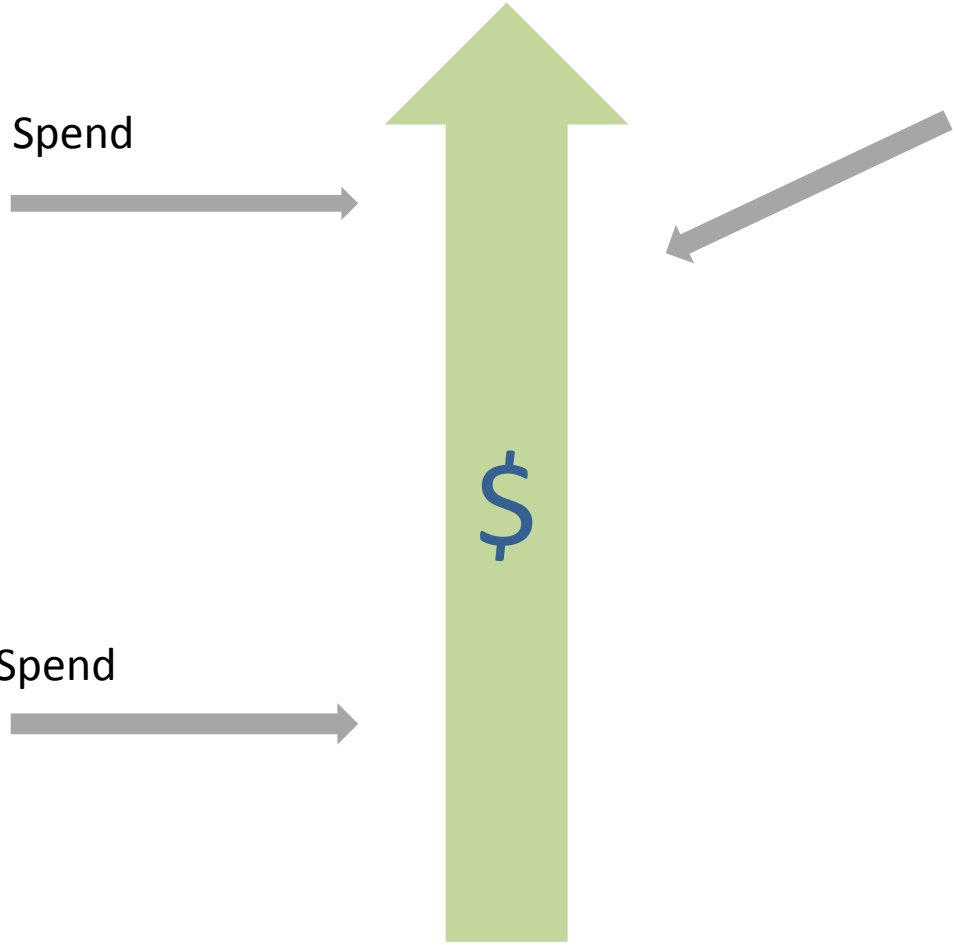
Care Team Composition

	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	✓✓	✓							

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	✓	✓	✓	✓	✓			✓				

Need to Spend



Current Spend

Care Team Composition

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Multi-Hospital Systems	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓✓	✓			✓
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Solo Practitioners	✓✓	✓							

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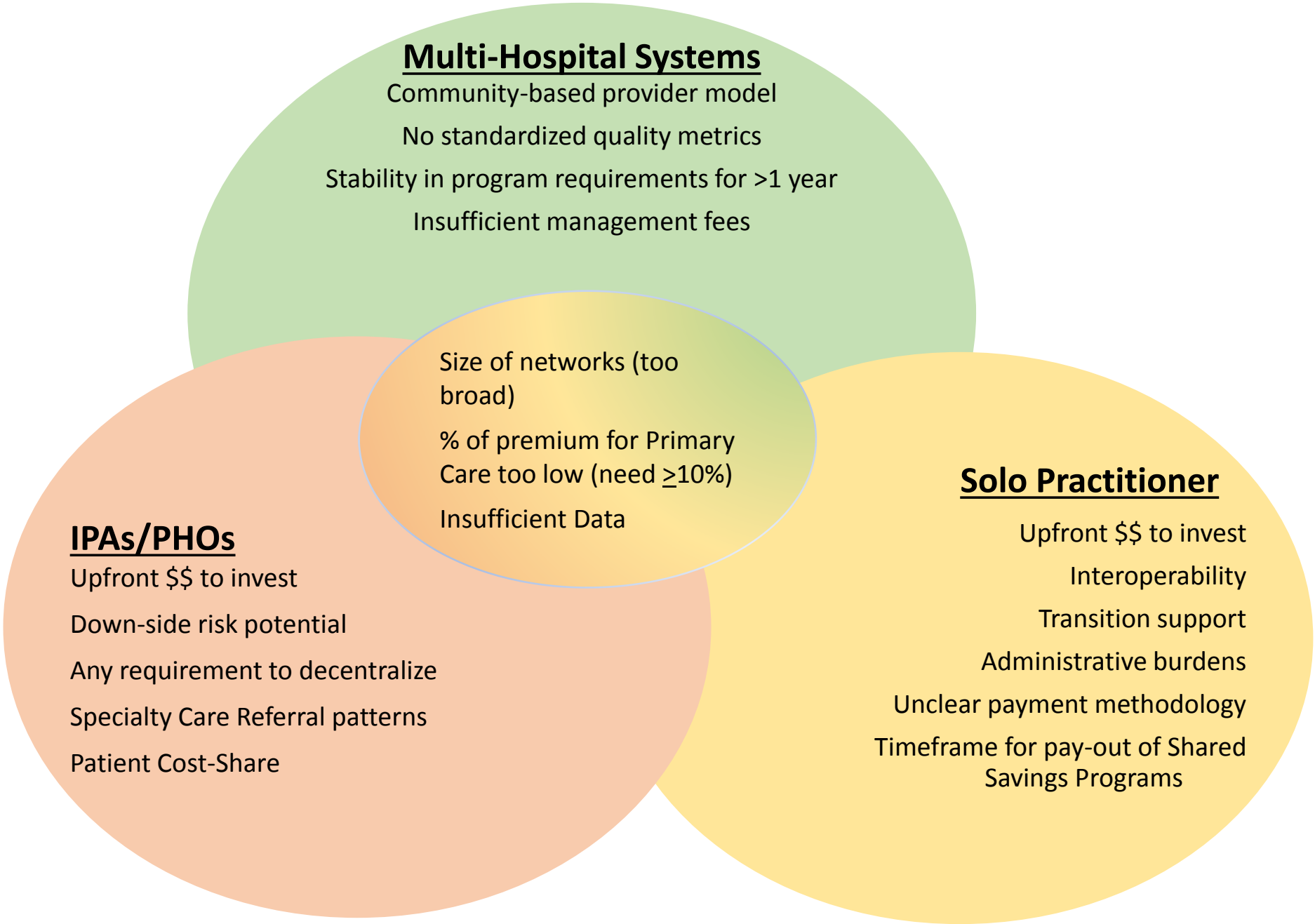
IPAs/PHOs		✓	✓	✓✓	✓✓		✓	✓✓				
Solo Practitioners	✓	✓	✓	✓	✓			✓				

Learnings from CT Provider Stakeholders - Barriers to Primary Care Reform



Learnings from CT Provider Stakeholders
What they're thinking about PCPM reform

"I would give my eye teeth for a social worker in my practice"

"I'm not looking to negotiate fee schedules, I'm looking to get paid for quality care"

"CCIP standards are great and we support them but the grant is insufficient to sustain the standard of care"

"FFS is unsustainable; we must transform payment models and care"

"Primary care providers should be encouraged to provide non-billable services, (e.g., email, group visits)."

"Providers in other markets are *'swimming in happiness'* with the CPC+ experience"

"Adding BH has been transformative for the practices where its embedded"

Payer Perspective

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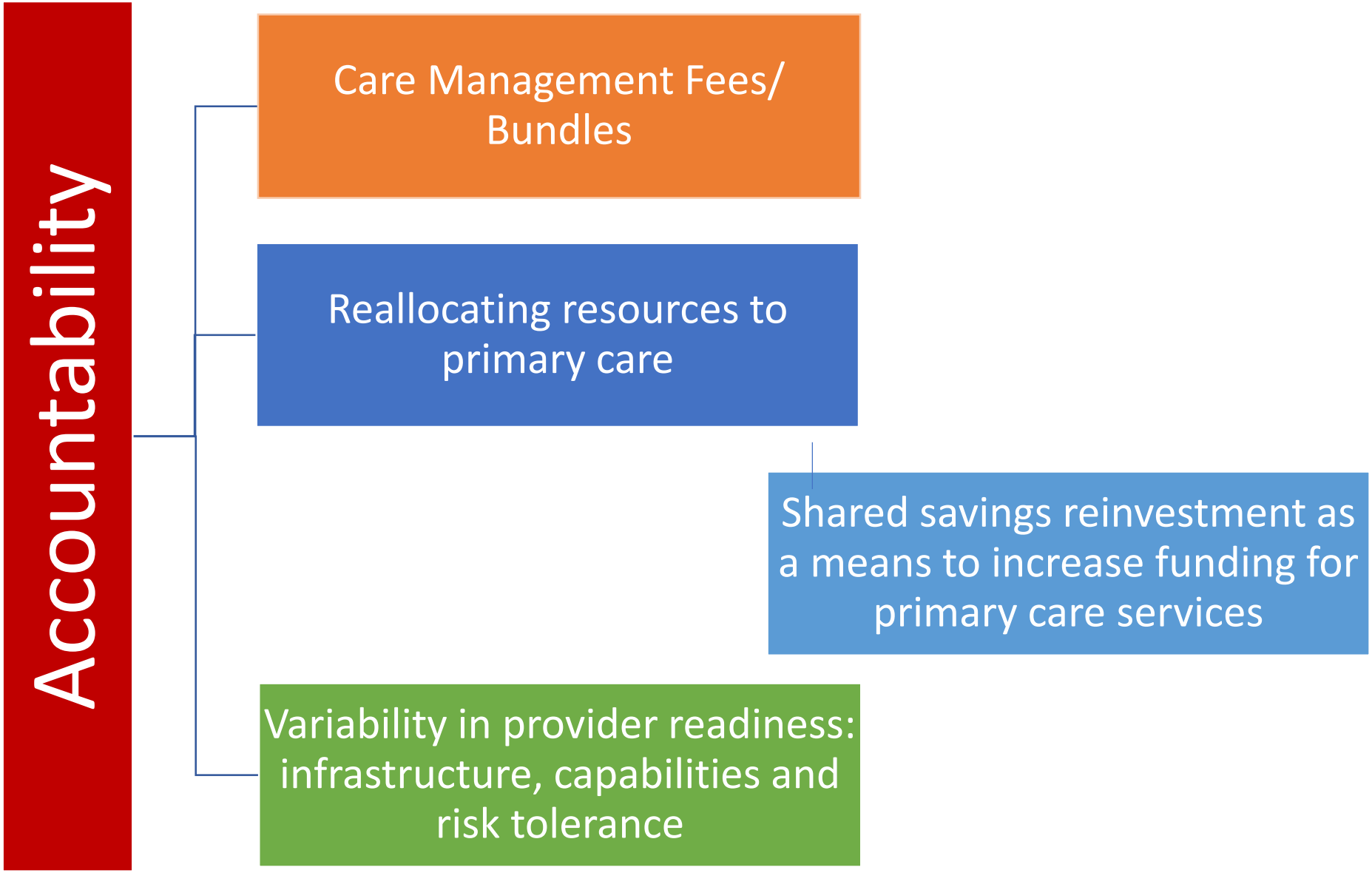

Consumer Perspective

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- Increased “touches” with primary care team
- Care team diversity with CHWs
- Easier and more convenient access
- Enhanced care services and coordination
- Prevention focus
  - < E.g., healthy lifestyle focus
- Opportunities for BH integration and care coordination
- Focus on measuring quality

- How will you know the impact on consumers?
- Will consumers pay more?
- What will be the impact on individuals with complex or rare conditions? Pediatric specialty care concerns
- Are providers ready? Won’t they need support?
- Can providers take on financial risk?
  - < Underservice risk?
- What will be the impact on independent practices?

Accountability

Summary of Pros and Cons

How might these models affect consumers?

Option 1: Partial E&M bundle with Risk-adjusted Care Management Fee	Option 2: Full E&M bundle with Risk-adjusted Care Management Fee	Option 3: Enhanced Risk adjusted Comprehensive Primary Care Bundle
Consumers may experience… • **More "touches" with primary care team** between office visits • "Touches" with **coaches and navigators** recruited from their own community • **Easier communication** with clinician by phone, e-mail and video resulting in less missed work, transportation and childcare barriers • Fewer office visits which means **lower out of pocket costs** • Care team members may be able to do **home visits** as needed • **Easier time finding a 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 **Care Management Fee payments are risk-adjusted** • Better support for **care transitions** • Because usual primary care services have at least partial FFS reimbursement, there is **no risk of under-service**	All of the benefits of Option 1; however, there is likely to be more of a willingness on the part of the primary care team to reduce unnecessary visits and engage patients through phone, e-mail, and video visits; the risk of under-service is minimal because providers still have to submit "no-pay" claims for visits	All of the benefits of Option 2; however; there may be a slightly bigger risk that providers may avoid some test and procedures that are part of the bundle; however, this may be mitigated by a requirement that providers submit no-fee claims for all formerly billable services so that utilization can be monitored; also some procedures/tests should remain FFS

Provider Considerations

Option 1: Partial E&M bundle with Risk-adjusted Care Management Fee	Option 2: Full E&M bundle with Risk-adjusted Care Management Fee	Option 3: Enhanced Risk adjusted Comprehensive Primary Care Bundle
Providers will find that higher revenue through Care Management Fees makes it possible to **hire a more diverse care team to meet a range of patient needs**; the E&M bundle will reduce the cost of doing more of their work with patients by phone, e-mail, or video; clinicians will **reserve office visits for sicker patients** and they will be happier about being able to **spend more time working with more challenging patients**; they will be freed up from doing a lot of the patient support work that can be done effectively by lower level professionals; they may enjoy leading a team. Providers **may still feel pressure to avoid a reduction in the time they spend per day doing patient visits** because this will result in a slight reduction in revenue.	All of the benefits of Option 1; however, providers will feel less pressure to maintain visit volume because all sick visit revenue is bundled; they will conversely feel they have more freedom to innovate. They may feel that E&M bundle introduces more risk, unless the bundle is risk-adjusted	All of the benefits of Option 2; total flexibility to meet consumer needs in new and innovative ways; however, the practices may be concerned about taking on some primary care risk, even if risk-adjusted

Payer Considerations

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Payers (and employers and consumers) will welcome **primary care flexibility, which should lead to happier consumers, happier providers and lower total cost of care**; however, **they may worry that premiums will rise in the near term** in order to cover additional Care Management Fee payments; they may want to introduce or raise the Care Management Fee payments slowly so that they can ensure that there is a return on investment and avoid an impact on premiums; payers **may find the partial E&M bundle difficult to administer** because of the need to pay reduced fees to attributed patients; payers will worry about how the additional dollars are spent and **will expect performance measures and also that providers report how money is spent** and how practice is changing (CPC+ provides a good model for this).	Same as Option 1 except that the full E&M bundle will require that they process and track no fee claims for E&M visits.	Same as Option 1 except that the full E&M bundle will require that they process and track all claims.

Questions for Discussion

Discussion- Considerations for Specific Populations

- Patients with Rare Diseases
- Pediatrics

Discussion

1. Should we recommend primary care payment reform?
2. Should we recommend a particular model?
3. Should we recommend that payers join CPC+? Is CPC+ the best way to get Medicare on-board?
4. Should the reform increase our investment in primary care?
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Discussion

1. Should we recommend primary care payment reform?

Discussion

2. Should we recommend a particular model?

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Discussion

3. Should we recommend that payers join CPC+? Is CPC+ the best way to get Medicare on-board?

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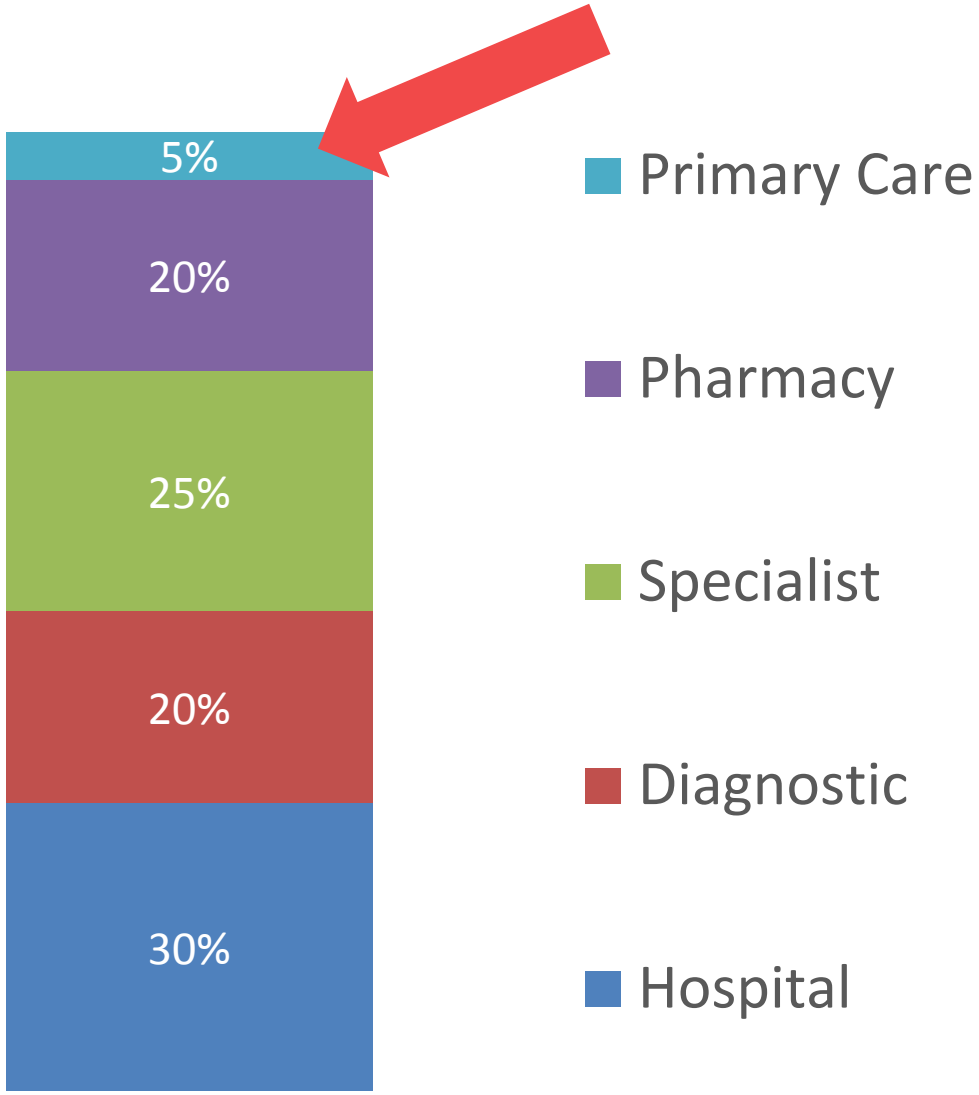
- CPC+ is flexible in its requirements, which could enable us to make **strong recommendations** regarding the model that would **most benefit CT consumers**

Discussion

4. Should the reform increase our investment in primary care?

What % of healthcare spending goes into Primary Care?



Discussion

5. How do we ensure that reforms don’t result in higher costs for consumers, employers and taxpayers?

How can we increase Primary Care spending?

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Upfront Primary Care Investment

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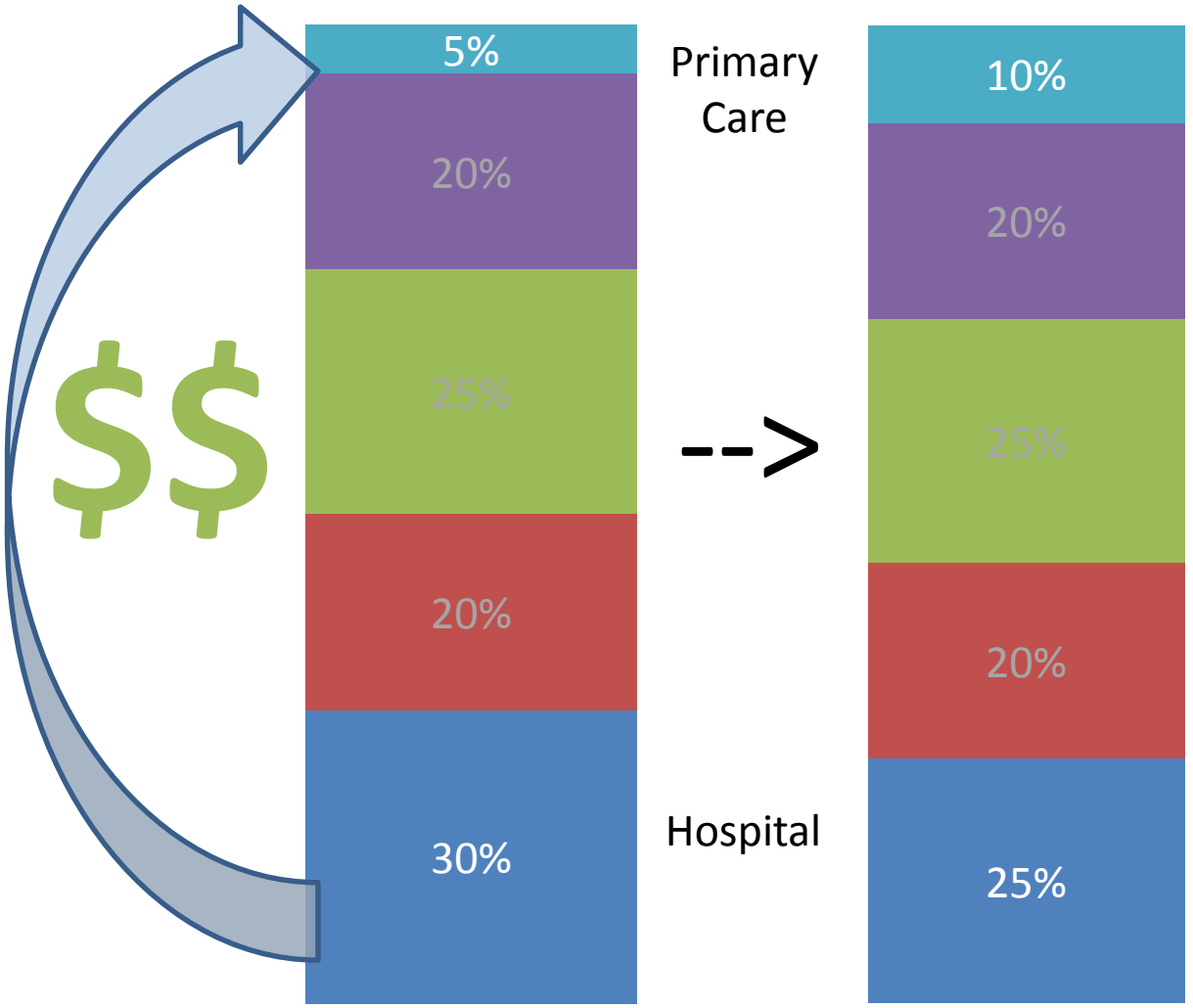
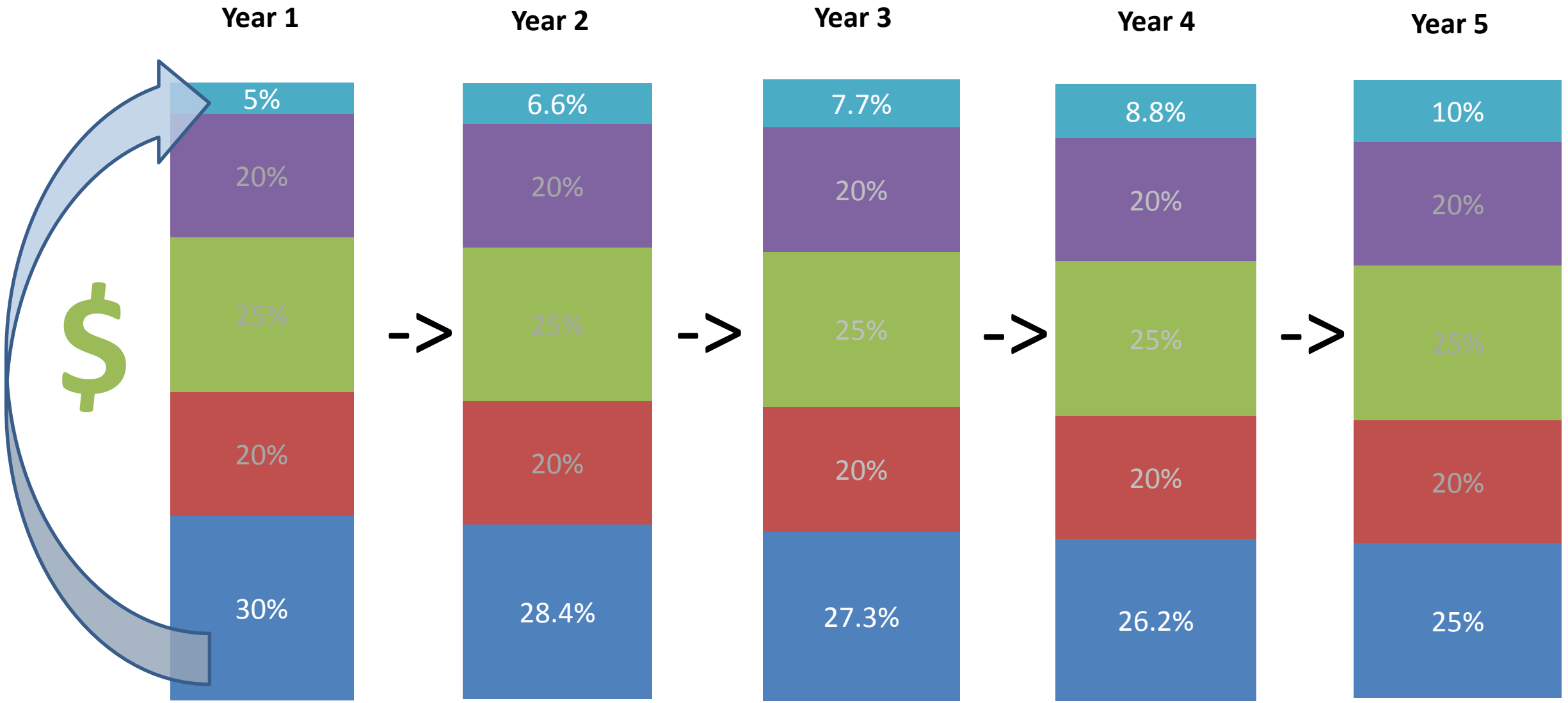
Improved Primary Care Outcomes

Reduced ED Visits and Hospital Admissions

Incrementally over several years

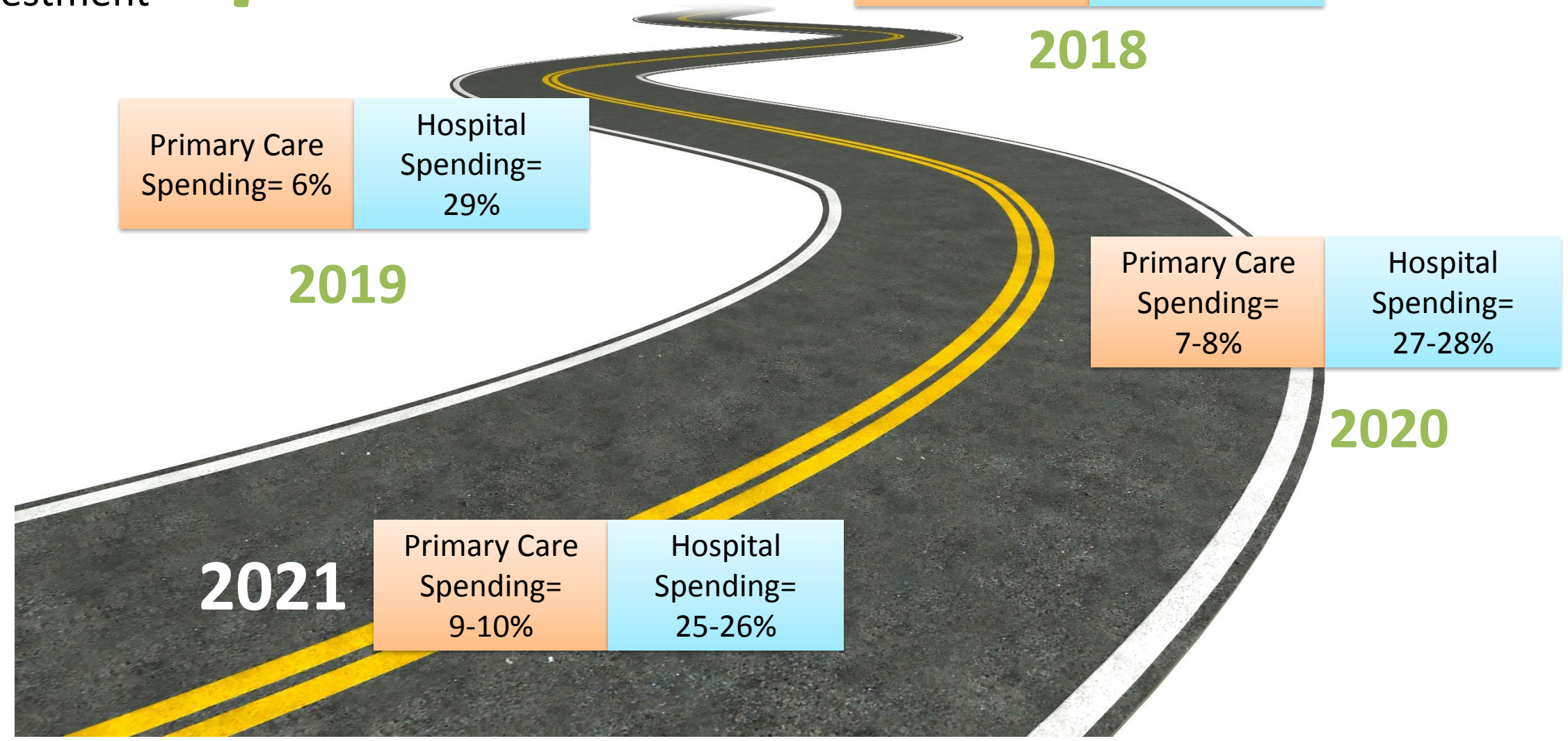


How can we increase Primary Care spending?



The Road to Increasing Primary Care Spending

Upfront Primary Care Investment



Primary Care Spending= 5%	Hospital Spending= 30%

2018

Primary Care Spending= 6%	Hospital Spending= 29%

2019

Primary Care Spending= 7-8%	Hospital Spending= 27-28%

2020

Primary Care Spending= 9-10%	Hospital Spending= 25-26%

2021

Discussion

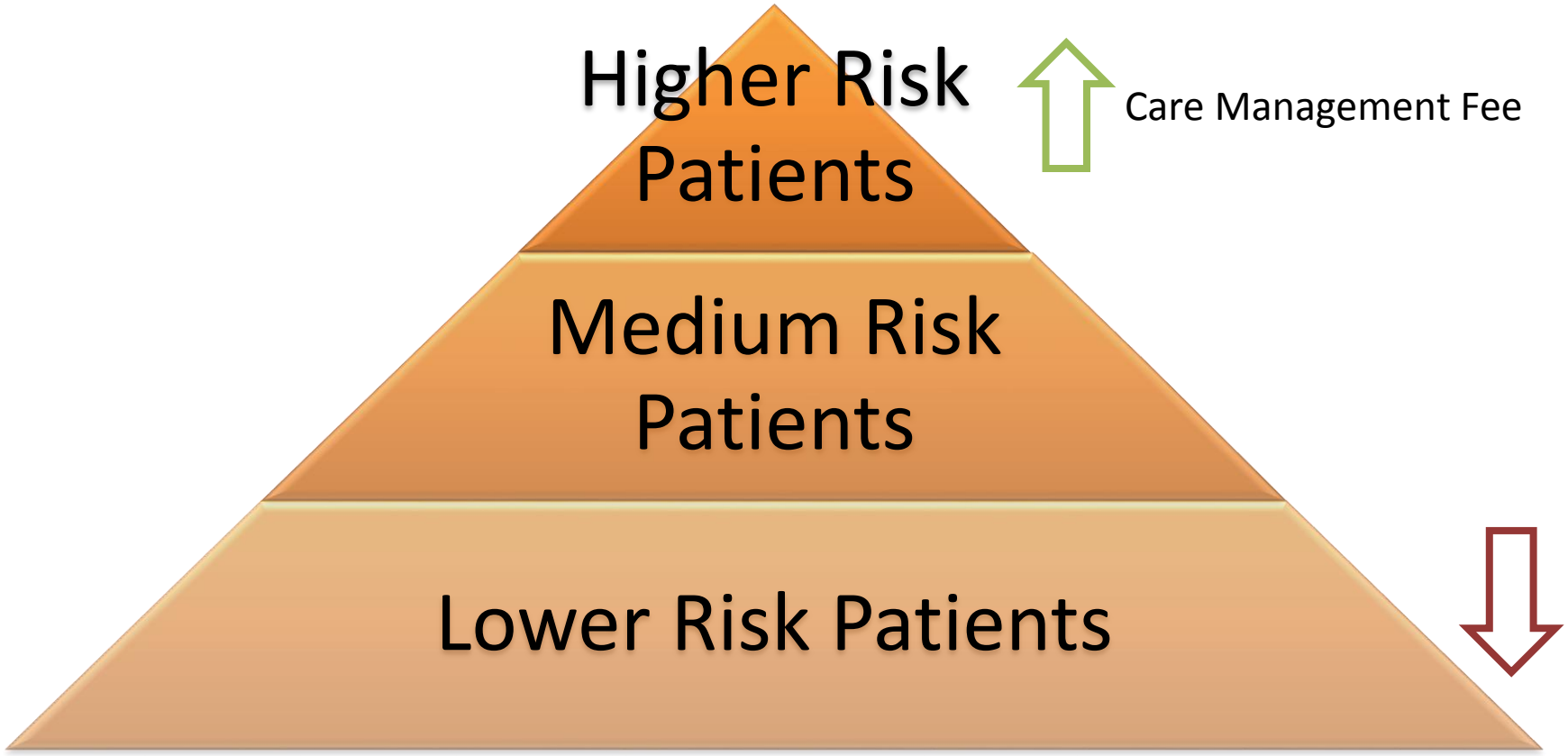
6. How do we ensure that consumers don’t have higher out of pocket costs?

Discussion

7. How do we make sure sicker patients are protected?

How do PCPMs account for sicker and healthier patients?

Risk Adjusted Care Management Fees



Discussion

8. How do we make sure our investments are well spent?

How can providers be held accountable?

Payer Review

Provider Submits to Payer

Report on Measures like Diabetes A1c and Blood Pressure Control

Report on practice changes like hiring of CHWs, adoption of e-visits

Project a budget and report on actual spending

Quality Measure Reporting

Care Delivery Reform Reporting

Budget Reporting