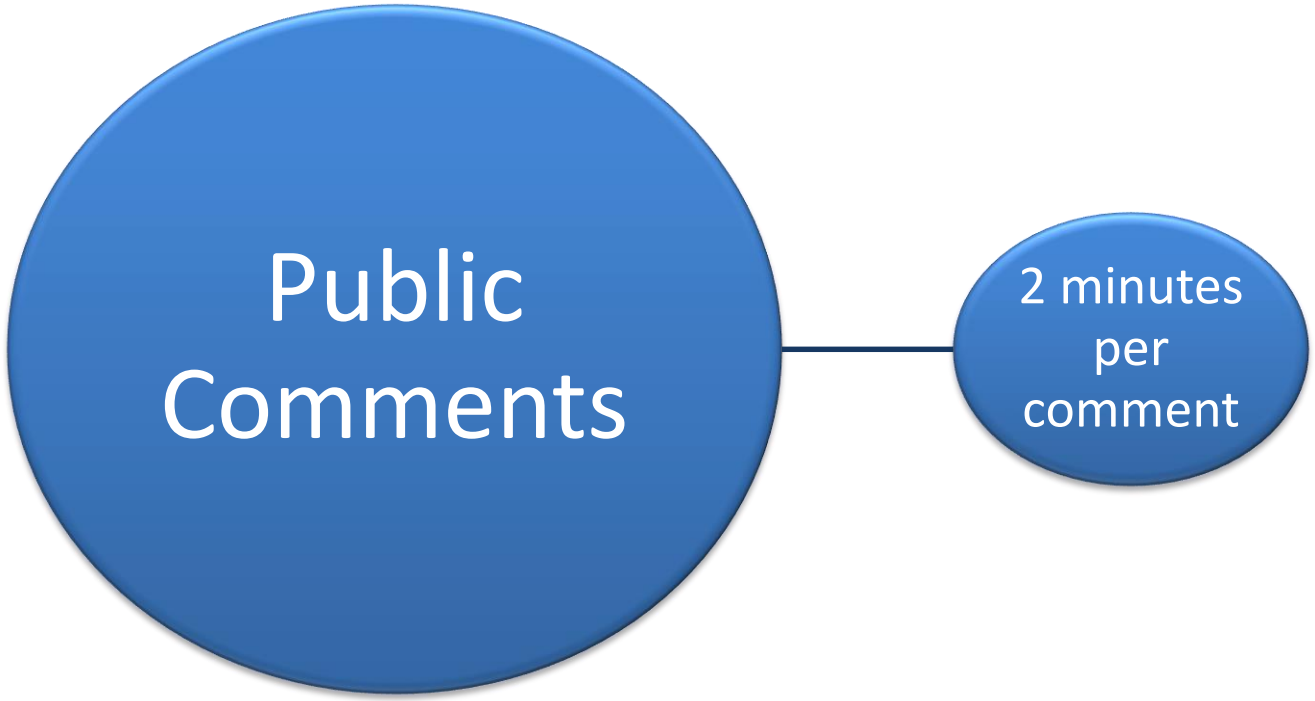
Practice Transformation Task Force

December 12, 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. Review and Discussion of PCPM White Paper	90 min
6. Next Steps and Adjournment	5 min


Public Comments
2 minutes per comment

Approval of the Minutes

Purpose of Today's Meeting

Objectives of Today's Discussion

1. Review the **goals** of the Primary Care Payment Model White Paper
2. Discuss the **components** of the White Paper
3. Respond to and discuss **questions** about the White Paper
4. Plan **additional meeting** to respond to and address additional questions

Review and Discussion of Primary Care Payment Model (PCPM) White Paper

PCPM White Paper Goals

1. Describe how primary care payment reform supports care delivery transformation
2. Demonstrate why current payment reforms in Connecticut are insufficient to support needed care delivery reform
3. Provide historical background and current examples of primary care payment reforms nationally and in Connecticut
4. Offer three concrete primary care payment model options for consideration in Connecticut
5. Present Connecticut payer, provider, and consumer perspectives on needed primary care payment reform
6. Recommend essential elements of primary care payment models considered for adoption in Connecticut (PTTF key recommendations)

High Level Contents

- *Introduction and Purpose of the Project*
- *Background*
- *Investing in Primary Care: Promising New Models*
- *Making Transformation Happen: PCPM Options*
- *Connecticut Stakeholder Perspective*
- *Conclusions and Recommendations*

White Paper Components

Introduction & Purpose of the Project

- SIM Overview
- Advanced Medical Home Program
- Community and Clinical Integration Program
- PCMH+
- Qualidigm's literature review, stakeholder interviews, and PTTF engagement process on PCPM
- PTTF Recommendations

White Paper Components

Background

- Early Payment Reform: 1980s and 1990s including CT experience
- Early Payment Reform and Clinical Innovation- how payment reforms have led to lasting care delivery reform
- The Medical Home Model- how the Medical home has improved outcomes and reduced costs
- Healthcare Payment Learning & Action network- Introduced framework for categorizing payment models and established goals for adopting “Alternative Payment Models” (APMs)

HCP-LAN Updated Framework

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	**A** APMs with Upside Gainsharing	**A** Condition-Specific Population-Based Payment
	B Pay for Reporting	**B** APMs with Upside Gainsharing/Downside Risk	**B** Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

White Paper Components

Background ctd.

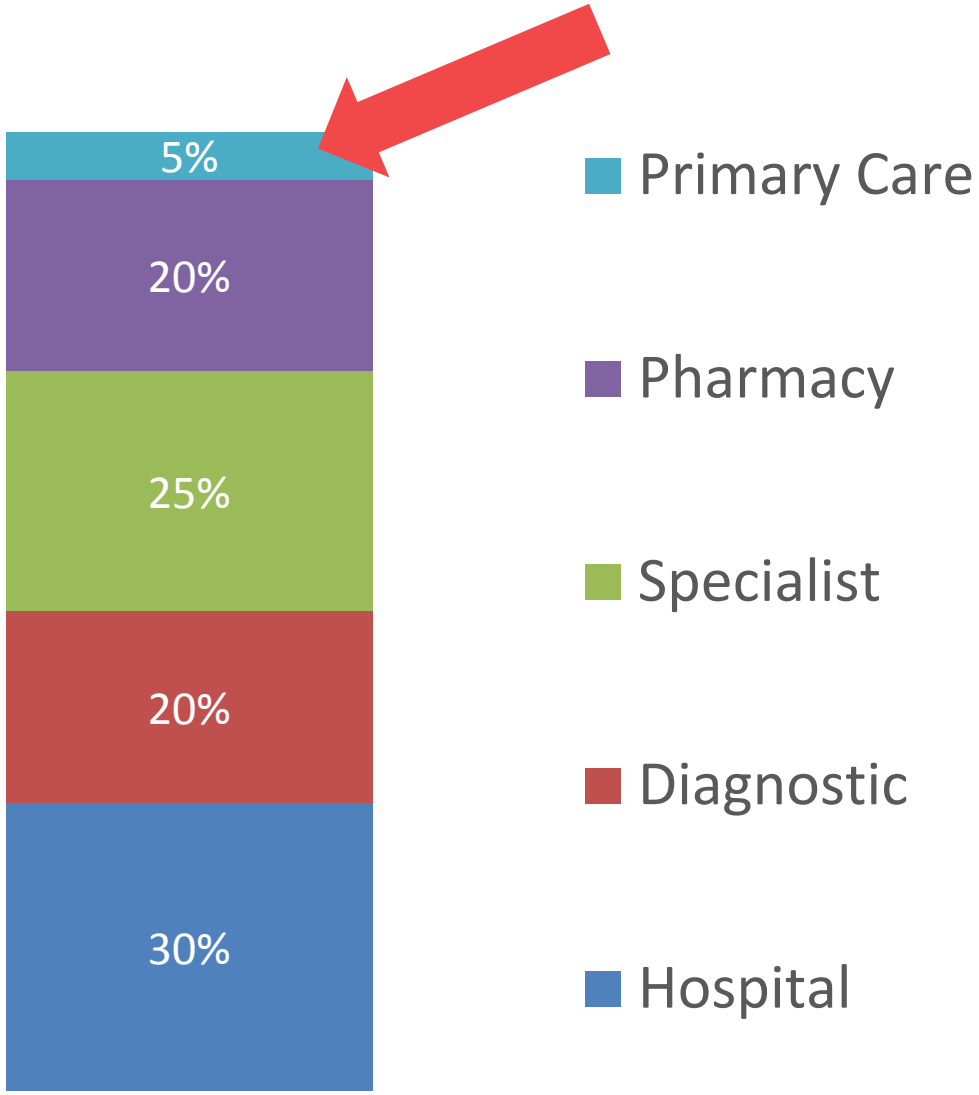
- A Closer look at Primary Care Payment using the HCP-LAN
  - Moving along the spectrum of payment models:
    - **Increases the flexibility of services that primary care payments can support**
    - **May introduce payment enhancements that increase the level of funding for primary care**

PCPM Review- Dr. Neil's Primary Care Practice

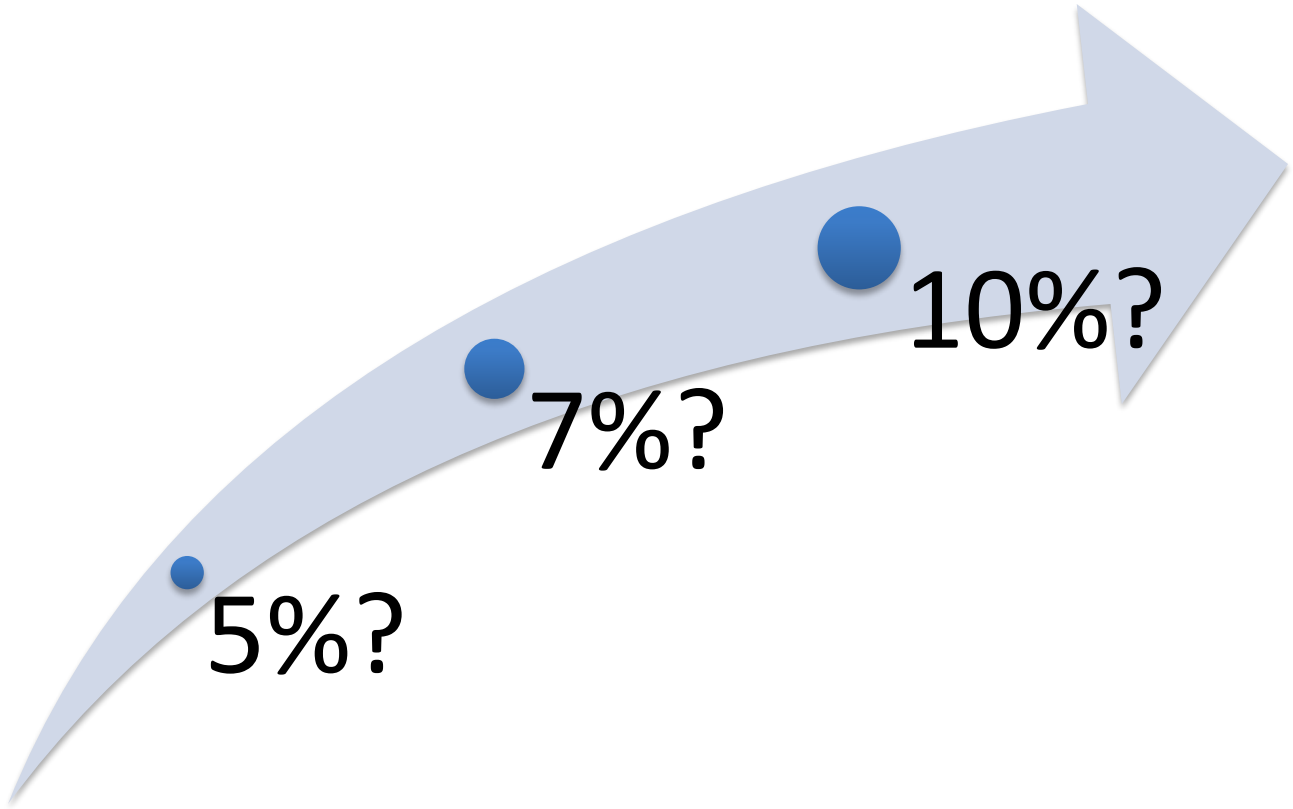
What does Dr. Neil want to do?

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	

What % of healthcare spending goes into Primary Care?



How much should we be paying for primary care?



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

Category 1

Fee for Service – No Link to Quality & Value

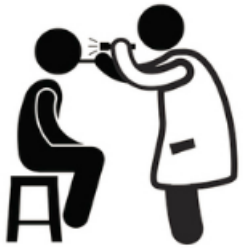
+ Low Risk

- No up front payments

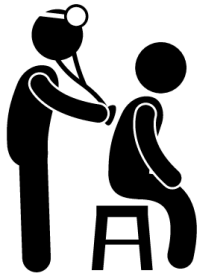
- Only 5% Healthcare spending on Primary Care

- 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

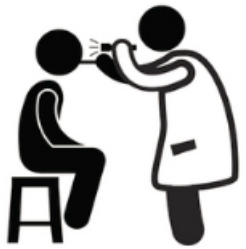
+ Low Risk

+ May have up front or enhanced payments

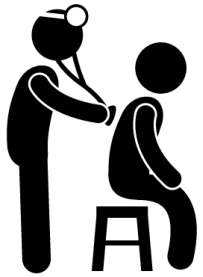
+ /- May increase Primary Care spending

- Flexibility limited

Types of Payment



Each Sick Visit



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

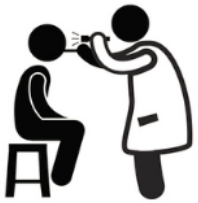
+ May have up front payment

+ 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

White Paper Components

Investing in Primary Care: Promising New Models

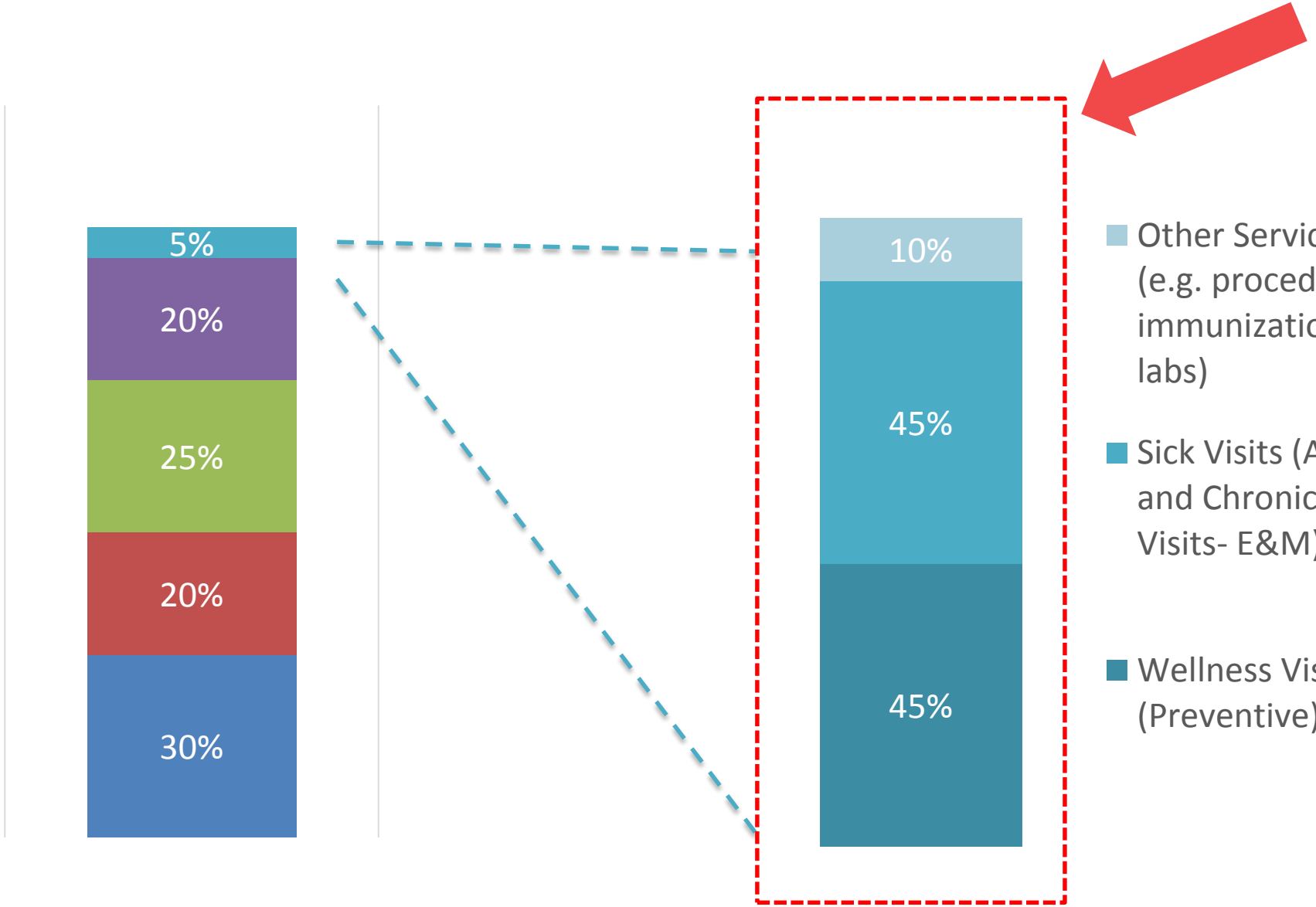
- Three Innovative Delivery and Payment Models
  - Evergreen Health- Category 4, risk-adjusted advanced payment, 10% primary care
  - Iora Health- risk adjusted budget, relies heavily on health coaches (CHWs)
  - Kaiser Permanente- global budget
- CPC+
  - National model that offers mostly non-FFS based payment through prospective bundles, care management fees, and the opportunity for quality bonuses
  - Recommended by PTTF but CT was not awarded

White Paper Components

Making Transformation Happen: PCPM Options

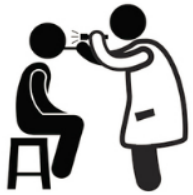
1. Care management fees and partial bundled payment for sick visits
2. Care management fees and full bundled payment for sick visits
3. Comprehensive bundled payment for most primary care services

How do Primary Care Providers typically get paid?



QUALIDIGM

Option 1: Care management fees and partial bundled payments for sick visits



Types of Payment

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

Other Services like Immunizations

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

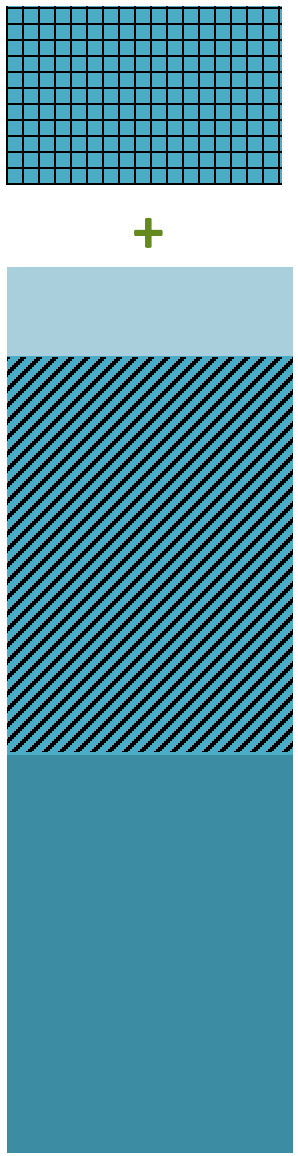
E&M- Each Sick Visit- lower amount

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.

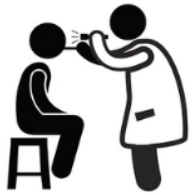
Option 2: Care management fees and full bundled payments for sick visits



Types of Payment

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

Other Services like Immunizations



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

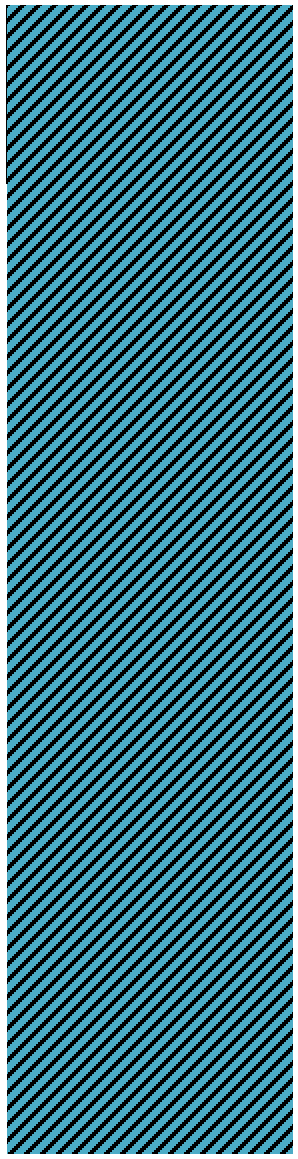
~~E&M Each Sick Visit lower amount~~

Each Wellness Visit

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: Comprehensive bundled payment for most primary care services



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

White Paper Components

Making Transformation Happen: PCPM Options

- Summary of PCPM Options
- Special Considerations for Pediatrics

White Paper Components

Connecticut Stakeholder Perspective

- Process to obtain Stakeholder Feedback
- Provider Feedback
- Payer Feedback
- Consumer Feedback

Conclusions and Recommendations

- Providers, payers, and consumers agree that the current payment reforms will not support the advancement of primary care needed to improve outcomes, reduce costs, and improve patient and care team satisfaction
- PTTF Recommendations

Task Force Recommendations

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.

Recommendation 2: Payers and providers are encouraged to use one of the three primary care payment models that are the subject of this white paper. However, provider organizations vary in their level of resources and capabilities, and they 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 ctd.

Recommendation 3: Prospective reimbursement for care management and other non-billable services, in combination with bundled payments for visit-based primary care services, provide practices with the resources and flexibility to achieve the goals of reform. However, these reimbursement methods should be introduced in a way that ultimately reduces the total cost of care, because increases in the total cost of care 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 SSP, that rewards practices for controlling the total cost of care.

Recommendation 4: The cost of providing advanced primary care is substantially greater than a typical practice earns today through FFS 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 SSP 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 ctd.

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 primary care bundled payments, rather than paid FFS 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.

Recommendation 6: 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.

Task Force Recommendations ctd.

Recommendation 7: Fee-for-service (FFS) payment may play a limited role as part of a blended primary care payment model 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.

Recommendation 8: 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 conditions. 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 9: 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- based services that support patient care and that demonstrably address social determinants of health to improve patient outcomes.

Task Force Recommendations ctd.

Recommendation 10: Payers that utilize 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).

Recommendation 11: 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

Next Steps

- Schedule follow-up meeting/webinar to address and discuss additional questions/comments
- Following next meeting, share White Paper with the Steering Committee to release for public comment
- Collect and respond to public comment
- Review and approve in February PTTF meeting
- Final draft reviewed by Steering Committee in March meeting

Adjourn