# Primary Care APM Work Group

## PILOT DESIGN AND IMPLEMENTATION

April 5, 2018

CRANSTON, RI

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

# Agenda

1. Welcome & Introductions
2. 2017 Primary Care APM Work Group Consensus Model Recommendations
3. Recent Payer Activity Regarding Primary Care APM
4. Multi-Payer APM Pilot for Primary Care
    - OHIC 2018 APM Plan
    - Pilot Goals
    - Pilot Parameters
    - Pilot Participants
5. Next Steps
6. Public Comment

# Background

**January 2017:** OHIC's 2017 APM Plan calls for development of Primary Care Alternative Payment Model

**Early 2017:** Medicare CPC+ program begins in Rhode Island (approx. 30 practices)

**Jan. – July:** OHIC Primary Care APM Work Group develops Primary Care APM Consensus Model

**Aug. 9, 2017:** Primary Care APM Work Group Consensus Model published

# 2017 Primary Care APM Work Group Consensus Model: Principles

1. The APM should be designed to achieve better care, smarter spending, and healthier people by improving the ability of PCPs to deliver patient-centered care using flexible approaches to communication, monitoring, and treatment.
2. The APM should complement Rhode Island's PCMH strategy.
3. The goal of the APM is not to reduce primary care spending or shift insurance risk to PCPs.
4. The APM should lend itself to multi-payer alignment (including by public payers Medicaid and Medicare for CPC+ Track 2).
5. The APM should preserve access for patients.

# 2017 Primary Care APM Work Group Consensus Model Recommendations

1. The standard primary care alternative payment model for the commercial market should be a **complete capitated payment** for included primary care services (while maintaining pre-existing cost-sharing arrangements).
2. *However*, individual insurers and providers **may agree to develop blended models** (such as the CPC+ model which pays FFS *and* capitation for included services) on a case-by-case basis.

# Incentives in a Capitated Payment System

1. Capitation *allows* providers to practice more flexibly, tailoring care to patient needs.
2. Capitation does not *automatically* lead to better care.
   - Providers can use the new flexibility to improve care and patient experience.
   - But...providers won't necessarily take advantage of the flexibility.
   - It is important to build capitation systems in the context of other efforts like PCMH and total cost of care accountability.
3. Capitation does not *automatically* reduce practice expenses.
   - Fewer office visits may not reduce practice costs (but they may free up clinician time!).
   - New modes of patient engagement may increase costs.
4. Capitation creates an incentive for less access and under-treatment.
   - The program should use monitoring and other tools to offset this incentive.

# 2017 Primary Care APM Work Group Consensus Model Recommendations

Minimize barriers to participation:

- No size threshold or practice model requirements
- No patient exclusions

Capitation includes:

- office visits (prevention or acute) and consultation
- typically bundled services (e.g., blood collection)
- urinalysis, electrocardiogram
- services subject to overuse (e.g., removal of skin lesions)

# 2017 Primary Care APM Work Group Consensus Model Recommendations

Other topics addressed in the Recommendations:

- **Patient attribution** (plan discretion)
- **Capitation rate** (general approach (annual) with plan discretion; cost-sharing offset from capitation)
- **Risk adjustment** (required, with plan discretion on implementation)
- **Quality** (aligned with other initiatives; include stinting measures; include measure of specialist and ED use)
- **Separate payment for visits during non-traditional hours**
- **Transparency and data sharing** (expectation is a high level of both)

# Recent Payer and Provider Activity

- What is the status of CPC+ activity with regard to primary care APM adoption?


- Have RI insurers and providers initiated any *non*-CPC+-related primary care APM contractual activity since last summer?

# 2018 Multi-Payer Primary Care APM Pilot

OHIC will facilitate a **collaborative process** between interested primary care provider groups and health insurers to implement an APM pilot. OHIC **will not mandate strict adherence** to the primary care APM model framework, but will **encourage as much cross-payer alignment of contracting terms as possible**, and OHIC will **encourage the selection of a common group of practices** among which to deploy the payment model.

- 2018 OHIC Alternative Payment Methodology (APM) Plan

# Pilot Goals –
# Straw Model and Questions for Discussion

1. Implement a primary care capitation pilot by October 1, 2018.
2. Establish a scalable framework to permit (and encourage) additional practices to join in future years.
3. Make additional recommendations to OHIC regarding next steps for facilitating primary care APM adoption.

What else should the pilot accomplish?

- Practice participation
- Practice transformation
- Financial performance

# Proposed Pilot Parameters (for discussion)

1. We will use the Consensus Model as a basis for pilot design
2. Practices and plans will individually negotiate the terms of the pilot to maximize participation, while honoring the principles of the primary care APM pilot.
3. The pilot will be one year in duration.
4. There will be ongoing evaluation of lessons learned.  OHIC will publish an evaluation report at the end of the period.

# Pilot Participants

The following organizations previously expressed some level of interest in pilot participation:

- BCBSRI
- CharterCARE
- RIPCPC

To the extent practicable, work group meetings will be open to other stakeholders who would like to understand or contribute to the process.

Participation in the work group is NOT a formal commitment to join the pilot, but OHIC's expectation is that work group members will make a good faith effort to "get to yes."

# Next Steps

# Public Comment