Primary Care APM Work Group

PILOT DESIGN AND IMPLEMENTATION

June 14, 2018

CRANSTON, RI

Agenda

1. Welcome and Introductions
2. Primary Care APM Implementation - Principles
4. Progress Report
5. Goals for the Phase 1 Pilot
6. Design Topics (time permitting)
    - Cost-sharing reconciliation

Proposed Approach to Primary Care APM Implementation: **Principles**

The Primary Care APM Pilot should:

1. adopt the OHIC Consensus Model principles to the extent possible;
2. maximize payer participation in order to have a 'critical mass' of patients under a capitation contract in participating practices;
3. complement Rhode Island's PCMH and TCOC strategies to advance affordability;
4. prioritize sustainability of primary care, including a commitment to 'do no harm' to primary care practices, and scalability so that it will support expansion to additional payers and practices of all sizes over time; and
5. encourage participants to share decisions made and lessons learned.

Progress Report: approach to Primary Care APM Implementation

Phase 1: Plans and providers implement primary care capitation on an "as feasible" basis to test and refine operations (e.g., payment systems, reporting).

Phase 2: Expanded multi-payer pilot designed to evaluate the impact of the APM. Anticipated participation by commercial, Medicare, and Medicaid payers with an aligned group of practices.

Phase 3: Based on pilot results, expand to additional practices.

Progress Report (see handout)

- ❑ Practice identification and engagement
- ❑ Capitation defined and implemented
- ❑ Patient population defined
- ❑ Rate development
- ❑ Risk adjustment
- ❑ Performance measurement
- ❑ Contracting
- ❑ Payment systems
- ❑ Reporting and other documents
- ❑ Technical assistance for practices

Goals for **Phase 1**: Preliminary Implementation

The overall goal of the Phase 1 pilot is to **test and refine the payer and provider operations** necessary to implement primary care capitation.

The evaluation will tie to our Principles and to the overall phase 1 goal above.

For the purposes of evaluation we will use qualitative and quantitative evaluation:

- Qualitative evaluation - payer and practice interviews, focus groups and/or surveys
- Quantitative evaluation - payer data (claims and encounters)

Options for Phase 1 **qualitative** evaluation measures

- Consistency of implementation across all four insurers and the impact of differences on provider experience.
- Insurer and practice experience of:
  - making and receiving timely, accurate and well-documented capitation payments
  - reconciling patient cost-sharing in a timely, accurate and well-documented fashion
- Effective practice accounting and financial management of capitation payments, including adjustments for patient cost-sharing.
- Practice experience changing business operations to account for the payment system transition
- Practice experience modifying clinical operations to use additional flexibility of capitated payment methods
- Experience with payer technical assistance to practices during the transition period

Options for Phase 1 **quantitative** evaluation measures

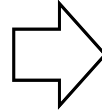
- Level of payer participation and provider participation (including qualitative investigation of why providers did or did not participate)
- Financial impact on practices (actual capitation payments versus hypothetical FFS payments)
- Change in quality measures tracked by CTC-RI (for CTC-RI practices)
- Change in practice office visit accessibility as measured through changes in office hours
- Stinting behavior as assessed using measures recommended by the Stinting Measure Subgroup

Design Topics: cost-sharing reconciliation

Consensus model: Insurers should measure cost-sharing (i.e., deductibles, coinsurance and co-pays that the provider is expected to collect from patients) from claims data monthly. The amount of this cost-sharing should be deducted from future capitation payments.

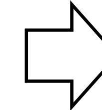
First month capitation
$10 x 100 members

$1,000 payment to provider



Office visits
$10 copay x 10 members
$100 cumulative deductible for capitated services

$200 cost-sharing is provider responsibility to collect



Second month capitation
$10 copay x 10 members
$200 cost-sharing deduction from prior period

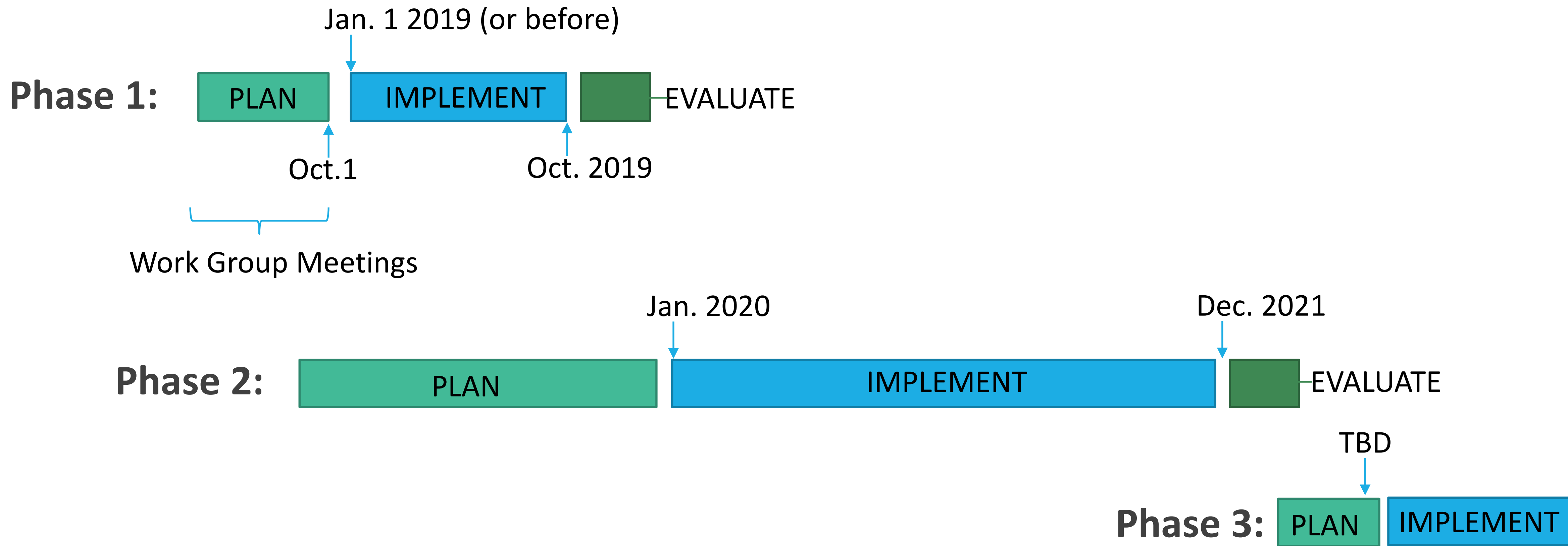
$800 payment to provider

Cost-sharing reconciliation issues

- Reporting – can providers report patient-level reconciliation of cost sharing deduction? (What happens today?)

- ‘Extra’ visits – the model is intended to allow providers to spend more time – including extra visits – with high-need patients, but per-visit cost-sharing is a disincentive. Are there possible fixes (e.g., waive co-pays when a patient visits more than 2 times in a month)?

Timeline and Next Steps



Topics for Work Group Meetings

1. Issues relevant to the preliminary implementation (this summer):
    - Provider-plan cost-sharing reconciliation expectations, including reporting
    - Special consideration of MAT for substance use disorder
    - Measuring productivity, access, and stinting
    - Supports for practices to succeed under capitated models
2. Additional primary care APM model development (longer time frame):
    - Evaluation metrics for Phase 2
    - Future plan design and patient cost-sharing rules
    - Integrated behavioral health care
    - Pediatric care (new OHIC work group)

Next steps

1. Next meeting: Friday June 29th
2. Recommendations from the Primary Care Stinting Measures Subgroup
3. Supports for practices to succeed under a capitation model in Phase 1
4. Special consideration of MAT for substance use disorder

Public Comment