**Primary Care Modernization FQHC Design Group Meeting Summary**

11/05/18

**Participants:**, Curt Degenfelder, Doug Olson, Robert Block, Ken Lalime, Suzanne Lagarde, Mary Blankson, Mark Schaefer, Mary Jo Condon, Alyssa Harrington, Ellen Bloom, Art Jones

**Not Present:** John Gettings

Alyssa Harrington began the meeting and facilitated introductions.

Mark Schaefer began the discussion with an overview of the role of the FQHC Design Group and how it fits in the context of the Payment Reform Council recommendations and the design work of Primary Care Modernization project more broadly. The purposes of each are:

- 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 maybe need to be tailored to better align with FQHC policies, practices and regulations.

FQHC representatives shared concerns about the current lack of adequate reimbursement for certain services including e-consults and additional care team members. An attendee added that for diverse care teams, one of the biggest problems from the ACO model is it says they'll give you savings if you make investments to generate those savings. However, that sets a high bar for adding new care team members to your team.

Dr. Schaefer reviewed the Task Force recommendations including doubling investments in primary care and increasing flexibility. He discussed why FQHCs may need a slightly different approach than the private practice advanced networks. FQHCs have different care teams in place, they already do some behavioral health integration, and they currently receive reimbursement in a partially-bundled system (prospective payment system).

FQHC representatives asked for additional information about how the model would impact dual-eligible beneficiaries and about the role of Medicaid in the PCM design work.

Dr. Schaefer explained Medicaid is participating in the Payment Reform Council, and he is hoping they will take recommendations from the Council and go through their own process for their beneficiaries. He noted that while Medicare is the focus of the Payment Reform Council's work and the FQHC Design Group, both groups can also make recommendations with an eye towards special considerations that might be needed for other payers.

Ms. Harrington explained the provisional recommendations from the Payment Reform Council and the attributes of the basic and supplemental bundles. Dr. Schaefer explained that the basic

bundle is purchasing the time of PCPs that has historically been funded through encounter-based reimbursements. The supplemental bundle would cover the cost of services not typically reimbursed today including new care team members and new investments in technology. Both would be risk adjusted. Risk adjustment of the supplemental bundle may include adjusting for social determinants of health. Initially, risk adjustment would be based on claims data overtime and may include data from electronic health records. Attendees raised one concern that will need to be addressed is how to prevent artificial increases in risk.

FHC reviewed the qualifications for participating in PCM, for both Advanced Networks and FQHCs and practices and providers within Advanced Networks. Participants discussed some FQHCs' resistance to enter into risk-sharing arrangements. There was discussion of how risk arrangements might work and it was noted that the model with Medicare would likely not begin until 2021.

Ms. Harrington reviewed the general approach to attribution recommended by the PRC, which is to use the payer's current attribution methodology while giving preference to providers affirmatively identified by patients. The PRC is currently not recommending requiring retrospective reconciliation for Medicare. The state is thinking through how to ensure all providers are paid for care delivered without paying twice when patients are attributed to multiple providers throughout the year.

It was asked if providers would get fee-for-service on those patients because they're not attributed anymore, to which it was replied that it depends on where that patient was seen (want to avoid paying twice). Dr. Schaefer noted it would be important for the state to think this through more carefully. He agreed retrospective attribution is more accurate. It was noted that additional discussion was needed regarding how to best account for patients that gain and lose coverage throughout the year.

FHC reviewed the basic bundle payment. Dr. Schaefer explained the PMPM is based on historical revenue that is then adjusted for risk, medical trend and other changes over time. Dr. Schaefer explained that the combination of monitoring and the incentive to reduce total cost of care should prevent advanced networks from limiting care or pushing patients to more expensive care sites. Shadow claims to support this data need would be possible in the short term until this data can be culled from EHRs. Dr. Schaefer also explained the PRC decided not to try to fix historical inequities in payment rates through the basic bundle. FQHC representatives urged the state to be thoughtful about the time period chosen for the historical base as providers could try to increase service use now to drive a higher basic bundle payment. FQHC representatives added they believed it would be important to include preventative visits and prenatal care in the basic bundle.

**Next Steps**

- Next FQHC Design Group Meeting will be November 14, 2018.