Primary Care Payer Action Collaborative (PAC)
Designing Payment to Support Advanced Team-based Care at the Practice Site

Practice Engagement

March 12, 2018

12:00 – 1:30 PM ET

HCP LAN
Health Care Payment Learning & Action Network

If you require technical assistance, please contact ***Kristian Motta*** at kmotta@rippleeffect.com.

Welcome and Introductions

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Logistics

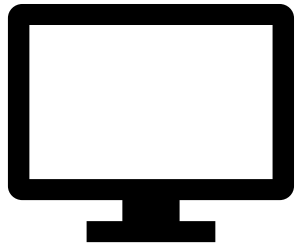
Two-step log in process:

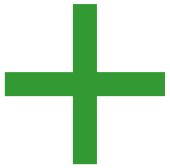
1. Use the ReadyTalk link provided
2. Dial-in for audio using the number listed in the invite

   U.S. Toll: 303-248-0285

   Access Code: 2712000

We encourage participants to ask questions by phone or in the chat box.





Please manage your own mute button on your phone and computer.

Lines will be left open.

Welcome

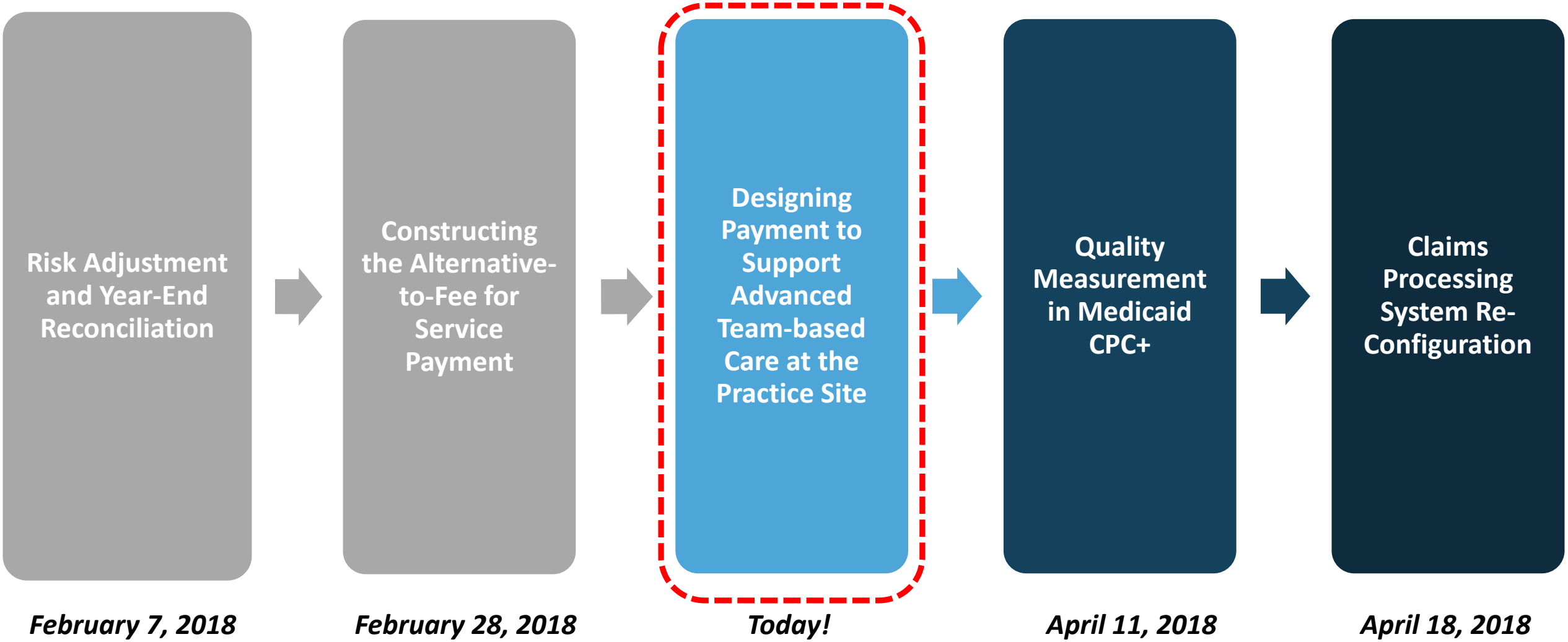
Edith Coakley Stowe
Senior Manager
Manatt Health (DC)

Susan Stuard
Independent Consultant (NY)

Dori Glanz Reyneri
Senior Manager
Manatt Health (DC)

Kaylee O'Connor
Consultant
Manatt Health (DC)

Curriculum, Topics and Calendar



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Today's Agenda

	Timeframe (EST)	Topic	Facilitators/Presenters
1	12:00-12:10 pm	Reminder of PAC, Interactive Polling, and Today's Objective	*Edith Stowe*
2	12:10-12:45 pm	• Foresight's journey from fee for service to population payments • "Do's and don'ts" for payers in the transition to fee for service alternatives	*Dr. Gregory Reicks, Foresight Family Physicians*
3	12:45-12:55 pm	Responding remarks	*Patrick Gordon, Rocky Mountain Health Plans*
4	12:55-1:00 pm	Interactive polling	*Edith Stowe*
5	1:00-1:30 pm	Optional additional Q&A and discussion	*Dr. Gregory Reicks and Patrick Gordon*

Reminder: LAN Action Collaboratives

A LAN Action Collaborative (AC) provides a results-oriented forum for sharing, integrating, and applying new knowledge and tailoring solutions.

This will support committed participants with a shared aim to take more effective action in their organizations to increase adoption of APMs and to make a collective impact on the U.S. health care system.

ACTION COLLABORATIVE

Reminder: PAC Overview

PAC

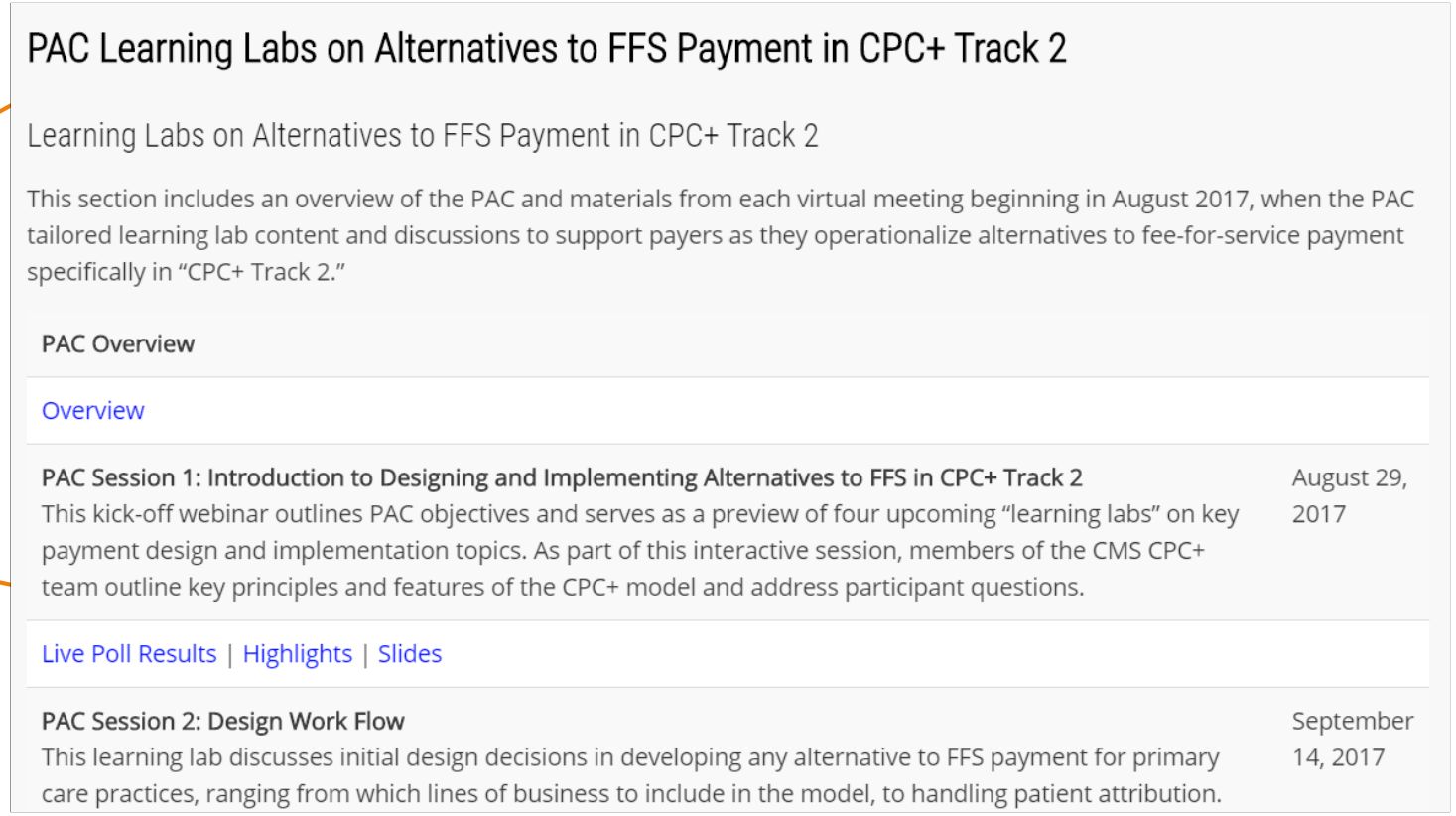
The Primary Care Payer Action Collaborative (PAC) serves as a "national table" for payers committed to improving the implementation of CPC+, a multi-payer primary care APM, to more effectively support practice-level transformation by:

- Identifying and committing to collective goals
- Sharing learning to accelerate action
- Tackling operational barriers to successful APM implementation

PAC Portal

- For more information and resources please visit the Primary Care Payer Action Collaborative (PAC) Portal.

- Slides, session highlights and polling results are posted from PAC fall webinars



PAC Learning Labs on Alternatives to FFS Payment in CPC+ Track 2

Learning Labs on Alternatives to FFS Payment in CPC+ Track 2

This section includes an overview of the PAC and materials from each virtual meeting beginning in August 2017, when the PAC tailored learning lab content and discussions to support payers as they operationalize alternatives to fee-for-service payment specifically in "CPC+ Track 2."

PAC Overview

Overview

PAC Session 1: Introduction to Designing and Implementing Alternatives to FFS in CPC+ Track 2 — August 29, 2017

This kick-off webinar outlines PAC objectives and serves as a preview of four upcoming "learning labs" on key payment design and implementation topics. As part of this interactive session, members of the CMS CPC+ team outline key principles and features of the CPC+ model and address participant questions.

Live Poll Results | Highlights | Slides

PAC Session 2: Design Work Flow — September 14, 2017

This learning lab discusses initial design decisions in developing any alternative to FFS payment for primary care practices, ranging from which lines of business to include in the model, to handling patient attribution.

Interactive Polling

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Polling Question #1a:

Which CPC+ Region are you from?

a) *Arkansas*
b) *Buffalo (2018 Start)*
c) *Colorado*
d) *Hawaii*
e) *Kansas City*
f) *Louisiana (2018 Start)*
g) *Michigan*
h) *Montana*
i) *Nebraska (2018 Start)*
j) *New Jersey*

Polling Question #1b:

Which CPC+ Region are you from?

a) *North Dakota (2018 Start)*
b) *Hudson/N Capital NY*
c) *Ohio/N Kentucky*
d) *Oklahoma*
e) *Oregon*
f) *Philadelphia*
g) *Rhode Island*
h) *Tennessee*
i) *Payer in multiple regions*

Today's Objective

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Objective

- 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
  - A payer

Antitrust Statement

PAC Participants agree that all activities are in compliance with federal and state antitrust laws. In the course of discussion, **no financial information from payer participants will be shared with other payers or the general public.**

During meetings and other activities, including all formal and informal discussions, each payer participant will refrain from discussing or exchanging information regarding any competitively sensitive topics. Such information includes, but is not limited to:

- ✓ PMPM
- ✓ Shared savings or incentive payments
- ✓ Information about market share, profits, margins, costs, reimbursement levels or methodologies for reimbursing providers, or terms of coverage

Speaker Introductions

Today's Speakers

Dr. Gregory Reicks
Physician
Foresight Family Physicians
Grand Junction, Colorado

Patrick Gordon
Vice President
Rocky Mountain Health Plans
Grand Junction, Colorado

Foresight's Journey

From Fee for Service to Population Payments

FORESIGHT
FAMILY PHYSICIANS

Foresight Family Physicians

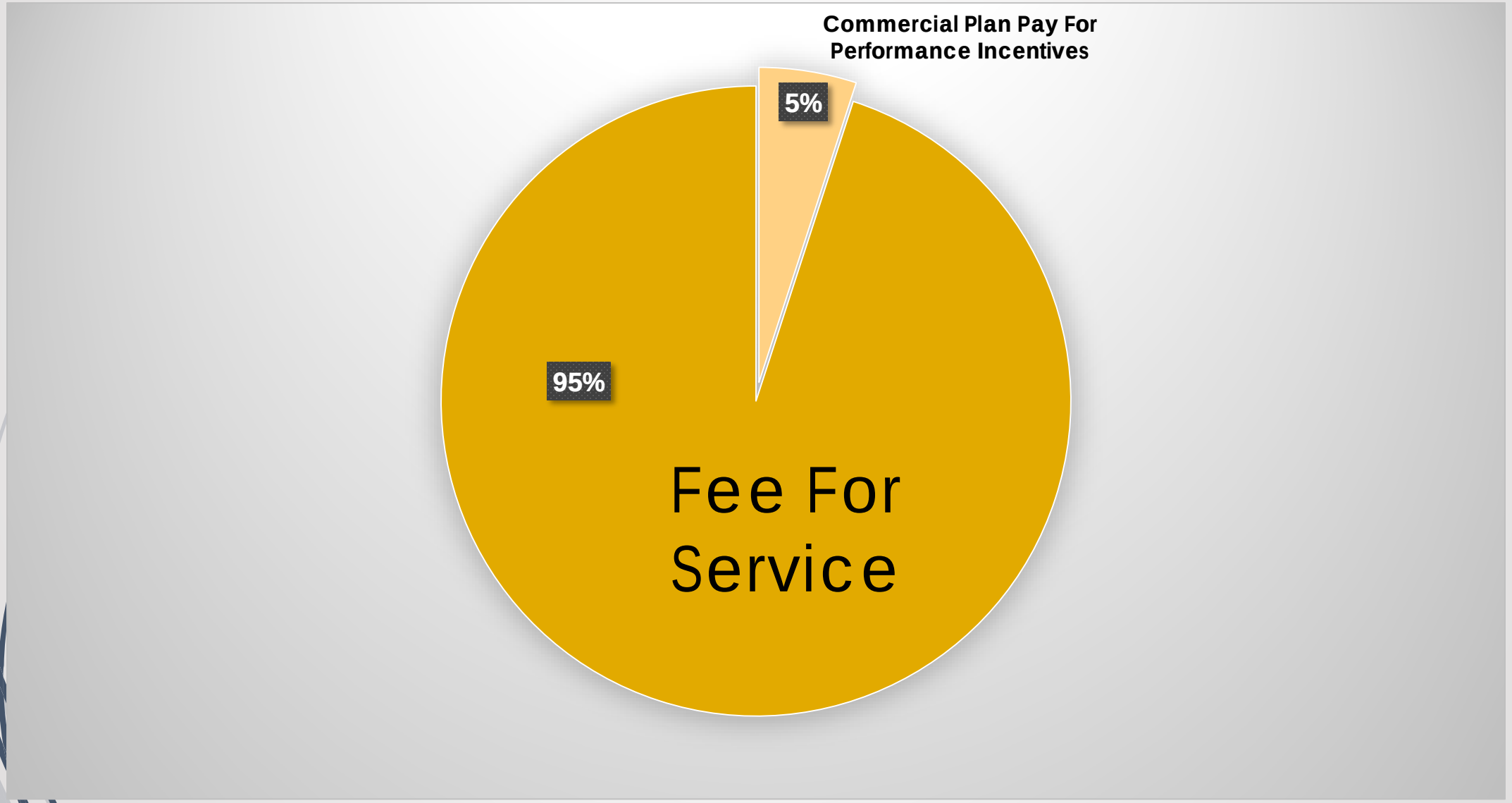
- **25 Total Staff**
  - 5 FTE Providers
    - 2 physicians, 3 Advanced Practitioners
  - 6.5 FTE Medical Assistants
  - 3.5 FTE Front Desk
  - 2.75 FTE Care Managers
  - 2 FTE Behavioral Health
  - 1 FTE Initiative Coordinator-Occ, Health
  - 1 FTE Biller
  - 1 FTE Office Administrator
  - 0.5 FTE Medical Records
- **4:1 Staff to Provider Ratio**

Foresight Patient Mix - 2017

- 32% Commercial (Fully insured and Self Funded)
- 31% Medicare (Managed and FFS+)
- 24% Medicaid (Managed and FFS+)
- 10% Occupational Medicine (FFS)
- 3% Self Pay

44% of Patients are attributed to CPC+ Payers

Foresight Revenue – 2012



The Transition - 2013

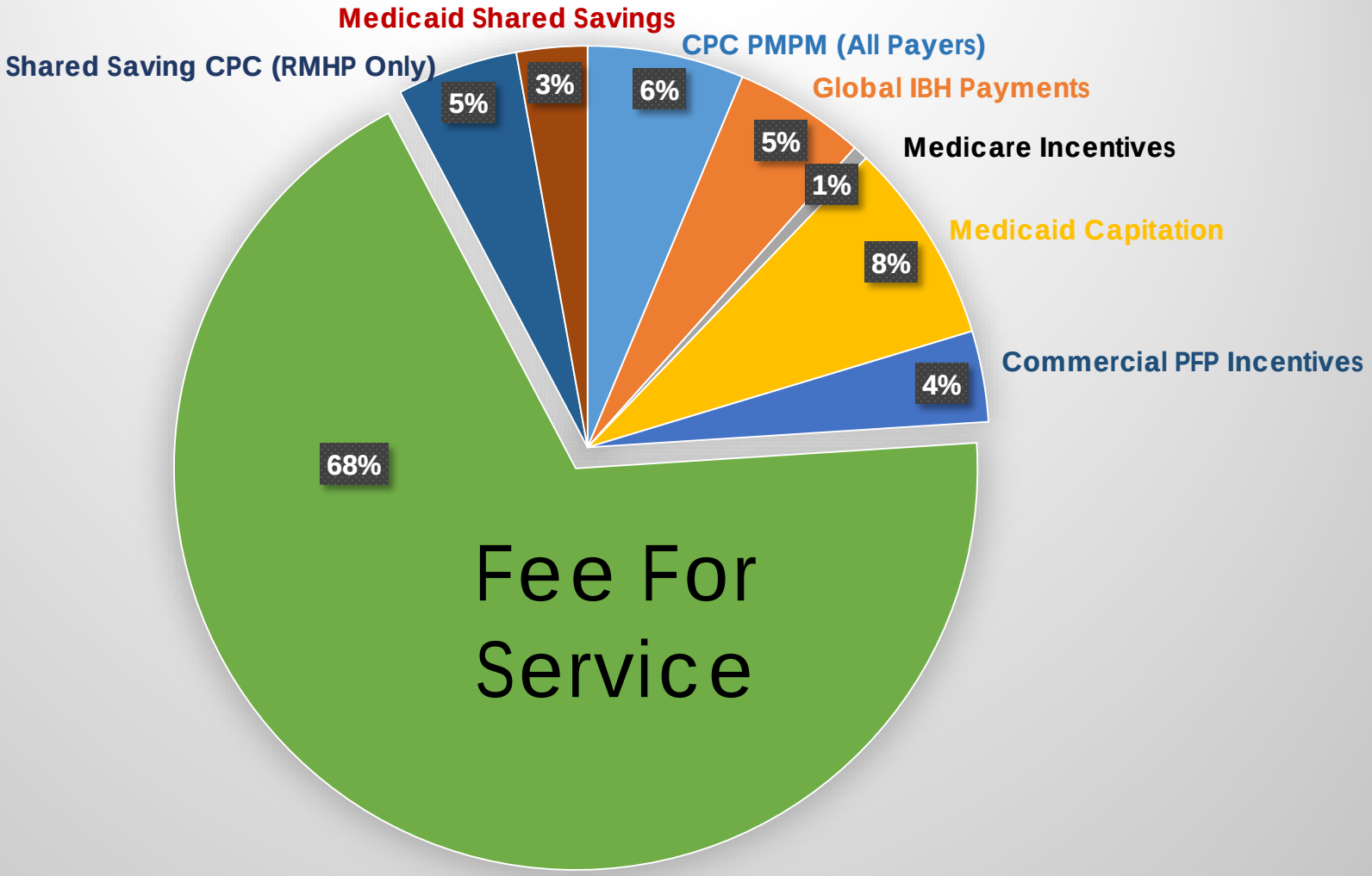
- Comprehensive Primary Care Initiative (CPC Classic)
- Rocky Mountain Health Plans Medicaid PRIME (Capitation)
- SHAPE (cost based payment for integrated behavioral health)

CPC
Comprehensive Primary Care

ROCKY MOUNTAIN
HEALTH PLANS®
Medicaid PRIME

SHAPE
Sustaining Integrated Care

Foresight Revenue – 2015



More Transitions – 2017

- Comprehensive Primary Care Initiative +
  - Medicare Alt. FFS (25%)
  - Medicare Performance Based Incentive Payment
- Capitation all LOB RMHP
- RMHP Community Integration Agreement
- Million Hearts
- Diabetes Prevention Program

CPC+
Comprehensive Primary Care Plus

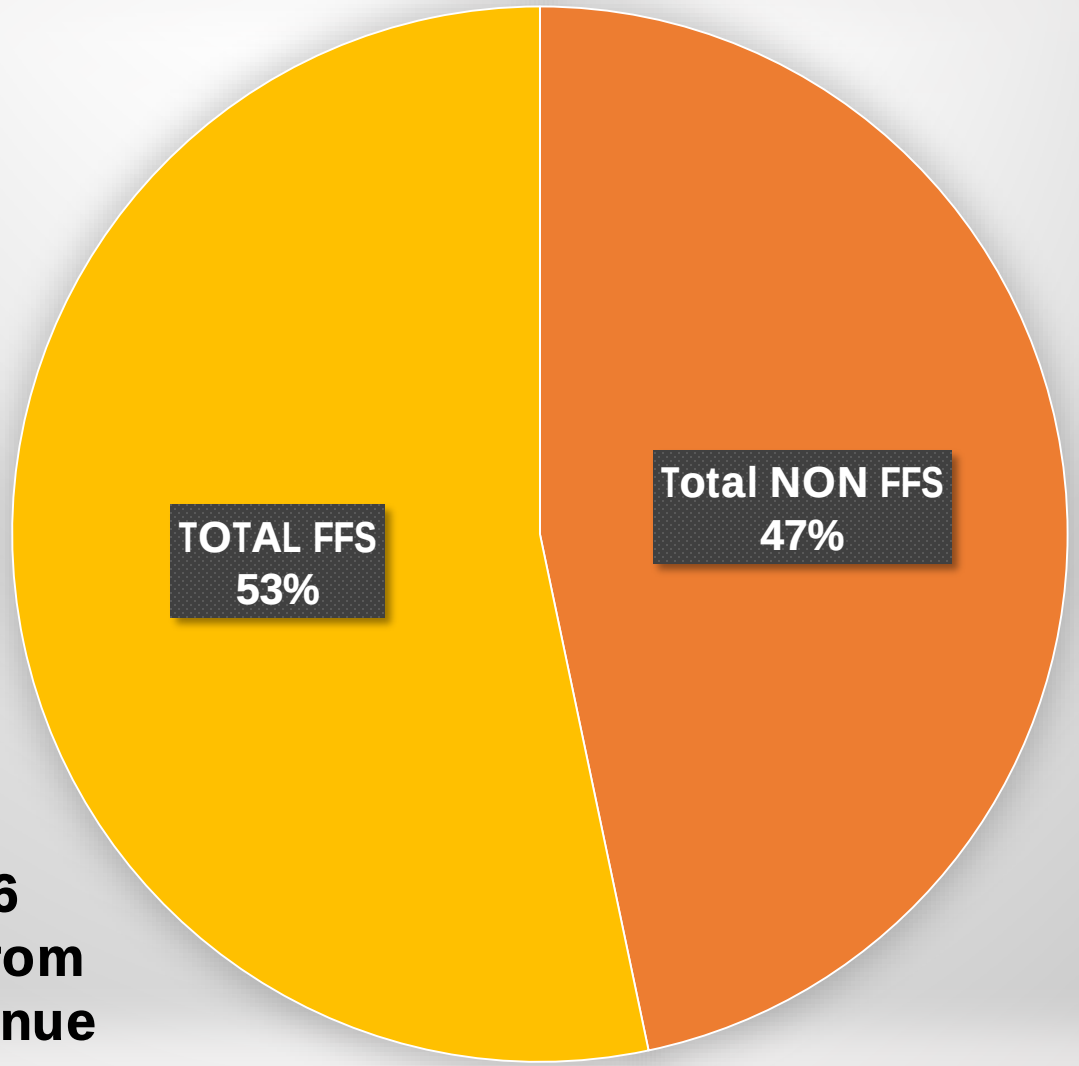
Rocky Mountain Health Plans®

Accountable Care Collaborative Phase II

Million Hearts®

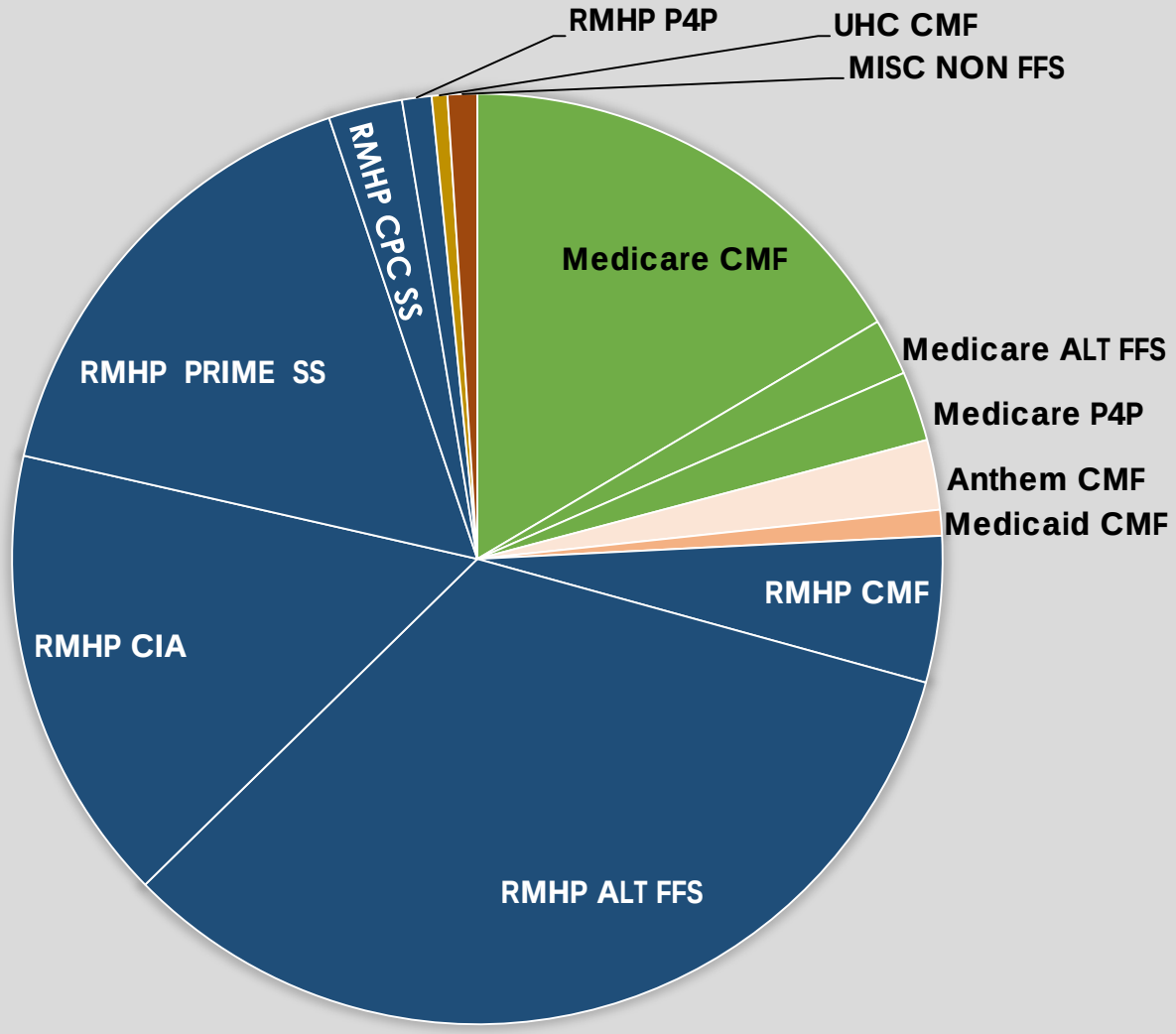
Medicare Diabetes Prevention Program (MDPP) Expanded Model

Foresight Revenue – 2017



Approximately $6 PMPM increase from 2012 in total revenue

Foresight Sources of Non FFS Payments – 2017



Changing Business Model

- Balancing Non-Billable Services.....
  - Integrated Behavioral Health
  - Care Management
  - Health Coaching
  - PCMH (Advanced Primary Care) activities
- To Match Alternative FFS, CMF Revenue expected
  - Care management PMPMs
  - Cost Based Payments
  - Enhanced Capitation

Changing Business Model – How are alternative FFS payments used?

- Less emphasis on face to face encounters
  - Telephone Visits
    - Lab reviews
  - Telehealth visits
  - Portal Visits
  - Group visits
- Lower cost resource visits
  - Health coaches
  - Care managers
  - Integrated Behavioral health
  - Medical Assistants

Changing Business Model

- Provider compensation
  - Move away from RVU based compensation to blended…….
  - Risk adjusted Population based payments
    - Encourages larger panel size (What is the optimum?)
    - Encourages more creative use of providers time
    - Compensation for participation in PCMH activities
  - Performance payments – Quality and Utilization
  - + Productivity
- Staff compensation
  - Incentives for…..
    - Team participation
    - Meeting quality benchmarks
    - Patient Satisfaction
    - Meeting Utilization Benchmarks, Panel Size targets

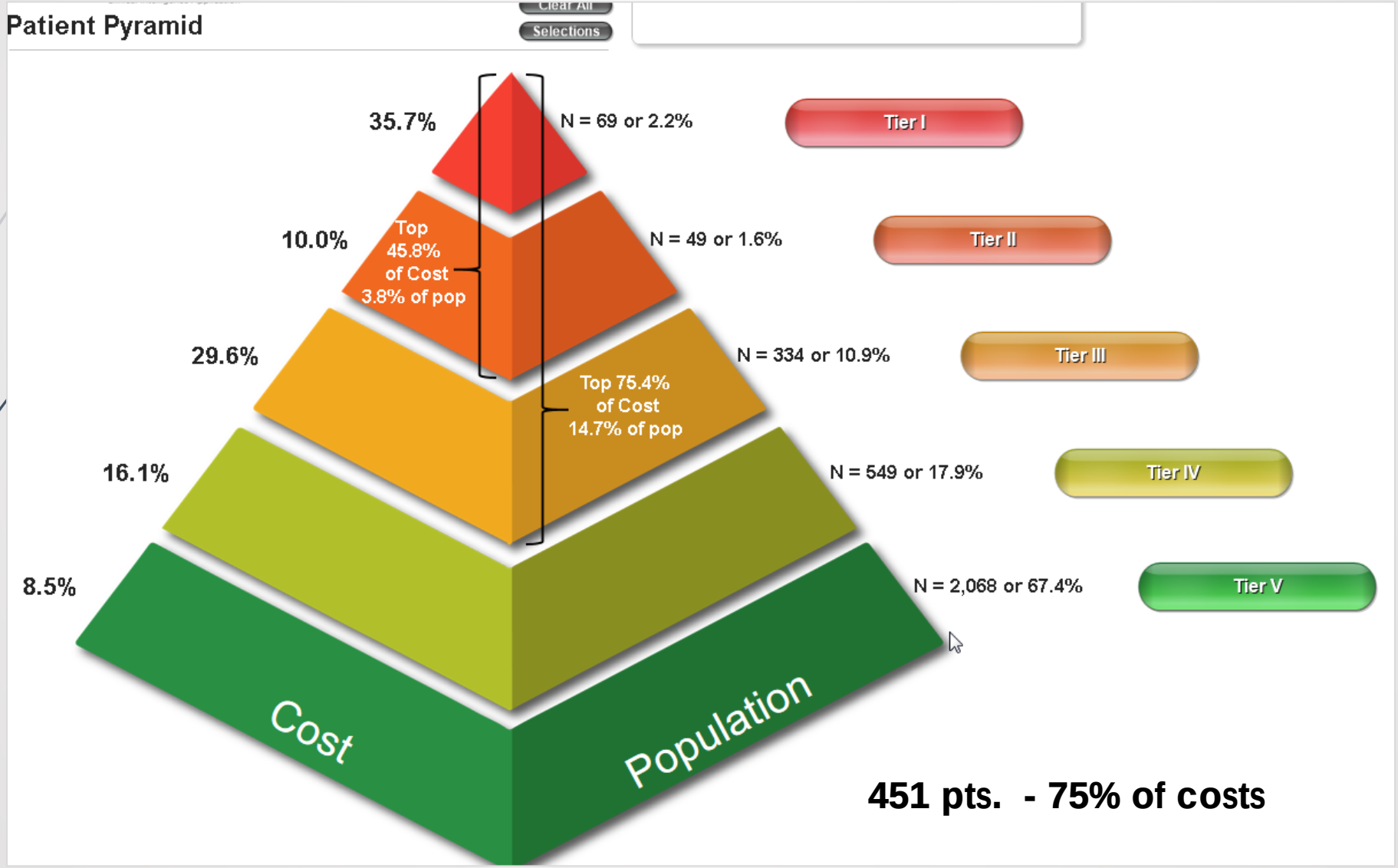
What does Foresight Advanced Primary Care Cost?

- Foresight Family Physicians – 2017
  - Total Expenses – $2,341824
    - Minus 10% allocation Occ Health
  - Total Adjusted Expenses - $2,107642
- Active patients ~ 4000 = 48000 Member Months
- **= ~$44 PMPM**
- Needs for 2018 – 2 FTE Care Manger , Health Coach
- = ~ $47 PMPM
- Appleton Clinic (Direct Primary Care) $79 PMPM

How are care management PMPMs used?

- Cover cost of care managers
  - Care planning high risk patients
  - Handoffs
- Cost of Integrated behavioral health
  - Care planning high risk behavioral health patients
  - Handoffs
- High Risk Care Team Meetings

Which Patients are Target Population?



Typical Morning of Foresight Care Manager

33

- Finish care plan – 68yo male –COPD, O2, OSA, HTN, CAD – 10 min
- TC – 64 yo female, DM, retinopathy, neuropathy, Stage 4 CKD – review BGs, nephrology consult, adjust insulin, med rec. – education, MI – 10 min
- TC – daughter of 94 yo female, struggling at home, needs more caregivers – assist with LTMC app – 20 min
- Covisit with Dr. - 56 yo male TOC hospital AMI, DM, HTN smoker – MI tobacco cessation, med rec, MDPOA, MOST – coordinate specialty f/u - CP -25 min
- TC HH 88 yo female – dementia, frailty, - review HH orders, update CP, discus with MDPOA – 15 min

- Update CPs 3 high risk pts. – 40 min
- TC Coordinate visit, orders to infusion center for pt. with chronic anemia – iron infusions – 15 min
- TC 35 yo male ESRD coordinate care with cardio, med rec. review recent ED visit – 15 min
- TC – review home tx with COPD high risk with influenza – 10 min
- CMM new Medicare pt. HTN, DM, COPD– CP, MOST, MDPOA, advanced directives – 30 min
- TC- 45 yo disabled female, bipolar, DM, morbid obesity, - review BGs, med rec. coordinate with mental health – 15 min
- TC 79 yo COPD, CHF high risk pt ER F/U – influenza – review self management, meds monitoring – 10 min
- handoff – 54 yo female new Dx DM – DM education – 15 min
- TC – 89 male high risk – CAD, CHF, afib – palpations – 10 min
- Discuss orders with Rehab re: TOC 77 yo frail S/P ORIF hip fx – med rec, -10 min
- MOCA 89 yo female – MDPOA, MOST, review with family – med rec– 20 min.

Typical Morning of IBH Foresight

- F/U 56 yo male, chronic pain, opiates, obesity, depression, HTN, prediabetes –review goals of healthier eating, exercise -15 min
- WHO 62 yo female, HTN, chronic depression, PHQ 14, obesity, DM –discuss sleep, exercise, stress management – 10 min
- F/U 27 yo female high ACE, PTSD, migraines, chronic pelvic pain, recurrent depression F/U stress management, counseling, med compliance, healthy behaviors– 10 min
- TC 34 yo male checking on referral to CMC for Bipolar, ADD, med compliance – 5 min
- TC 15 yo female migraines, PTSD, F/U re: ADHD symptoms management, healthy eating, wt loss – 5 min

- TC F/U 60 female major depression, migraines, PTSD, chronic pain d/t trauma, social isolation, PAM 3 – discuss meds, small goals, healthy diet – 10 min
- WHO 40 yo female multiple unexplained symptoms, generalized pain, high ACE, PAM 2– relaxation, meditation, spousal support – 15 min
- TC F/U 18 yo major depression suicidality, referred for counseling, medication tolerance – 10 min
- WHO 70 yo male alcoholism, major depression recent incarceration, social isolation - identified local resources for social enagement – 15 min
- WHO 22 yo female morbid obesity, recurrent depression, PHQ 12 – goals for exercise and nutrition – 15 min
- WHO 83 yo female a fib, chronic anxiety, frailty, recent death of spouse, grieving and worry about her health – relaxation, refer to grief support, counseling – 15 min
- Identify pts. Coming in tomorrow needing PAM, repeat PHQ, GAD, Audit Screens – 30 min
- WHO 75 yo male early dementia, DM, HTN, BKA – coordinate support when wife has major surgery – 15 min

What Drives Utilization in Primary Care?

Do current risk adjustment models work in primary care?

Current risk adjustment works with these patients

- Multiple Chronic Diseases in the same pt.
- Frequent inpatient utilizers

Current Risk adjustment doesn't work for these patients

- Worried Well"
- Personality Disorders
- Chronic Mental Illness – esp. PTSD. GAD, Somatization
- Chronic Pain Disorder
  - Fibromyalgia
- Substance Use Disorder
- Active Cancer
- Single dx with expensive drugs
  - Multiple sclerosis

Risk Adjustment and Capitation – Perils for Primary Care

- 56 yo male – Commercially insured
  - DX Metastatic Malignant melanoma - HHS - HCC Score 25.82
    - **TCC 9/16 – 12/17 - $280,490**
- **PCP Capitation ~ $150/mo - $2250 in the claim period**
- Seen TWICE by PCP in 15 mo. time period
  - No calls, refills
- Clinical and Nonclinical labor costs of care
  - ~$75/visit -
  - Non labor fixed costs ~$161 PMPY
- **PCP Cost of care delivered ~ $345**

Risk Adjustment and Capitation – Perils for Primary Care

- 63 yo male – Commercially Insured
  - Chronic Low back pain, Chronic Depression, ADHD, PTSD, - HHS-HCC 0.65
  - TCC 9/1/16 – 12/1/17 - $8646
- **PCP Capitation - $11.38/mo - $170 in the claims period**
- Cost of Clinical and nonclinical care delivered
  - Five 20 minute office visits - $110/visit
  - 3 warm handoffs IBH - $30/handoff
  - 29 Telephone calls (refills, questions, referrals, follow-ups - $10/PC
  - 8 counseling visits Integrated Behavioral Health - $50/visit
- Non labor Fixed costs - $161 PMPY
- **Cost of Care delivered - $1525 in the claims period**

Keys to Effective Alternative FFS Payments – Payers

- Transparency
  - Clinicians, Practice Managers, Practice accountants need to understand the process
    - Make it simple to explain – what will still be paid 100% FFS?
    - Be prepared to answer all of the "what ifs"
    - Make sure you can demonstrate that the total payment a practice will receive is more than would be expected under 100% FFS
      - What is the risk to the practice – can it be defined?
      - Semi annual or Annual comparisons
    - Do not disincentivize visits that need to be face to face (new patients, physicals)
    - Attribution is critical to the practice with these models – what is the method?
  - Expect resistance – Many see this as a way to reduce primary care spend
    - Many may not be aware of what they signed up for with Track 2

Response: Patrick Gordon, Rocky Mountain Health Plans

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ROCKY MOUNTAIN HEALTH PLANS®

Response: *Patrick Gordon, Rocky Mountain Health Plans*

Interactive Polling

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Polling Question #2:

Please rate your overall satisfaction with this event.

a. *Very satisfied*
b. *Somewhat satisfied*
c. *Somewhat dissatisfied*
d. *Very dissatisfied*

Please type additional thoughts in the chat,

especially any suggestions for improvement

Polling Question #3:

Today's Lab enhanced my knowledge of the subject area.

a. *Strongly Agree*
b. *Agree*
c. *Disagree*
d. *Strongly Disagree*

Please type additional thoughts in the chat,

especially any suggestions for improvement

Polling Question #4:

I will take action or work with others in my organization to take action based on today's lab.

a. *Strongly Agree*
b. *Agree*
c. *Disagree*
d. *Strongly Disagree*

Please use the chat to tell us what you will act on,
or why the information was not actionable

Polling Question #5:

The PAC is helping my organization make progress towards its goals in CPC+.

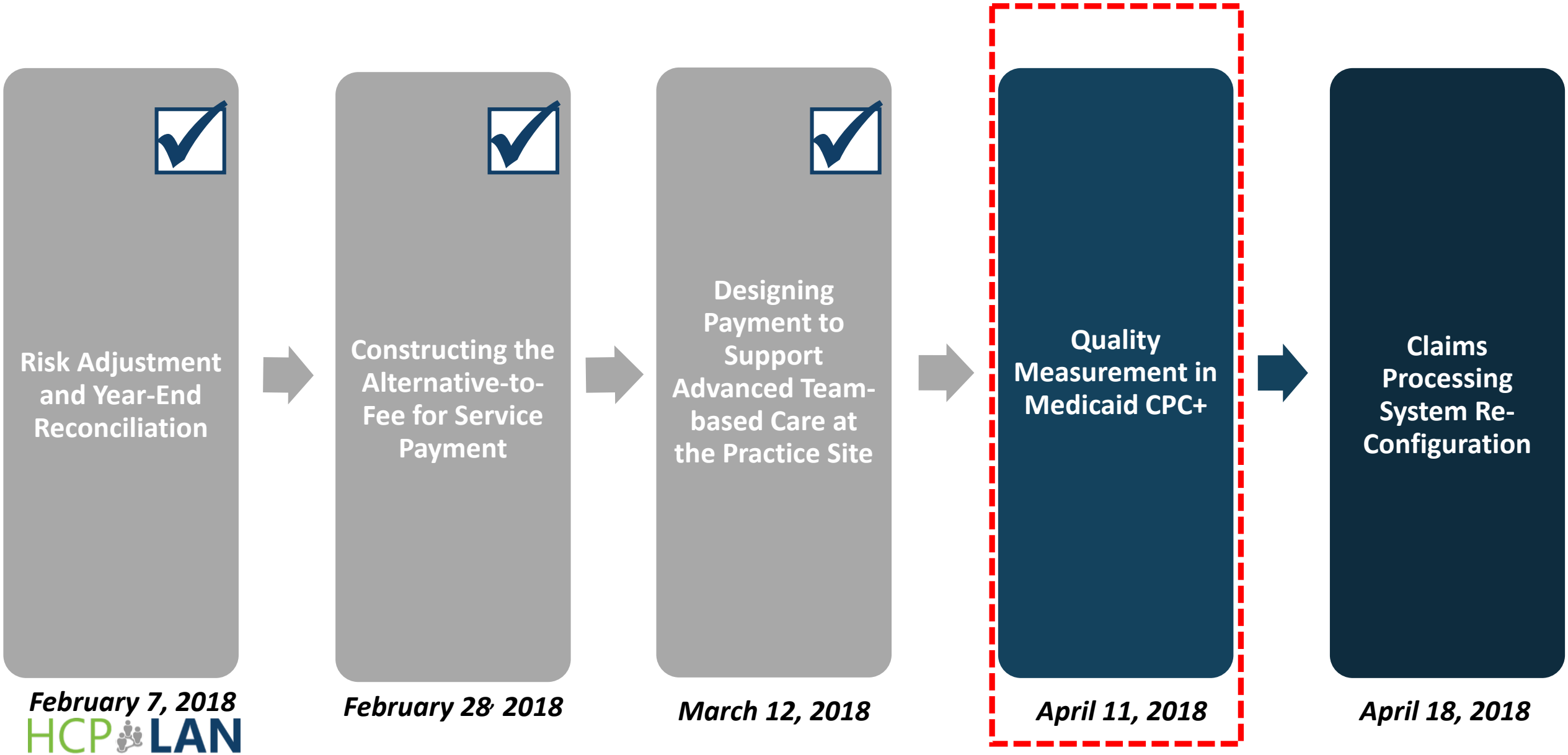
a. *Strongly Agree*
b. *Agree*
c. *Disagree*
d. *Strongly Disagree*

Please type any additional thoughts in the chat, especially any suggestions for improvement.

Questions and Discussion

Wrap-Up

Next Time



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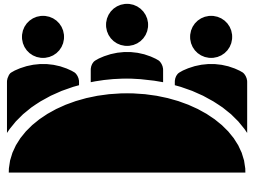
Upcoming Events

Mark Your Calendars



PAC In-Person Meeting

Monday, May 7

1:00 – 4:00 pm ET

Baltimore Convention Center

Baltimore, Maryland

Register here: https://hcp-lan.org/pac-spring-meeting-rsvp/

This meeting will correspond with the Annual CPC+ Meeting on May 8.

Thank You!

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