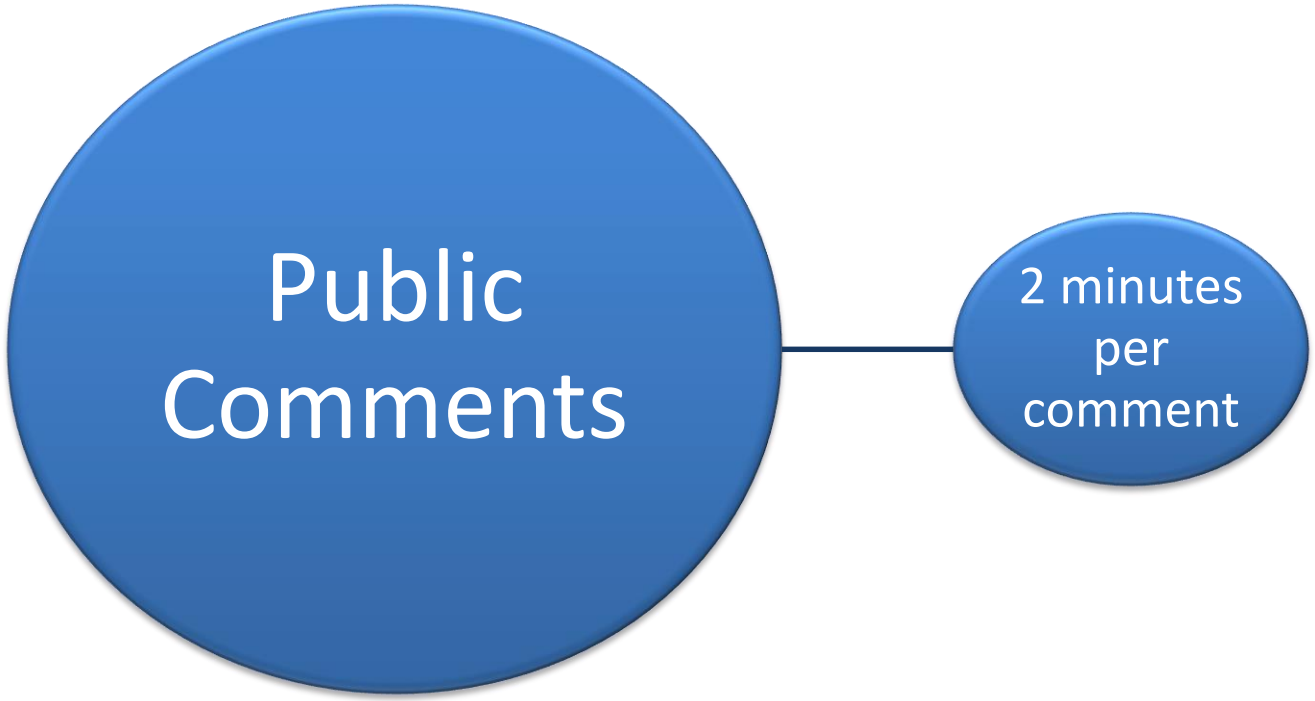
Practice Transformation Task Force

Primary Care Payment Reform

May 9, 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. Purpose of Today's Meeting	5 min
5. PCPM Recommendations Review and Discussion	60 min
6. Next Steps and Adjourn	5 min


Public Comments
2 minutes per comment

Approval of the Minutes

Objectives of Today's Discussion

- Review and finalize PCPM recommendations for inclusion in draft report

PCPM Recommendations

Comments to include in recommendations

The Task Force recognized that it is difficult for practices to re-engineer the way that primary care is provided and expand the team that provides it for only a subset of their panels. Although local or regional leadership of commercial health plans and Medicaid can elect to undertake a payment reform, it is difficult for Medicare to do the same for individual states or regions. Accordingly, one challenge that the Task Force faced is how to ensure that Medicare participates in a primary care payment reform if other Connecticut payers decide to do so. During the course of this work, CMMI released a solicitation for the Comprehensive Primary Care + (CPC+) initiative, in which public and private payers were invited to participate with Medicare in a primary care payment reform. Recognizing the merits of the CPC+ model and the significance of this opportunity to engage Medicare in primary care payment reform, the Task Force recommended that Connecticut's payers apply. This recommendation was ultimately narrowed to include commercial payers only in light of the administration's determination that Medicaid was unable to participate on the timetable required for this solicitation, which ended April 3, 2017.*

*See appendix

Comments to include in recommendations

The Health Care Payment Learning and Action Network (HCPLAN) undertook a comprehensive examination of primary care payment reforms. The HCPLAN convened a Primary Care Payment Model workgroup to undertake this project, which resulted in a white paper published in March of this year. This white paper served as a point of reference for the Practice Transformation Task force in its examination of this topic for Connecticut. In addition to the Connecticut specific recommendations set forth below, the Task Force wishes to acknowledge and endorse the findings and recommendations contained in their white paper entitled Accelerating and Aligning Primary Care Payment Models.

Task Force Recommendations

- ***Does the Task Force recommend primary care payment reform?***
- ***Recommendation 1****: Connecticut's payers should implement primary care payment reform as a means to incentivize non-billable innovations in consumer engagement and expanded care teams.*

- ***Do we recommend a particular model?***
- ***Recommendation 2****: Payers and providers are encouraged to use one of the three models that are the subject of this white paper. However, provider organizations vary in their level of resources and capabilities and may feel that one or another model will best suit the needs of their practices and patients. Accordingly, the choice of which primary care payment model to adopt for a particular provider should be determined by the payer and provider during the contracting process. The payer should offer an incremental* strategy *if practices prefer to build their capabilities over time.*

Task Force Recommendations

- ***How do we ensure that reforms don't result in higher costs for consumers, employers and taxpayers? Should the reform increase our investment in primary care?***
- ***Recommendation 3****: The use of prospective bundled payments and care management fees are important ways to provide practices with the resources and flexibility to achieve the goals of reform. However, such payments should be introduced in a way that does not add to the total cost of care, because such cost increases would ultimately be borne by employers, consumers or taxpayers. Accordingly, primary care payment models should be coupled with an alternative payment model, such as a shared savings program, that rewards practices for controlling the total cost of care.*

Task Force Recommendations

- ***Recommendation 4****: The cost of providing advanced primary care is substantially greater than a typical practice earns today through fee-for-service reimbursement. Accordingly, primary care payment models should use prospective primary care bundles or care management fees to increase the amount of money dedicated to primary care as a percentage of the total cost of care. In order to achieve this increase without adding to the total cost of care, the shared savings program arrangement should provide for the reinvestment of a portion of the savings into the prospective bundles or care management fees each year that savings targets are achieved.*

Task Force Recommendations

- ***How do we ensure that consumers don't have higher out of pocket costs?***
- ***Recommendation 5****: The design of primary care payment models should not increase out of pocket costs. As much as possible, the cost of new services should be included in the determination of the prospective bundled payment, rather than paid fee-for-service as this will ensure that the costs of such services are not subject to the deductible. In addition, providers should not be permitted to charge co-payments for non-billable services such as phone and video communication or services offered by non-billable staff such as community health workers.*

- ***How do we make sure that services are consumer centered and that our sicker patients are protected?***
- ***Recommendation 6:*** *Primary care payment models should ensure that primary care practices reflect patient goals, needs, and preferences in the care plans they develop collaboratively with the patient.*

Task Force Recommendations

- ***Recommendation 7****: Primary care payment models should use risk adjustment to adjust payments to account for underlying differences in the patient populations served by different primary care practices. To the extent feasible, risk-adjustment methods should take into consideration both clinical and social-determinant risks. The risk adjustment and bundled payments with which they are linked should be updated frequently enough to enable practices to support patients whose needs and complexity are increasing.*

- ***Recommendation 8:*** *Fee-for-service payment should still play a limited role as part of a blended primary care payment model; it will be used to incentivize certain services that need to be performed in a face-to-face encounter; promote more efficient, comprehensive primary care; and protect against under-service.*

Task Force Recommendations

- ***Are there particular services or capabilities that our payment models should emphasize?***
- ***Recommendation 9:*** *Primary care payment models should hold primary care practices accountable for, and provide the resources to enable, the management of mental health and substance use services. This recognizes the critical role behavioral health plays in overall health, supports better integration between these services and primary care, and promotes shared accountability at the organizational and clinical levels.*

- ***Recommendation 10:*** *Primary care payment models should maximize the flexibility that primary care teams have to expend resources on health promotion and coordination with community services, including the use of community health workers as care team staff and direct support for community programs that demonstrably address social determinants of health to improve patient outcomes.*

Task Force Recommendations

- ***How do we make sure our investments are well spent?***
- ***<u>Recommendation11</u>:*** *Payers that implement primary care payment models should a) ensure that quality of care is measured and rewarded and b) should employ minimally burdensome methods that are aligned across payers to enable practices to demonstrate that they are investing in and have implemented transformational change (e.g., care team composition, engagement in non-visit-based activities).*

- ***How do we make sure that practices can successfully transform?***
- ***<u>Recommendation 12</u>:*** *To effectively incent and enable practice transformation, primary care payment models should be multi-payer, cover the majority of a practice's patient population, and provide practices with external coaching support and technical assistance.*

Next Steps

Adjourn

Medicaid and CPC+

The communication below represents the position of the Administration as it pertains to Medicaid participation in CPC+. The Administration has carefully reviewed the Comprehensive Primary Care Plus (CPC) solicitation that has been released by CMS, and has decided that for the following reasons, Connecticut Medicaid will not submit a letter of intent:

- The Medicaid program, overall, is facing existential threats associated with proposals to radically re-structure its federal funding, both in present day and over time. The Governor has released a statement (please find attached) that details the anticipated human and fiscal impact of the proposed American Health Care Act. This arises to such a foundational set of concerns that the program must focus concerted efforts on illustrating the value of the current approach, modeling various impact scenarios, and mitigating harm to currently enrolled members.
- It is well documented that the $6 b. Connecticut Medicaid program has achieved many gains since implementation of the Affordable Care Act. In addition to increasing access through eligibility expansion, the program has successfully incorporated diverse care delivery strategies (e.g. Person Centered Medical Homes, Intensive Care Management, health homes), has improved quality indicators and care experience, and has reduced per member per month costs by 1.9% over the four years since migration away from capitated managed care arrangements.
- Under the auspices of the State Innovation Model agenda, the Department of Social Services has just launched PCMH+, a first ever upside only, shared savings initiative for Connecticut Medicaid that explicitly builds upon key planks of the Department's reform agenda - Intensive Care Management and Person Centered Medical Homes. PCMH+ seeks to enable enhanced care coordination activities - notably, behavioral health integration - through both a value-based payment approach and connections with the community-based entities that have capacity to influence social determinants of health. Under PCMH+, participating FQHCs are receiving supplemental care coordination payments that they may use consistent with their own needs and priorities, which may include hiring of community health workers. Development and implementation of PCMH+ has represented a huge lift for the Department. Considerable resources must be brought to bear in overseeing the program and assessing its impact on people and their health and care experience outcomes. Further, it is the opinion of the Administration that this initiative merits time to mature before building in additional strategies.

Medicaid and CPC+

- The Administration, with the endorsement of the legislature, has invested significant financial and in-kind resources in Connecticut primary care practices. These include: 1) PCMH program enhanced fee-for-service payments that totaled almost $6.6 m. in CY'16; 2) PCMH program incentive and year-over-year improvement payments that totaled over $311,000 in CY'15; 3) EHR payments; and 4) in-kind multi-disciplinary practice transformation coaching through the medical Administrative Services Organization, CHNCT. Although it is conceivable that CMS would entertain conversion of a portion or all of the current payments to a bundled payment, that action would require a detailed review of whether this is in the interest of Medicaid members, careful conceptualization, stakeholder review and comment by the Medical Assistance Advisory Council, advance advisory discussion with CMS, and a formal State Plan Amendment process. Further, providers are currently in reliance on receiving these payments under the current terms, and revision may alter their continued willingness to participate. For the above stated reasons, the Department cannot focus its efforts on these actions.
- Finally, the Department is in process of rolling out other, complementary initiatives that will have direct benefit for primary care practices. Most significant among these are discussions with CMS in support of enabling specialists to directly bill for e-consults. Approval of the same will enable primary care practitioners to consult in real time. This is anticipated to help more conscientiously honor appropriate boundaries of the scope of care, reduce the need for follow-up visits, and minimize frustrating experiences with members who fail to participate in scheduled appointments.