

CONNECTICUT
HEALTHCARE
INNOVATION PLAN







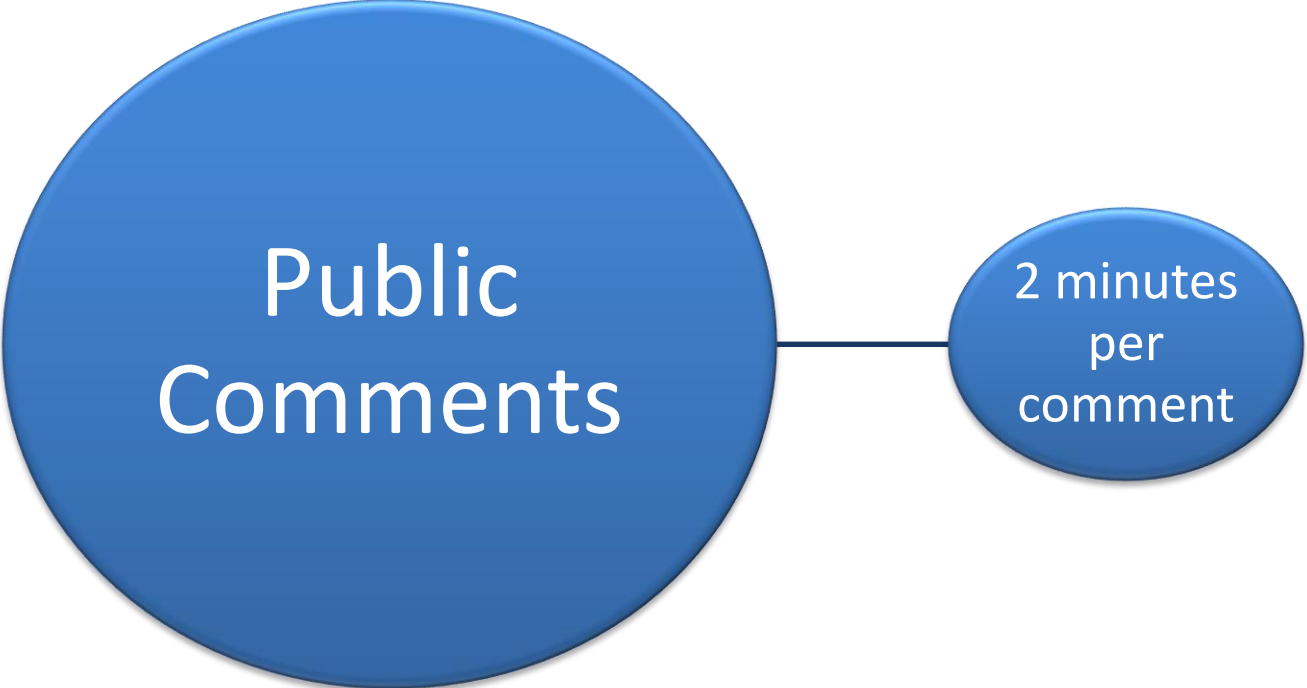
Practice Transformation Task Force

Primary Care Payment Reform

April 25, 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



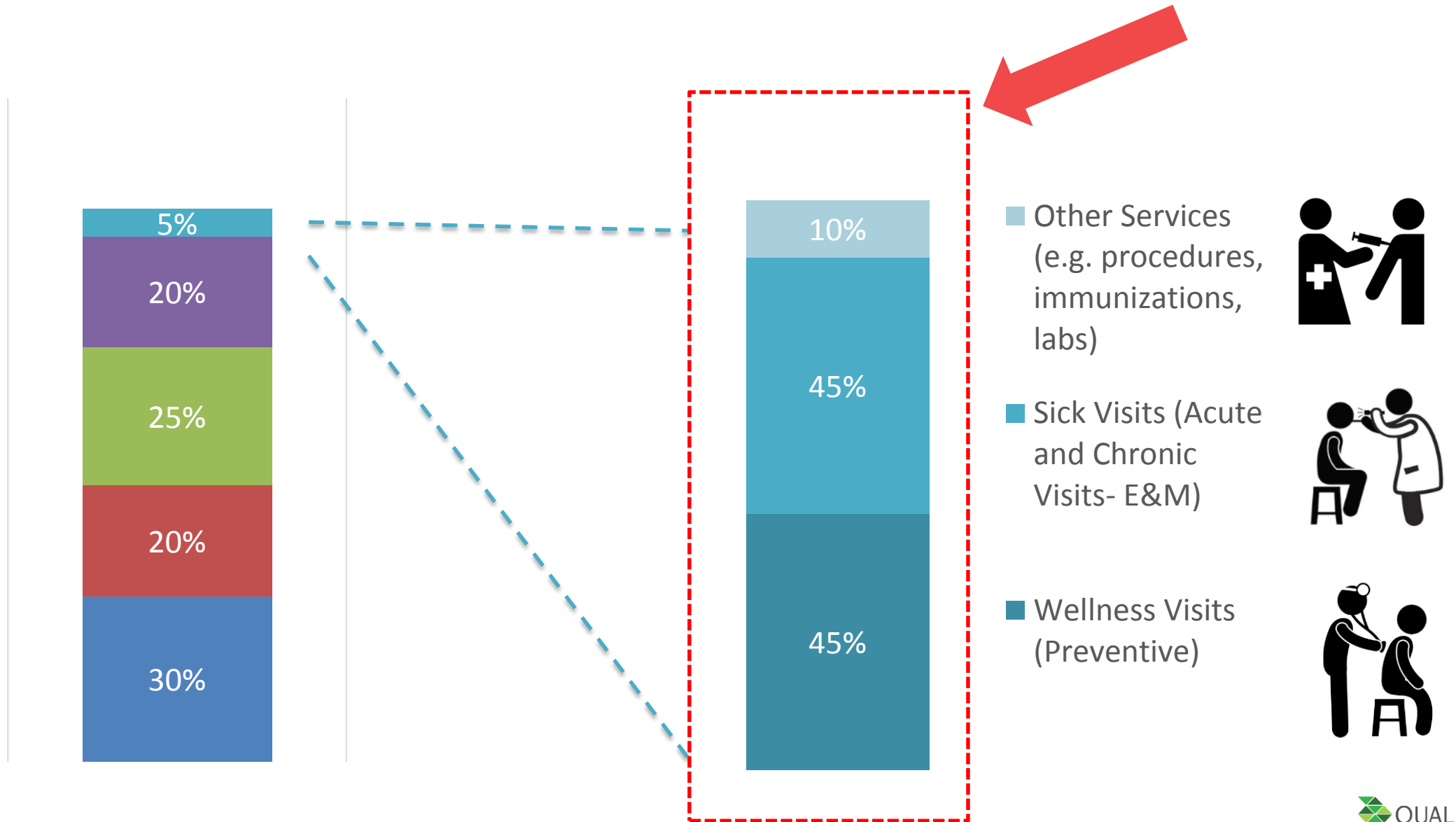
Approval of the Minutes

Objectives of Today's Discussion

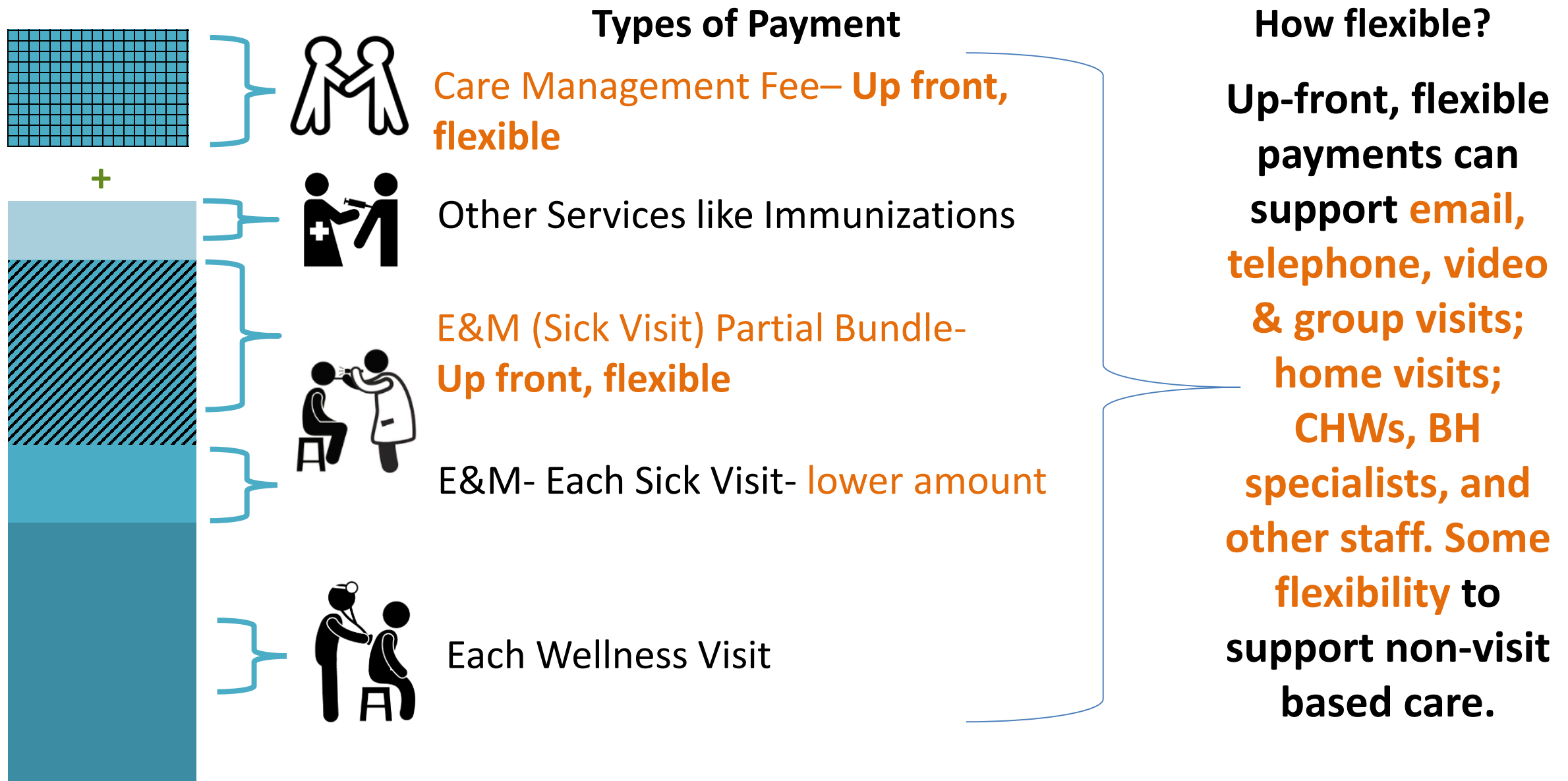
- Review Key Concepts
- Report outcome of HISC review of PTTF & CHW Advisory Committee recommendations
- Discuss questions 5 through 8
- Consider HCPLAN recommendations

PCPM – Review of Key Concepts

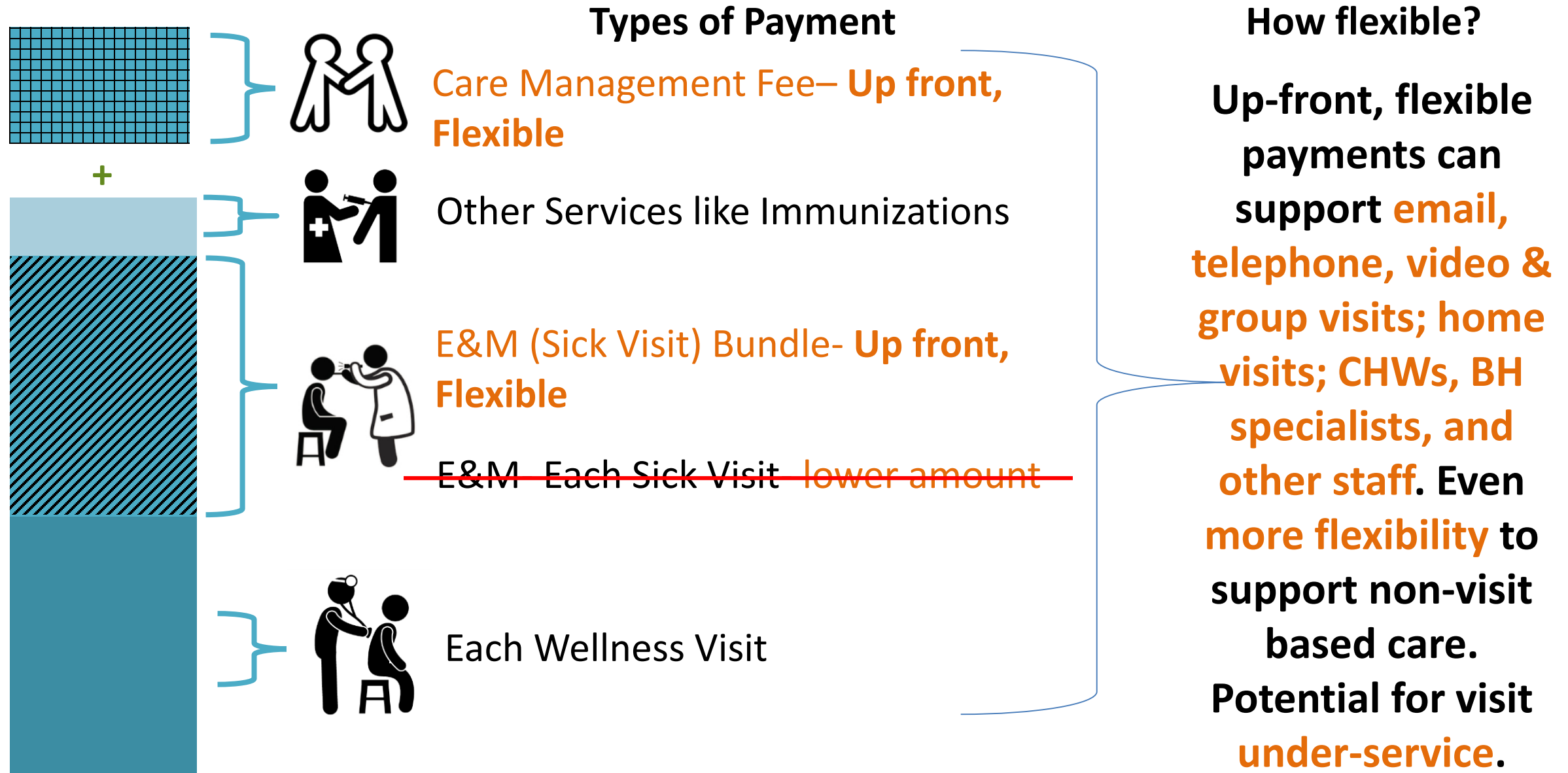
How do Primary Care Providers typically get paid?



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

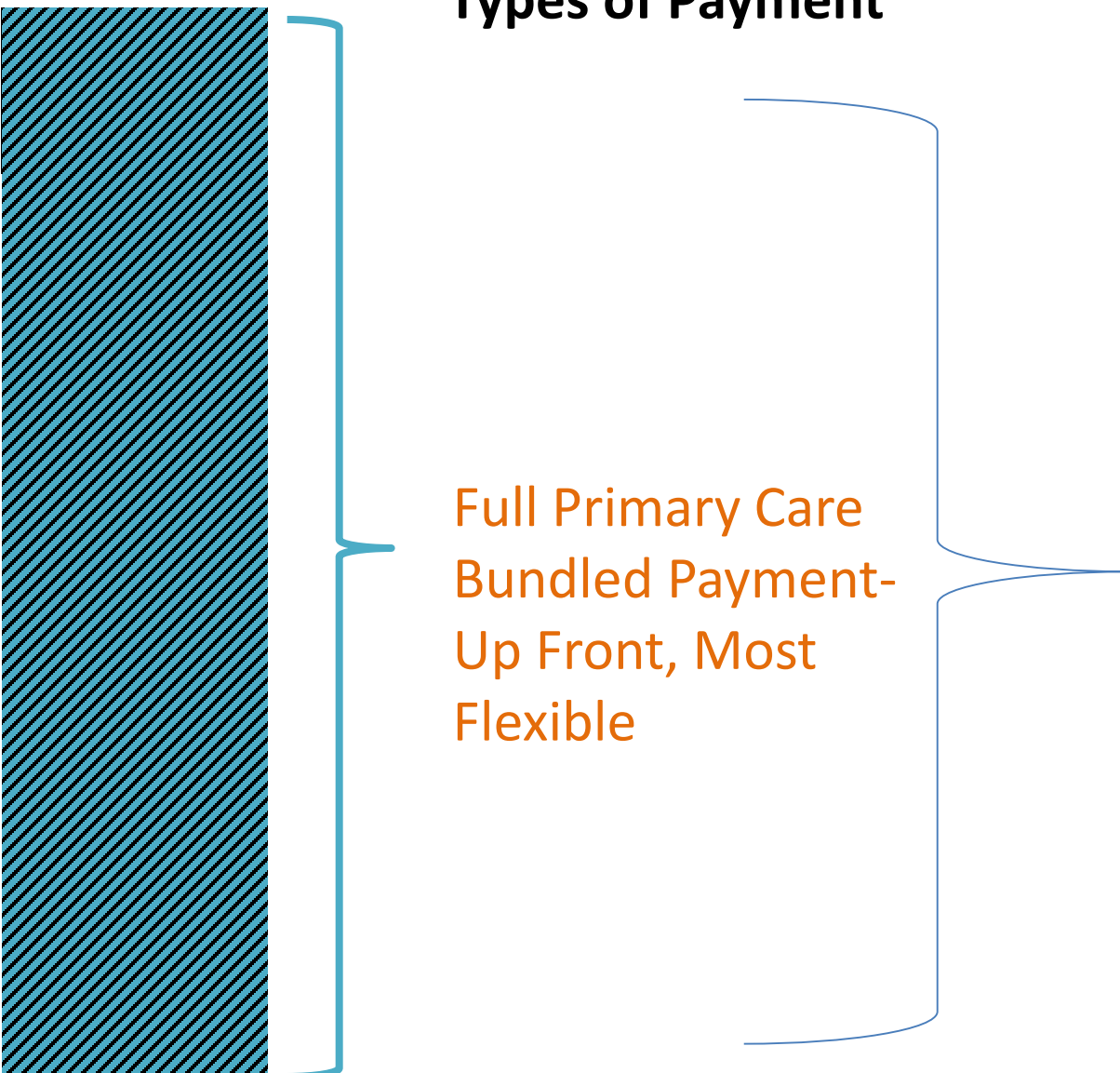


Option 2: Full E&M (Sick Visit) Bundle



Option 3: Full Primary Care Bundle

Types of Payment

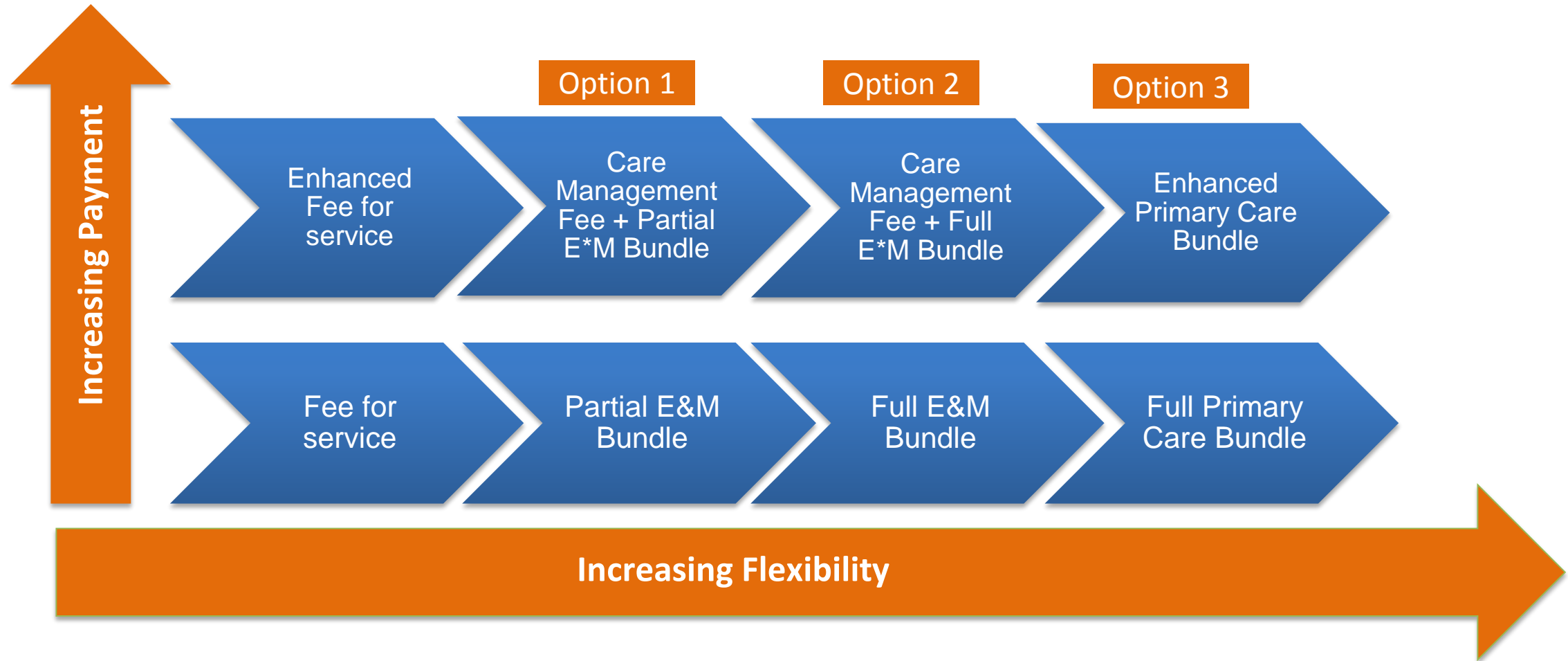


Full Primary Care
Bundled Payment-
Up Front, Most
Flexible

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



How might these models affect consumers?

Option 1: Partial E&M bundle with Risk-adjusted Care Management Fee

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**

Option 2: Full E&M bundle with Risk-adjusted Care Management Fee

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

Option 3: Enhanced Risk adjusted Comprehensive Primary Care Bundle

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
<p>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.</p>	<p>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</p>	<p>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</p>

Payer 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
<p>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).</p>	<p>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.</p>	<p>Same as Option 1 except that the full E&M bundle will require that they process and track all claims.</p>

Primary Care Payment Reform Recommendations

Healthcare Innovation Steering Committee – March 23, 2017

- PMO presented the recommendations to the PTTF and the CHW Advisory Committee with additional framing language based on the motion and discussion
- Steering Committee met to discuss the recommendations
- Steering Committee considered Medicaid position with respect to participation in primary care payment reforms, and specifically, CPC+ (see attached)
- Steering Committee accepted the recommendations of the PTTF and CHW Advisory Committee, with the proviso that such recommendations be limited to Medicare and commercial payers
- Accordingly, the recommendations that follow apply only to Medicare and commercial

PTTF Recommendations

- Connecticut's payers should implement primary care payment reforms as a means to incent non-billable innovations in consumer engagement and expanded care teams.
- 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 option (such as Option 1) if practices prefer to build their capabilities over time.
- Connecticut's payers should apply to participate in CPC+, as this offers the best opportunity to engage Medicare in primary care payment reform and Medicare engagement is essential to the success of such reform
- The cost of providing advanced primary care is substantially greater than a typical practice earns today through fee-for-service reimbursement. Accordingly, the primary care payment reforms should increase the amount of money dedicated to primary care as a percentage of premium, with an emphasis on health promotion. This should be done in a way that does not add to the total cost of care.

CHW Advisory Committee Recommendations – revised to comport with HISC recommendation

- The proposed primary care payment reforms represent an opportunity to sustainably finance CHWs as members of the care team.
- Primary care payment reform should include a requirement that providers incorporate Community Health Workers into their care teams.
- Payers should apply to participate in CPC+.

Discussion Questions

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?
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?

How can we increase Primary Care spending?

\$
Upfront
Primary Care
Investment

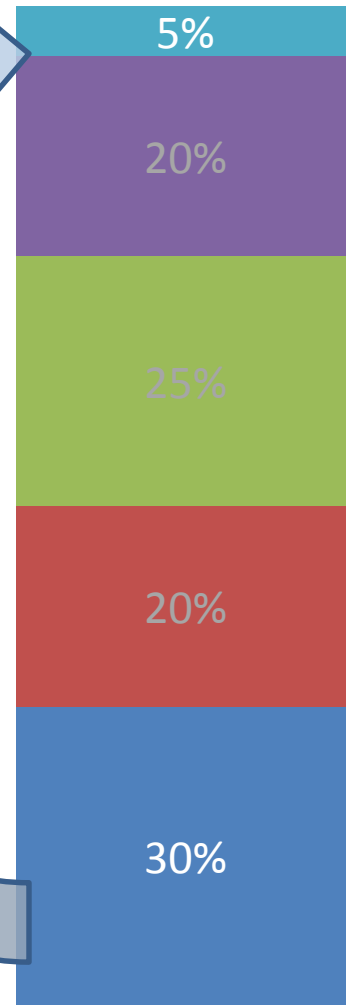
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↑ Improved
Primary Care
Outcomes

↓ Reduced ED
Visits and
Hospital
Admissions

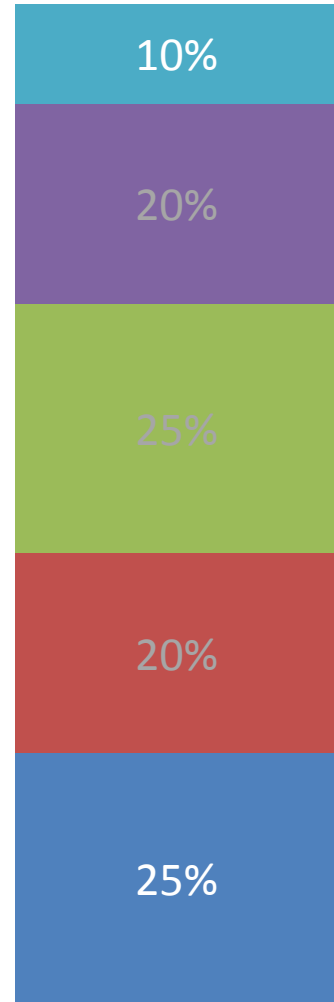


Incrementally over several years

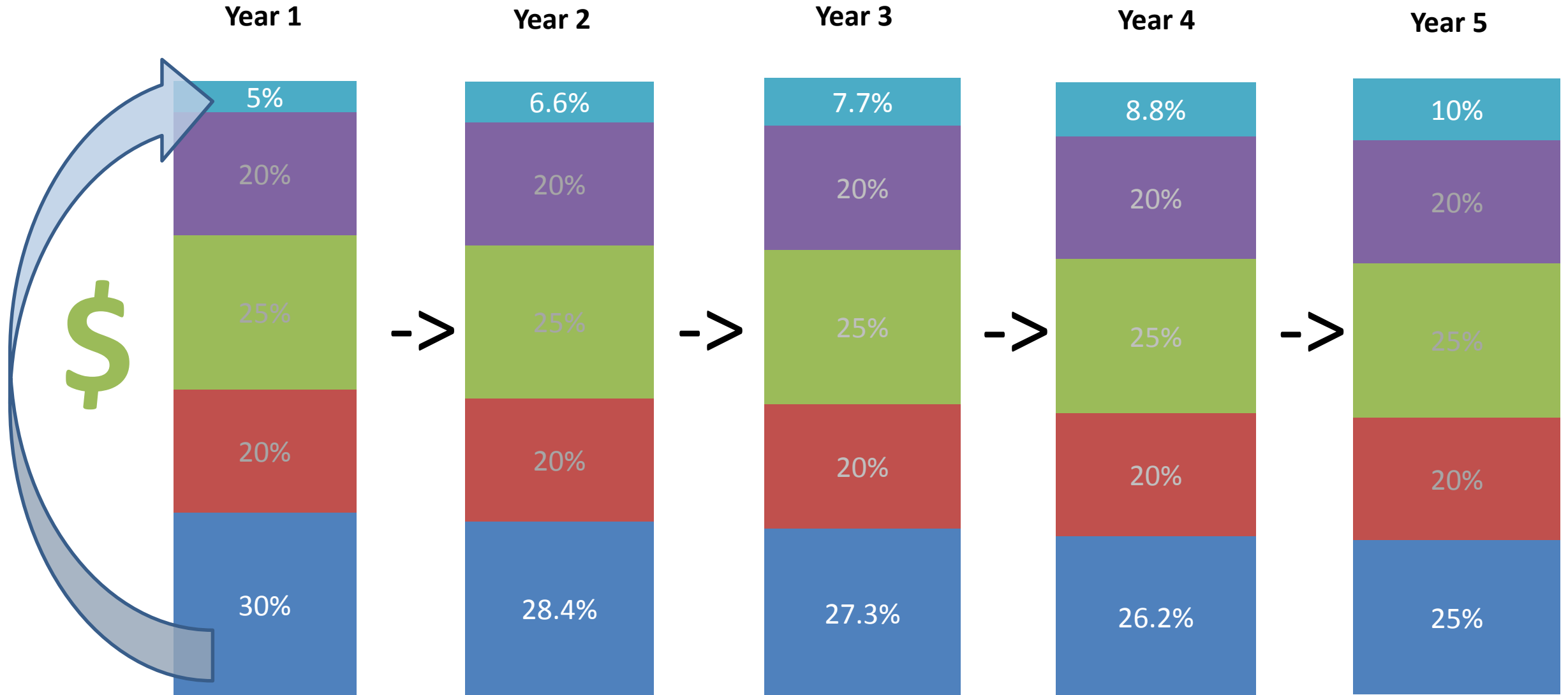


Primary
Care

Hospital

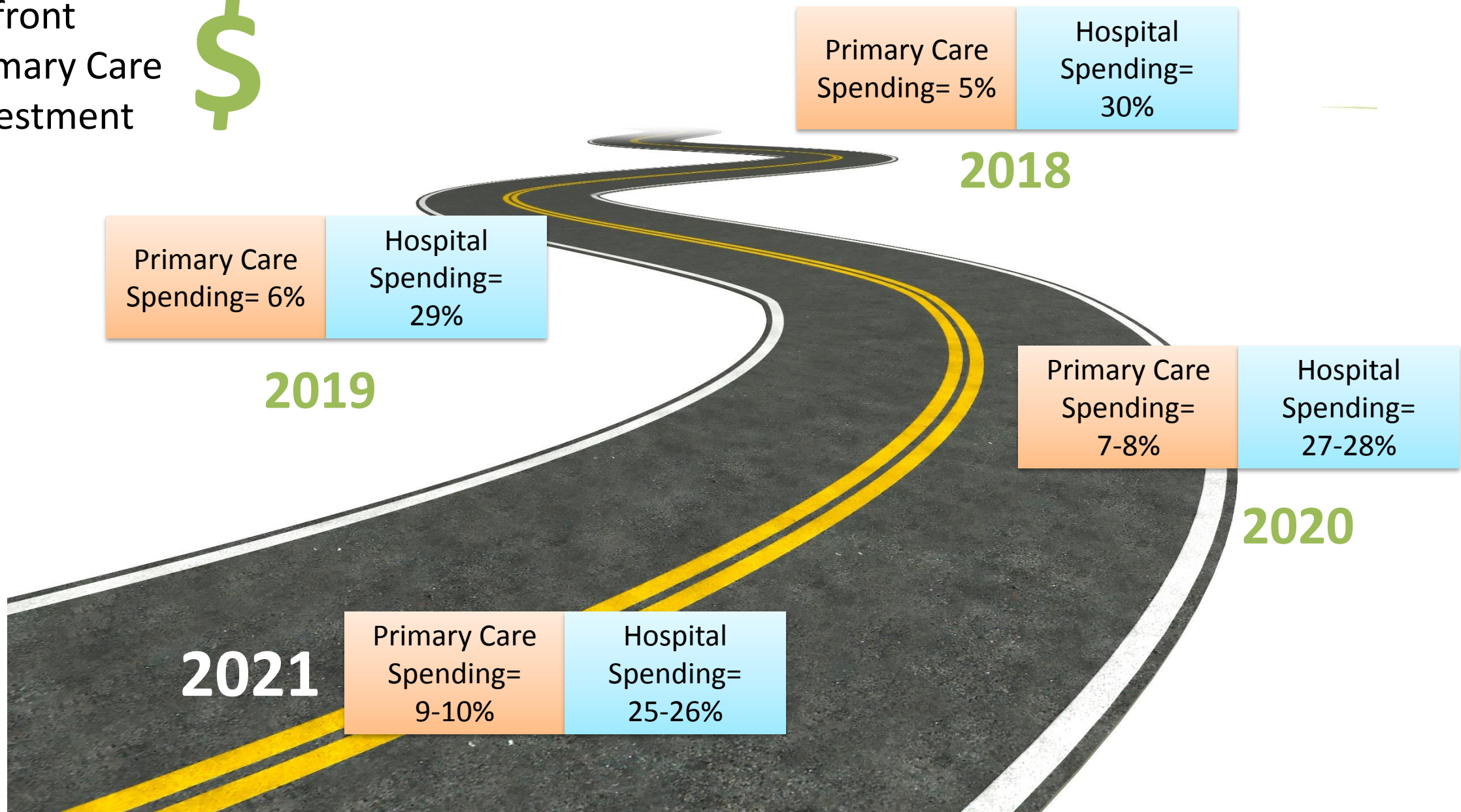


How can we increase Primary Care spending?



The Road to Increasing Primary Care Spending

Upfront
Primary Care
Investment



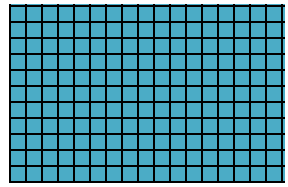
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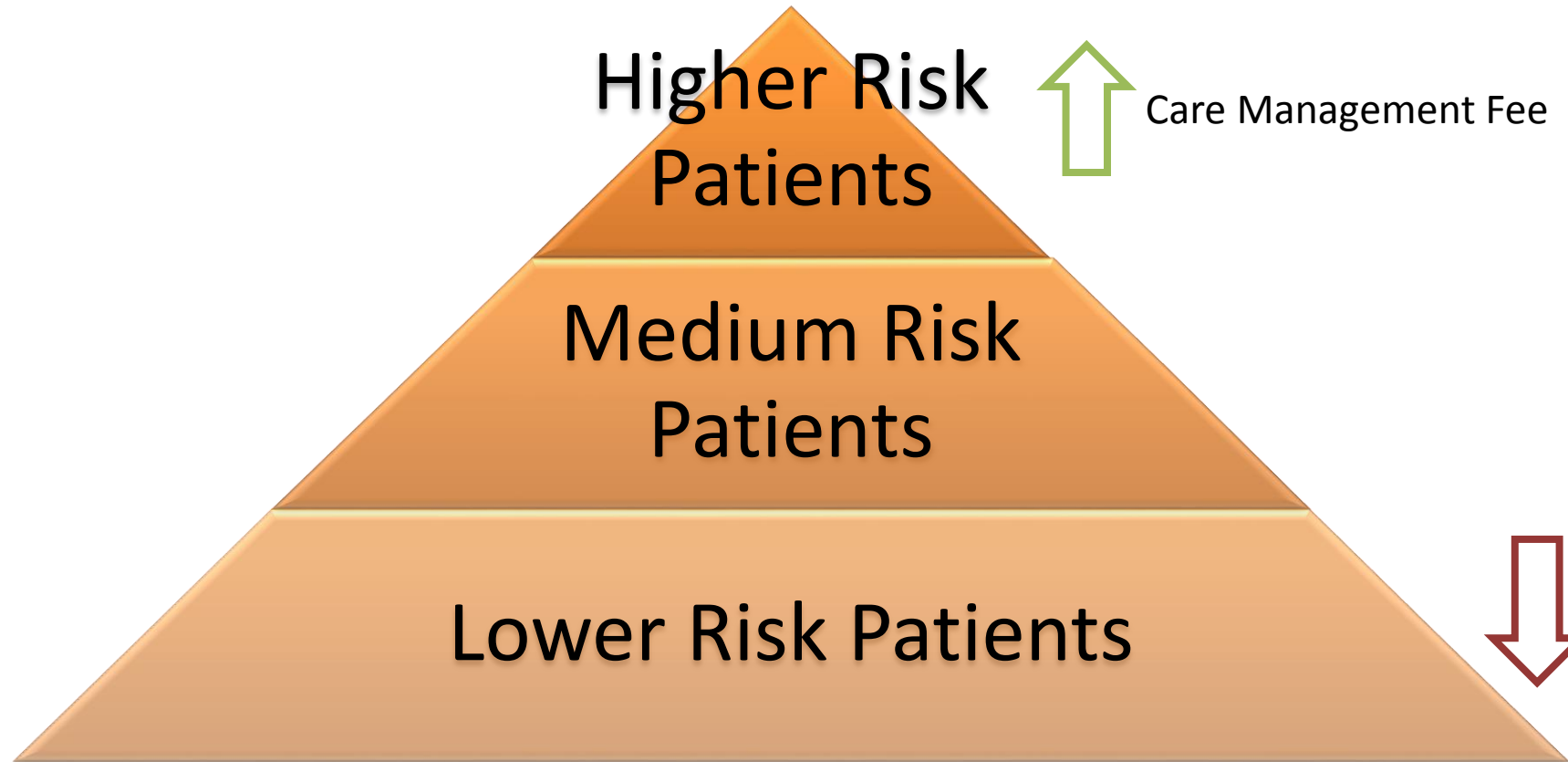
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How do PCPMs account for sicker and healthier patients?



Risk Adjusted Care Management Fees

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Care Management Fee



Care Management Fee

Relevant HCPLAN PCPM Recommendations

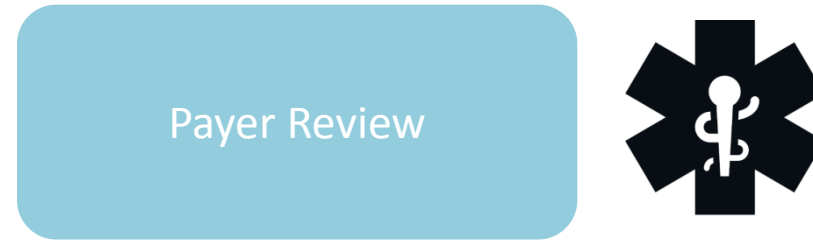
Recommendation 2: PCPMs should adjust payments to account for underlying differences in the patient populations served by different primary care practices.

Recommendation 7: Fee-for-service payment should still play a limited role as part of a blended PCPM; it will be used to incentivize certain services that need to be performed in a face-to-face encounter and promote more efficient, comprehensive primary care.

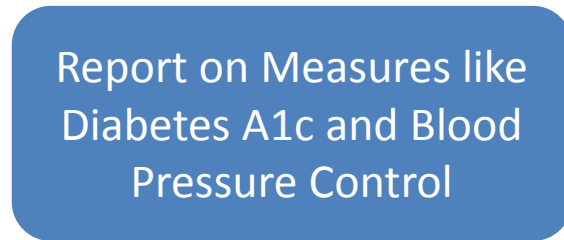
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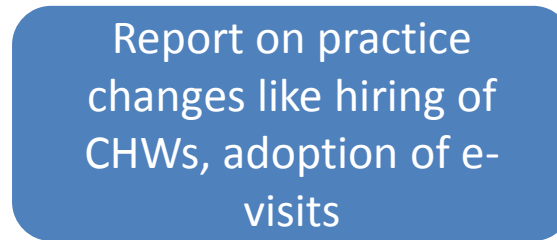
How can providers be held accountable?



Provider
Submits
to Payer



Quality Measure Reporting



Care Delivery Reform
Reporting



Budget Reporting



Other HCPLAN PCPM Recommendations

Recommendation 4: To effectively incentivize practice transformation, PCPMs should be multi-payer and cover the majority of a practice's patient population.

Recommendation 12: PCPMs 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 13: PCPMs should maximize the flexibility primary care teams have to expend resources on coordination with community services, including direct support for community programs that demonstrably address social determinants of health to improve patient outcomes.

Other HCPLAN PCPM Recommendations

Recommendation 14: PCPMs should ensure that primary care practices reflect patient goals, needs, and preferences in the care plans they develop collaboratively with the patient

Recommendation 18: Primary care practices should receive external coaching support and technical assistance to help them transition to new payment and delivery models.

Appendix

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.