

Meeting Four: FQHC Design Group Discussion Guide

For our fourth meeting, as we wrap up this initial phase of design work, we would like to revisit a few key issues that have been surfaced during previous conversations. We would also like to brainstorm a list of tasks for future phases of work.

1. Impact of Uninsured on Primary Care Modernization

- Please see attached overview

2. Revisiting “Risk Lite” Strawman

- PCM was intended to be coupled with shared savings models (MSSP/Next Gen) that financially align providers with goals of improving care delivery and patient experience while reducing cost. Medicare has proposed that downside risk will be requirement for participation in future programs.
- The Payment Reform Council is considering ways to mitigate risk to enable time for new investments to impact patient outcomes and cost of care while considering the recent changes to the MSSP framework.
- Consumers have voiced concerns about the introduction of downside risk in Medicaid and some providers have expressed concerns about readiness for downside risk in the early years of this initiative.

We are sharing for discussion a potential strawman alternative for certain payers (e.g., Medicaid) with a low level of readiness to share risk. Considering new MSSP rules, CMS will likely require those rules be the default standard. PCM could ask for a reduction in the percent of the supplemental bundle payments that are factored into total medical expense for the purpose of shared savings and losses calculations. The Payment Reform Council will be considering this at its next meeting.

CPC Plus Track 2	Care Management Fees	Performance-Based Incentive Payment	Medicare Physician Fee Schedule
	\$28 average per beneficiary per month (PBPM) including \$100 PBPM to support patients with complex needs	\$4 PBIP tied to quality, patient experience and utilization performance	Hybrid bundled payment for office visits: Reduced FFS w/ primary care bundle
Potential PCM Adaptation	Tier 1 Supplemental Bundle Payment	Performance-Based Incentive Payment	Full Basic Bundle
	\$18-\$20 average target, with increased payments for high-needs populations	\$4 PBIP tied to quality/patient experience and utilization performance	Full basic bundle payment. Same as other PCM AN/FQHCs.

- Providers receive PBIP at the beginning of each year. Only the PBIP is returned at the end of the performance years if quality and utilization targets have not been met; risk cautious provider can simply bank the PBIP for the year.
- Elimination of total cost of care accountability addresses concerns about incentives to reduce necessary specialty referrals, diagnostic tests and procedures.
- Purchasers may be concerned that reduced pressure on cost accountability reduces the likelihood that return on investment will be achieved in excess of supplemental payment.

3. Outstanding Questions from Meeting Three

- How will concerns around PPS equivalency be addressed?
- Will the basic bundle include vaccines etc. currently included in the PPS payment?

4. Next Steps

- Some of the questions and comments that have surfaced during our work will be important to discuss with payers during future phases of work.
- It will also be necessary to conduct data analysis to determine appropriate payment levels going forward.
- What next steps should occur and what questions should be answered during future phases of work to support FQHCs in better understanding the PCM opportunity?