Designing Payment to Support Advanced Team-based Care at the Practice Site: *Practice Engagement*

Virtual Session

Primary Care Payer Action Collaborative

March 12, 2018

12:00-1:30 pm (EST)

1. **Session Objectives**
   - Explore the transition from a predominantly fee for service payment environment to one substantially based on population payment, including perspectives from a primary care practice and a payer.
2. **Speaker Panel**: Dr. Gregory Reicks, Physician, Foresight Family Physicians, Grand Junction, Colorado; Patrick Gordon, Vice President, Rocky Mountain Health Plans, Grand Junction, Colorado

I. Introduction

- **Practice Overview:** Foresight Family Physicians (Foresight) of Grand Junction, Colorado, has five full time medical providers and a host of support staff including medical assistants, front desk staff, and care managers. As Foresight transitioned from CPC Classic to CPC+, there was a significant need for additional on-site staffing support (e.g., behavioral health). They found that a 4:1 staff to provider ratio is adequate for the services that they deliver. The patient mix is an important component of advanced primary care – as Colorado is an expansion state, 50 percent of the practice's patient mix is derived from government programs. Understanding that the patient mix is largely Medicaid is important in the context of resources; practices should take into account population risk and complexity. Currently, 44 percent of Foresight's patients are attributed to CPC+ payers.

- **Practice History:** Prior to CPC in 2012, Foresight's revenue was approximately 95 percent fee-for-service (FFS). The transition began in 2013 with the first year of CPC Classic, which brought in additional per member per month (PMPM) revenue. Foresight also participated in SHAPE, a Rocky Mountain Health Plan (Rocky) funded study that tested a cost-based reimbursement model with integrated behavioral health and primary care. During the same time, Rocky transitioned to a fully capitated model for Medicaid. In 2015, Foresight experienced a further change in revenue, with FFS dropping to 68 percent and alternative type payments accounting for approximately 32 percent of revenue. Alternative type payments included commercial pay for performance, Medicaid capitation and shared savings, and SHAPE, among others. Another change occurred in 2017 with the initiation of CPC+. Foresight opted into Track 2 and elected to have 25 percent of Traditional Medicare revenue as alternative-to-FFS payments (CPCP); this year, Foresight has elected 40 percent. Additionally, Rocky decided to capitate all lines of business (LOB), and SHAPE transitioned into a cost-based reimbursement model known as the community integration agreement.

- **Revenue:** Foresight's current revenue is split almost evenly between FFS and non-FFS (largely due to Rocky's payment arrangements). Since 2012, Foresight has seen a $6 PMPM increase in total revenue and has been thinking a lot about the question: "What percentage of non-FFS revenue does it take to substantially change the way we are delivering care?"

II. The Business Model

- **Non-Billable Services:** Foresight is constantly trying to balance billable with non-billable services (e.g., integrated behavioral health, care management, health coaching and patient centered medical homes (PCMH)). Efficiency in this regard is very important, as it is hard to reconcile providing services that are not billable. However, with increased non-visit-based payment, Foresight has seen the shift from fewer face-to-face visits to increased telehealth, care through the portal, and group visits (e.g., tobacco cessation). Telehealth appointments are now scheduled for one hour per week for each provider, which is anticipated to grow. The most intensive resource still remains the provider's time, so Foresight has been exploring ways to leverage the time of other staff, such as health coaches and care managers. Care managers are responsible for telephone calls (TC) and warm hand offs (WHO); likewise, the integrated behavioral health consultants do phone calls, screenings, and hand offs. None of these activities generate a claim, so right now it is essentially invisible to the payers.
    - **Q for Rocky:** What can you do as a payer to track the non-face-to-face touches?
      A: Rocky acknowledges that this is a hurdle. Payers and providers are not on the same page when it comes to data – as evidenced by use of electronic health records (EHR) on the practice side versus administrative and analytic tools on the payer side. Potential ways to bridge this include: asking providers to adopt more tools as networks become more tiered; and/or investing in community health information exchange (i.e. messages and alerts). The latter seems to be the most logical path forward for Rocky, and they encourage other practices to look to this solution as well.
    - **Q for Foresight:** How does Foresight track telehealth internally, how many hours are they spending on telehealth, and how do they feel about using a portal to track non-FFS work?
      A: Foresight tracks through visit type and can run reports on activities to reasonably document the work done and provider input, none of which generates a claim. They are somewhat resistant to work in multiple payers' platforms and have tried to avoid this if at all possible. A common platform might be a good solution. At some point, Foresight should be able to stop sending claims.
    - **Q for Rocky:** Does it defeat the purpose of non-FFS if Rocky is looking at claims? What is the ultimate goal of knowing how much telehealth practices are doing?
      A: The vision and commitment remains moving off code-based payment. The APMs allow Rocky to accomplish more within the code-based framework, but it isn't good enough. Rocky would like to think that they are moving towards integrated behavioral health with no FFS history that adequately reflects the resource need or the opportunity in primary care. Integrated behavioral health is such a small part of overall spend that they were able to take a budget based approach and circuit everything else. The state and the federal government both play a big role in this because everything is so encounter based. Colorado Medicaid has "led them off" Healthcare Effectiveness Data and Information Set (HEDIS) and electronic Clinical quality measures (eCQM) for several measures, which has been a major breakthrough to align payers and practices.
    - **Q for Foresight:** Do patients notice or know much about changes occurring in the practice?
      A: Patients notice the opportunity for care to be delivered in a non-face to face manner. Some patients welcome this change, and others are more resistant. The ideas behind measurement are prominent in the practice, so patients understand the goals being set.

Having integrated behavioral health and care management has changed the delivery model so that patients see multiple staff members in one visit – familiarizing them with team based care. Some patients are satisfied with the team based approach, while others are resistant to it. In general, most patients want a robust care team taking care of them.

- **Changes in Provider and Staff Compensation:** At Foresight, provider compensation is moving away from pure RVU based compensation to a more blended model looking at the risk adjusted population based payments, which encourages:
    1. A larger panel size (note: the "optimum" panel size is still unknown);
    2. More creative use of the provider's time (note: there has been a shift in provider attitude around pressure to fill their schedules);
    3. Participation in PCMH activities;
    4. Performance around quality and utilization metrics; and
    5. Productivity/RVU (emphasis to decrease with time).

  Staff compensation is based on team participation, quality benchmarks, patient satisfaction, and utilization benchmarks at Foresight.

III. The Advanced Primary Care Model

- **Cost of Advanced Primary Care:** Foresight believes that the cost of providing their care model is approximately $44 PMPM, which "may seem high" knowing that traditionally, payers have paid around $20-$25 PMPM in the commercial market. Foresight feels they are still short on care management and coaching staff, which if fulfilled, would push the PMPM up to around $47. The rationale for this could be the patient mix (Medicare and Medicaid patients demand more resources on average than commercially insured patients). As a comparison, the direct primary care clinic across the street from Foresight charges a $79 PMPM membership fee.

    - Care management PMPMs are used to pay:
        - The wages for care managers, who conduct the high risk care planning and handoffs;
        - The cost of integrating behavioral health; and
        - The cost of high risk care team meetings.

- **Link Between Practice Budget and Care Management:** In Foresight's market, payer claims are entered into a tool called Stratus, which practices can use to access measures and trends and compare their population to other practices in CPC+. Foresight's Stratus reports indicates that 450 patients account for 75 percent of costs and divides the panel into 5 strata. While not all of these patients need care management, it still helps to identify those who may need it.

- **Rocky's Response:** Rocky can only pay a high PMPM to practices that are excelling, such as Foresight. This requires a tough conversation around "tiering" of practices in the market. Direct primary care is a competitor. Payers are pressed to support models that members want, but ambivalence around advanced primary care may lead to cannibalizing the core basics needed to do this work. Payers need to help support practices in taking this on.

IV. Lessons Learned and "Payer Do's and Don'ts"

- **Importance of Risk Adjustment:** Foresight's experience with risk adjustment has been such that it seems to work with patients with multiple chronic diseases and those with frequent inpatient utilization. Conversely, risk adjustment does not work as well with patients who generate lower risk scores but are high utilizers (e.g., patients with chronic mental health conditions or substance use disorder) or vice versa (e.g., cancer patients).

- **Lessons Learned from the transition:** For Dr Reicks, advance notice and transparency are key in the transition to alternative-to-FFS payments, especially in thinking about changes in the cash flow process for practices. Payers should help practices understand the changes, including what the voucher looks like; the services that will continue to be paid FFS; the "what ifs;" the attribution methodology; and the total payment difference before and after the changes.
    - **Q:** Greg has been a leader in this work for so long. If payers move where the puck will be, what should they be working on?
      A: Payers should work on their systems and technology to support alternative payments in a way that providers can understand. Payers should look to the current claims processing systems and leverage technology to support the system and generate data that does not revolve around claims. CPC+ provides a great opportunity to experiment.

- **Rocky's Perspective:** Rocky was able to demonstrate the difference between FFS and the alternative-to-FFS payment, addressing the fear that payment models will pay practices less in the long-term and building a foundation for the payer/ practice relationship. Despite best efforts, Rocky still had a few practices drop out of the market due to concerns about the model and a lack of communication. On risk adjustment, providers tend to come to the table thinking about the advantages of population payment; however, payers are competing with the "shark bite" argument, or this one patient is who is extremely high cost. Payers should be prepared to address this and "adjust the adjuster." From Rocky's experience, the transformation for payers is just as difficult as it is for providers. Initially, Rocky faced challenges around operationalizing the support system solutions once the model was brought online. Rocky's communication started off well, but fell short over time. While sustained communication can be a challenge, it is also an opportunity for payers and practices to come together and make progress.
    - **Q:** Is Rocky giving Track 2 practices the option of not taking the contract and staying FFS?
      A: It is the latter. While there are many things Rocky could have done better in Track 2 implementation, they now feel positioned to support it well. Practices are not going to regress to Track 1, despite feeling as though they did not know what they signed up for. Rocky considers themselves a comprehensive alternative payment model (APM) across the board. If practices do not wish to participate, they can select to go to the lower tier, which is a lower rate of FFS. It is problematic if top tier practices elect to go to a lower tier, but the structure is imperative to move forward.
    - **Q:** What is Rocky's data saying around total cost of care and revenue for CPC versus non-CPC practices?
      A: Everything hinges on total cost of care; Rocky has been evaluating this in earnest since 2012. Since then, they have seen lower cost trends longitudinally (approximately 2-4 percent better performance) for practices that participated in CPC, SIM, and other advanced payment models. Rocky also continues to see variation across the network, with some practices tracking to the unsustainable average cost of care, while others

beat it. Cross-sectional analysis has demonstrated tiering in the network. Overall, payers should look at total cost of care performance on a monthly basis, and practices should understand and be exposed to it.