MULTIPAYER PRIMARY CARE NETWORK

Milbank Memorial Fund

CPC+ PAYER COVID-19 SURVEY SUMMARY

Q1 2020

Q1. What is your name and organization?

43 payer organizations submitted responses

Q2. Is your organization paying for telemedicine visits with in-person visit codes?

- **HIPAA-compliant or non-HIPAA compliant technology?** 90% said yes, and of these positive responses, 90% are paying at par with in-person visit codes
- **Via telephone?** 75% responded yes, and all of these are paying at par with in-person visit codes

Q3. Has your organization waived patient payments for COVID-19-related conditions?

> 90% waived deductible payments, co-pays and/or co-insurance charges.

Q4. Has your organization instituted interim payment programs for primary care practices?

Of the respondents:

84% - Value-based contract-guided payment to practices
16% - Historically-based (using claims from a previous time period as a tool) up-front payment to practices

Q5: Are you observing any differences in pandemic response capacity between participating CPC+ and non-CPC+ practices? In practices with other value-based or capitated payment arrangements and strictly fee-for-service practices?

NO/NOT SURE/NOT APPLICABLE

60% of plans surveyed stated that they did not see a discernable difference in capacity between practices in CPC+ or other value-based or capitated payment arrangements and those strictly in fee-for service. Comments related to this response noted general increased practice stress without performance changes, a pre-existing increased capacity for telemedicine adoption, and a general increased capacity regardless of CPC+ participation. Several payers said that it was too early to tell what differences exist between practices with various payment arrangements were.

YES

40% of payers answered yes. Their comments fell into the following general categories:

Telehealth – Payers noted challenges related to provider and patient connectivity, discernable impact of a practice's level of sophistication/experience, large increases in the number of telehealth visits, and payment model-related capacity

Staffing changes – Payers seeing reduced on-site visits by 55-70% since pandemic, staff furloughed or deployed.

Reduced hours or visits – Reports of clinics fully closed or reduced hours (up to half-day), huge effect on pediatricians due to drop in well-child visits, and even many virtual meeting cancelations.

Adaptability – One payer said they through CPC+ practices were "more forward leaning, perhaps more adaptable", another noted that their long-term commitment to a front-loaded risk adjusted global payment on a per member per month (PM/PM) monthly basis allowed offices that are struggling with their number of visits to remain financially viable and target their patients in greatest need.

Q6: Please describe other Covid-19 response programs or policy changes that affect primary care your organization has put in place. Please exclude what you have been directed by regulation to implement, and the activities outlined in Questions 1, 2, and 3.

Note: Bullets represent individual respondent comments

NO

7% of payers said “no” – that there were no program or policy changes. One of these has a fully capitated payment to their CPC+ primary care practices in place, which remained unchanged from baseline at the time of the survey.

YES

93% of payers answered yes. Their comments fell into the following general categories:

Accelerated Payments – Payers have accelerated quality payments to practices to help with cash flow and enhanced existing quality incentive programs, offered early release of 2019 surplus and accelerated move to pre-payment for PCP services. Several noted an escalation in providers wanting to move to PCP capitation.

Policy and Administrative Changes – Payers listed a wide variety of procedural changes, including:

- Extensive reduction of policy changes and administrative requirements between March and June.
- Devising ways to assess changes in claims submission (compared to pre-pandemic levels; splits of in-person and telehealth, etc.)
- Eased requirements and administrative burden for Credentialing Community Health Excellence Grants Risk withholds waived for all lines of business
- Eliminated care plan audits and chart retrievals
- Relaxed requests for medical records
- Covering PCP home visits for suspected and positive COVID-19 patients.
- Devising ways to assess changes in claims submission for pop-up clinics, field hospitals and other "new" provider locations
- Changed quality metrics for year 2020 as patients are not coming into the office and care gap closure will be affected.
- Waived time filing requirements for CY 2020
- We have extended our original due date for self-reported quality measures.
- Extended appeal timeline.
- Reimbursing contracted and non-contracted providers for COVID-19 testing based upon CMS announced rates
- Covering the cost of screenings, tests, and visits related to COVID-19
- We were approved for a Section 1135 Waiver for COVID-19
- Referrals and authorizations waived (see below)

Telehealth – Telehealth-related changes were extraordinarily well-represented.

- Addition of Telehealth services not otherwise reimbursed outside of the emergency period such as well child checks for children over 2.
- Allowing offices to bill telemedicine visits with POS 11 and 95 Modifier during the COVID timeline.
- Reviewing splits of in-person and telehealth
- Assessing cost impact for changes in delivery types, adjustments in coverage, etc.
- Using our integrated call center to conduct COVID risk assessments and schedule PCP telehealth visits
- Expanding coverage and access to virtual care services
- Supported capitated partners to use excess funding to invest in Telehealth capabilities
- Working with SHS on their Telehealth investments and outreach
- Increased member outreach and engagement to communicate the ability to receive health care services through telehealth
- Implemented all procedure codes provided in our state Medicaid guidance
- Created pay parity for telehealth services throughout the provider network

Durable Medical Equipment/Pharma/Expanded Socio-economic Services – Payers described non-visit related areas of increased support for members/beneficiaries

- Covering delivery of blood pressure cuffs to patients.
- Allowed early refills, waiving limits on early medication refills, increased accessibility of 90-day medication supplies
- Allowed our capitated provider to expand the services beyond the scope of the contract, including meal delivery, grocery and bank rides, and other essential transport services, keeping the contracted drivers employed while normal utilizations have dropped.
- We are encouraging surplus funds to be used to assist members with housing assistance

Prior Authorizations and Referrals

- Waiving or relaxation of prior authorization requests
- Payment of treatment costs, diagnostic and serologic testing for COVID
- Virtual ER at no cost share
- Extension of prior authorization timeframes; extension of timely filing of claims, reduction of services requiring prior authorization.
- Waived High Dollar claim reviews during this period

Q7: Please describe any new primary care payment reforms or adjustments your organization is contemplating in response to the new landscape.

Note: Bullets represent individual respondent comments

Only 16% of payers responded no to this question. An additional 11% said they were in very early discussion stages internally. Several noted that any organizational policy changes had to take 2020 metrics and external factors (vendors, fundamental industry impacts) into account.

For the majority of payers, their future plans clearly reflected a need to modify "business as usual" in response to the pandemic. For some that meant doubling down on already ongoing innovations. Opportunities identified fell into the following categories:

Accelerated payments

- We are implementing interim payments in response to the crisis AND as an ongoing process
- We are considering implementing interim payment programs for primary care providers.
- Pre-payment for PCP services/Advance payments
- We are contemplating a mechanism to advance 3 to 6 months' worth of Per Member Per Month payments to PCMH Practices in good standing

IT Support

- Assisting practices with purchase of hardware and new cellular options to help them navigate the technology requirements in rural markets.

Telemedicine

- Taking a broader look at telemedicine from a longer-term strategy
- Need to explore ongoing policy around telemedicine as multiple organizations have expressed desire to continue to fully embrace telemedicine beyond the pandemic.
- Including tele visits in attribution methodology
- Understanding what will be appropriate to leave in place for tele visits going forward.
- We have implemented more extensive telemedicine coverage guidelines that we are contemplating implementing on a more permanent basis moving as the immediate crisis dissipates. (3 regions)

Alternative Payment Models (APMs) - "This pandemic has revalidated the importance of moving away from a FFS model and the need for a consistent revenue stream based on attribution and quality."

- APMs with specific provider partners
- Responding to increased interest in APMs by providers
- Capitated payments for all value programs in consideration.
- Considering potential acceleration of a partial/global payment methodologies.
- We continue to look at a risk model with payment away from FFS.
- Engaging with other PCP clinics on value-based contracting in addition to a sub-capitated model.
- We are seeking an 1115(a) demonstration waiver to establish a safety net fund to reimburse hospitals, providers and medical labs for increased costs associated with providing COVID-19 treatment to uninsured individuals

Specialty-directed Changes – One payer was focused on specialty providers.

- Most of the payment reform discussions have focused around the specialty community, as our Primary Care Payment model (EPC) has been successfully implemented for 10+ years.

Quality/Cost Measure Requirement Modification – Payers were mindful of the devastating impact on their partner practices, scaling back quality and utilization requirements.

- We are looking at how we can better incentivize providers more real-time for quality performance.
- Modifying total cost of care expectations for performance year 2020
- Modifying quality and efficiency thresholds for performance year 2020
- We are looking at how to make sure practices are not penalized for not hitting 2020 quality or financial targets. We are looking at the support practices will need when we get back to the new normal.
- As a payer partner for CPC+ under the PCMH program, we are considering programmatic adjustments for provider performance measurement to account for the impact of COVID-19.
- Relief from quality requirements for access to surpluses
- We are certainly evaluating the needs of our primary care providers as we want to ensure their financial stability as well as an adequate network of providers for our members.