CONNECTICUT
Office of Health Strategy

Primary Care Modernization Initiative

FQHC Design Group

Agenda

- Review purpose of Payment Reform Council and FQHC Design Group
- Review provisional recommendations from the Payment Reform Council and discuss possible accommodations to better align with FQHC policies, practices and regulations.
- Review agenda topics for future meetings

Purpose

- **Payment Reform Council:** Develop payment model options for Medicare Fee-for-Service that increase flexibility to make primary care more convenient, community-based and responsive to the needs of patients, and ensure a return on investment. It will also make recommendations to other payers for minimum requirements to be deemed aligned.

- **FQHC Design Group:** Make recommendations to the Payment Reform Council about how its payment model options may be need to be tailored to better align with FQHC policies, practices and regulations.

Payment Model Goal: Increase spending on primary care, reduce total cost of care, prevent underservice

Upfront, flexible payments offer a financial reason to provide the most effective, efficient and convenient care.

When Providers Are Paid Today

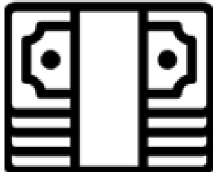
When Providers Aren't Always Paid Today

To make sure all patients achieve their best health, we can:

- Adjust payments to account for the different needs of patients
- Measure use of services and look for trends that suggest lack of access
- Make providers more responsible for long-term health outcomes

Payment Reform Council Consideration of Practice Transformation Task Force Model Options

Basic Bundle



Supplemental Bundle

Fee for Service Payments

MSSP or Other Shared Savings or Downside Model Risk Puts Pressure on Total Cost of Care

Payment Reform Council Key Questions

- Which ANs are qualified to participate in PCM?
- Should practices continue to receive reduced FFS payments for services in the basic bundle?
- What will be included in the basic and supplemental bundles? What will remain fee for service?
- How should patients be attributed to providers?
- How will bundles be adjusted for differences in patient populations and over time?
- How will performance be measured in ways to ensure accountability for PCM goals?

Payment Reform Council
Provisional Recommendations to Date

Attributes of Basic and Supplemental Bundles

Basic Bundle

- An advance payment for primary care services, such as office visits.
- It will be calculated using historical claims data and adjusted over time.
- The basic bundle is a mechanism to purchase the time PCPs historically billed for office visits, and in turn, offer PCPs and patients more flexibility.
- PCP time remains focused on patient care. Other activities may include managing team members, learning and collaboration opportunities.

Supplemental Bundle

- An advance payment to support activities and investments not ***typically*** billed fee for service.
- It will be based on a standardized target for all providers in a specific carrier's program, which aims to introduce more equity in payments.
- Payments will differ based on patient characteristics and provider capabilities or performance. Risk adjustment strategy will be aligned with patients' care management needs.
- Providers accepting greater levels of risk will be eligible for higher payments than those who do not.

Qualifications for Participation in PCM

Advanced Network or FQHCs

- Has the legal ability and administrative organization to contract with payers
- Responsible for the care (typically total care) of a defined population
- Is able to effectively measure the quality and efficiency of care delivery
- Coordinates clinical efforts among all participating providers (e.g. primary care, specialists, inpatient facilities)
- Will participate in Medicare programs (MSSP, Next Gen) risk criteria TBD, or similar program via Medicaid/Medicare/Commercial

Practice (as defined by TIN) within AN

- Providers will have a primary care specialty
- All practices must meet core capability requirements
- Should be able to be clearly defined to ensure bundles are calculated and paid appropriately
  - Medicare: If participating in MSSP/Next Gen, needs to participate in PCM and vice versa
  - Other Payers: Commercial plans will leverage existing contracting structures.

Attribution

PCM will leverage payers existing prevailing attribution methodologies while incorporating certain elements important to consumers including prioritizing patient self-reporting and offering providers an accurate prospective patient list.

Proposed PCM Attribution for Medicare FFS

Patient Self Report = Patient Assigned

Gold standard but not always available (MSSP, Next Gen)

OR

Majority PCP Charges = Patient Assigned

If patient does not self-report, then patient behavior (charges) dictates (MSSP, Next Gen).

Prospective Patient List Provided to ACO

Prospective list supports AN care management and budgeting (CPC+, MSSP, Next Gen)

Quarterly Updates

Process would vary by program (CPC+, MSSP, Next Gen)

Final Retrospective Reconciliation

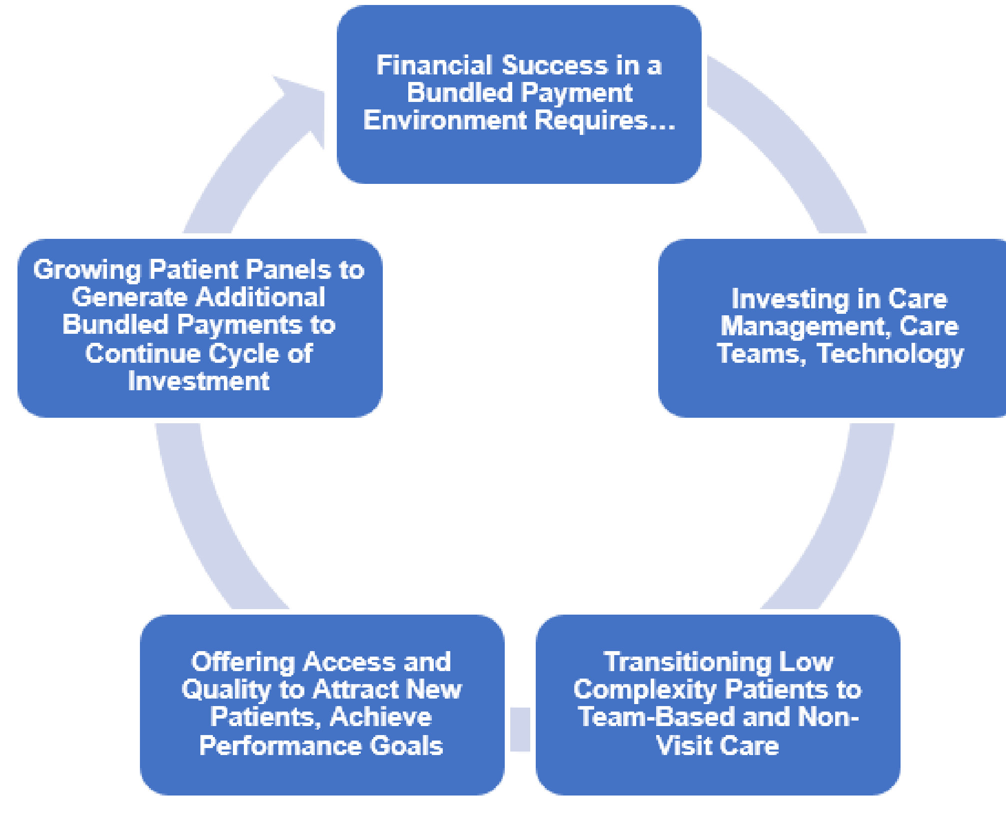
Subject to review by providers as part of the settlement process (MSSP)

To be determined

Basic Bundle Payment

Services in the bundle basic will no longer receive fee for service payments.

A full bundle model offered the best opportunity to support care delivery transformation.



Basic Bundle Services

“Strawman” Services Included in the Basic Bundle:

- **Included for all Practices**: Office Visit, new or established patient; Prolonged Encounter; Encounter Payment for FQHC Visit; Behavioral Health Screening; Cognition Assessment; Phone/Email/Text; Telemedicine; Home Visits (only relevant in limited circumstances and for certain populations – pediatrics, older adults and people with disabilities); and Shared Visits (optional and only applicable in some circumstances).

- **Not Included at this Time**: Hospital, SNF Rounding; Immunization Administration; Preventive Medicine Visit; Preventive Counseling; Annual Wellness Visit

While these are the recommended services for Medicare FFS, other payers may choose to add other services. For example, payers with large percentages of children may choose to include wellness and preventive visits to make the bundle a larger portion of pediatricians’ office visit revenue.

Basic Bundle Adjustments

The basic bundle will be calculated using historical claims data as a basis and adjusted. Payers would use the equation below as a framework and would determine the specific methodologies used to complete the equation.

(Base Period Claims (+/-) Addition or Deletion of Services Included) * Population Risk Adjustment * Use Trend * Unit Cost Trend (Induced Demand Factor, if needed)

Definitions below correspond to components of the equation above.

Base period claims represents a calculation of historical use of basic bundle services and price.

Addition or deletion of services included represents the value of services added or subtracted from the bundle. These could be valued based on history or expert projections (for a new service where history is not applicable).

Population risk adjustment represents the change in the risk of the population served by the bundle normalized to the overall population.

Use trend represents the projected change in primary care services for the period covered by the bundle. These projections may leverage historical changes in use, assumptions about the overall environment and assumptions about service availability.

Unit cost trend is the change in provider rates from the base period to the bundle period.

Induced demand factor is leveraged to reflect changes in coverage that impact costs (i.e. VBID).

Considerations for FQHCs: Principles

- Demonstrable patient benefit - enhanced access to patient-centered care, more convenient and effective
- Comply with federal PPS rules
- Inclusion of the bulk of current primary care services
- Inclusion of services amenable to practice redesign in the most efficient, care team-based and member-centric fashion
- Avoid cost-shifting from the bundle to a separate fee-for-service revenue stream
- Avoid incentive for under-provision of services and have ability to monitor for this
- Ability to delineate services by individual provider (included/excluded from the basic bundle) from submitted claims
- Services that count toward attribution
- Change in scope (***future discussion***)
- Others as identified by FQHCs (uninsured load, differences in enabling services) (***future discussion*)**

Billable FQHC Primary Care Services for Discussion

- Prenatal care including centering group visits
- Gyne services (by OB-Gynes and/or other primary care providers)
- Preventive/wellness visits that also address acute care conditions
- Specific billable visits for some payers
  - RN visits unless provided incident to a medical encounter with another billable provider
  - Tobacco cessation counselling by allied health professionals
- Optometry
- Podiatry
- Other specialty
- Dental
- Behavioral health services by PCPs vs. BH licensed clinicians

Topics for Meetings Two and Three

Meeting Two: Adjusting Bundled Payments to Meet PPS Regulations or Identify Needed Overrides

- Trending the basic bundle to assure at least MEI equivalent
- Reconciliation process to assure at least PPS equivalency
- Change in scope

Meeting Three: Supplemental Bundle, Other Regulatory Issues, Other Issues as Identified

What are other FQHC-specific issues for future discussion?