

Primary Care Modernization FQHC Design Group Meeting Summary

12/10/18

Participants: Curt Degenfelder, Doug Olson, Robert Block, Ken Lalime, Suzanne Lagarde, Mary Jo Condon, Alyssa Harrington, Ellen Bloom Art Jones, Mary Blankson, John Gettings, Athena Dellas

Mary Jo Condon began the meeting and facilitated introductions.

The group began with a conversation of the basic bundle. The group agreed with the revised recommendations (below) but had additional questions around how vaccines, which are currently included in the PPS rate, would be addressed. It was agreed this topic would be put on the next meeting agenda. Further, Ms. Condon pointed out that if existing staff members are currently performing tasks related to the capabilities, those staff members' salaries could be paid out of the supplemental bundle in the future and additional staff members may not need to be hired.

Revised Recommendation (changes highlighted in yellow):

- For Medicare and Medicaid, the basic bundle would include all services currently included in the Medical PPS rate including sick visits, wellness/preventive visits, nursing visits, tobacco cessation counseling and prenatal care.
- Assuming currently BH services provided by a medical provider are paid under the medical PPS rate, those would be included in the basic bundle. Behavioral health services delivered by BH clinicians would be paid via the existing Behavioral Health PPS rate and left out of the basic bundle.
- Consistent with the PRC recommendation, services paid via the basic bundle would not be eligible for FFS payment.
- Assuming FQHCs can distinguish the subspecialty of the provider in historical claims, either through name or taxonomy, then services provided by subspecialists would not be included in the basic bundle.
- Dental services would be excluded from the bundle and paid via the dental PPS rate.
- For Medicare and Medicaid, registered nurses would be paid via the basic bundle when providing face-to-face visits for acute or chronic needs (consistent with today) and via the supplemental bundle when providing all other services. For commercial payers, registered nurses would be paid via the supplemental bundle the same as ANs.

The group then moved to discussion of PPS equivalency. Dr. Lagarde said she felt it was important that PPS equivalency be determined using only the basic bundle. Ms. Condon said that may be difficult as some services currently calculated in the basic bundle such as prenatal care would be paid fee for service and other services currently included in the PPS rate would be paid via the supplemental bundle. She suggested payers may need to calculate an equivalent basket of services and calculate PPS equivalency based on that basket.

The conversation of PPS equivalency led to some design group members asking for more information on role of Medicaid in the PCM design group process and its interest in implementing PCM. Ms. Condon said she could not provide an update on Medicaid’s interest but noted Medicaid Director Kate McEvoy was serving on the Payment Reform Council.

The group then transitioned to discussing the “risk lite model” which was developed as an option to address concerns about the introduction of downside risk in Medicaid and some providers readiness for downside risk in the early years of this initiative. This strawman alternative was created for certain payers (e.g., Medicaid) or an entry level option for providers, including some FQHCs, with a low level of readiness to share risk. The strawman is shown below. Group members said this model was a positive step to address concerns around risk sharing but there remained other concerns about whether Medicaid will be interested in participating and whether the bundle amounts will be sufficient across payers.

Risk Lite Strawman:

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.

Next Steps

- Dr. Lagarde noted that she thought further discussion was needed on the issue of PPS equivalency and reiterated her position that it should be based on the basic bundle.
- Ms. Blankson noted it would be helpful to have more discussion on whether vaccines and non-service items would be included in the basic bundle.
- Ms. Condon said both of these issues would be discussed further at the next meeting.