State of Rhode Island
Office of the Health Insurance Commissioner
Primary Care Alternative Payment Model Work Group
Consensus Model

August 9, 2017

Contents

I. Introduction

This document describes the process and decisions made during an OHIC workgroup in spring 2017 towards the adoption of a multi-payer Primary Care Alternative Payment Model in Rhode Island. The recommendations described herein are intended to facilitate discussion between payers and providers towards adoption of a primary care capitation payment method. OHIC encourages payers and providers to use these recommendations to maximize the benefits of multi-payer alignment, but recognizes that payers and providers may mutually agree on different terms than those identified – especially in the areas where case-by-case decision-making is noted below as particularly appropriate.

At this time, OHIC is not setting a specific adoption target for these recommendations, but OHIC intends to monitor insurer progress in implementing primary care capitation over coming contract cycles and the impact of such contracts on the non-FFS spending target.

A summary of all recommendations is included as Appendix 1.

II. Background on the Development of a Primary Care Alternative Payment Model (APM)

1. Overview

A commitment to primary care has been a consistent feature of OHIC's Affordability Standards. OHIC strategies to strengthen primary care have included setting targets for primary care spending by insurers, encouraging primary care practice transformation using the Patient-Centered Medical Home model, and directly supporting primary care practices, including leadership in the Rhode Island Care Transformation Collaborative.

In the fall of 2016 members of OHIC's Alternative Payment Methodology Advisory Committee expressed their support for extending APM application to primary care in the form of primary care capitation. Their advice informed the development of the OHIC *2017-2018 Alternative Payment Methodology Plan* in which OHIC set out its plans to develop a Primary Care Alternative Payment Model:

> "There is a growing recognition that fee-for-service payment is a poor fit for transformed primary care. Rhode Island insurers and primary care practices have interest in learning about and potentially implementing alternative primary care payment models. OHIC will convene a work group of insurers and interested primary care organizations in January 2017. The work group will begin by defining the principles and objectives for the payment model. OHIC will invite presentations by representatives from organizations with implementation experience and ask them to

address questions pre-identified by the work group before commencing the design work. The payment model design work will begin with service-based definitions of primary care and will include study of the CPC+ Track 2 hybrid model."

Work to develop a Primary Care Alternative Payment Model is intended to be complementary to other OHIC work, including but not limited to engaging more practices in the Medical Home model and encouraging ACO development and total cost of care accountability.

Following 2017-18 APM Plan finalization in January 2017, the Primary Care APM Work Group met five times to develop this consensus methodology for primary care capitation in Rhode Island. Work group participants included representatives of Rhode Island insurers, providers, accountable care organizations, and additional interested parties including the Health Department, EOHHS and the Care Transformation Collaborative among others.

In addition to providing a framework for consistent contracting in Rhode Island, this Consensus Model is intended to be used by Rhode Island insurers to fulfill their obligations under the Memoranda of Agreement with the Centers for Medicare & Medicaid Services regarding support of the Comprehensive Primary Care Plus (CPC+) initiative. Rhode Island is one of the participating regions for CMS' CPC+, with BCBSRI and UnitedHealthcare participating insurers. Milestone #4 of the CPC+ "Payer Partner Roadmap" calls for paying hybrid fee-for-service (FFS)/capitation to Track 2 practices beginning in 2018. See Appendix 2 for a comparison of this model with CPC+.[1]

This document represents the results of a participatory process facilitated by OHIC during the first half of 2017. While not all participants agreed on every discussion topic, this document summarizes the direction deemed desirable by most of the participants. OHIC will continue to work with Rhode Island commercial insurers to encourage timely adoption of the primary care APM described in this report.

2. Primary Care Alternative Payment Methodologies and Payment Reform

The development of alternative payment methodologies for primary care is part of a broader set of OHIC strategies under the agency's Affordability Standards to reduce the cost of care and improve quality. In several places, this document reflects the importance of aligning primary care payment strategy with other initiatives. One important strategy has been the promotion of total cost of care contracts and delivery models. Primary care alternative payment models can be useful whether or not a practice is part of a system that is responsible for total cost of care because it can directly increase the flexibility – or perceived flexibility – of the primary care practice by reducing the reliance on in-person visits for revenue. However, payers may wish to

[1] More information about CPC+ is available at https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

adapt the primary care payment methodology model when contracting with groups who are accountable for total cost of care. For instance, application of performance incentive measures to evaluate out-referral and ED use would be redundant to TCOC incentives.

III. Principles for Primary Care Alternative Payment Models.

The work group adopted the following principles for developing a Primary Care APM:

(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 CPC+ Track 2).
(5) The APM should preserve access for patients.

IV. Primary Care Capitation Model

The work group considered both a primary care capitation model and a blended (i.e., fee-for-service plus capitation) model.

Primary care capitation entails paying a primary care practice a fixed prospective payment for each patient for which it is responsible, whether or not that patient receives care in a particular month. The capitation payment replaces fee-for-service payment for defined primary care services.

Capitation has been implemented in other jurisdictions and the experience of those payers helps inform this document. For example, the work group heard a presentation by Eileen Wood, Vice President for Clinical Integration and Chief Pharmacy Officer, from Capital District Physicians' Health Plan in Albany, New York. CDPHP has been operating a primary care capitation model since 2008.

Rhode Island insurers have expressed the perspective that a full capitation model would be significantly easier to implement and operate than a blended model.

A blended primary care APM model requires paying a prospective payment for a portion of anticipated care, but continuing to pay (reduced) fee-for-service payments for each primary care capitated service. This approach was adopted by Medicare as "Track 2" in the CPC+ program. Some Rhode Island providers have expressed a concern that changing primary care payment

from FFS to full capitation in one step would create a large financial risk for practices and have suggested that initial adoption of a blended model would help mitigate this risk.

Consensus Model: 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). 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.

V. Definition of Primary Care

1. Primary Care Providers

There are two questions with respect to identifying providers for whom a primary care APM should be applied:

- Which *practices* are appropriate to contract on a capitated basis?
- Which *providers* within those practices should be paid on a capitated basis (for instance, a specialist billing an E&M code might be paid FFS even if a primary care provider in the same practice was capitated)?

The work group first discussed whether there should be a minimum size threshold for contracting on a capitated basis. The general sense of the work group was that providers with any size panel with a given insurer could succeed under a capitated arrangement, particularly if the provider was contracting with several insurers on that basis.

Consensus Model: Insurers should not establish a fixed minimum size requirement, unless it would be administratively impractical to contract with very small attributed panels. Insurers may prioritize contracting with larger groups, and may decline to contract with a provider who has demonstrated an inability to manage under a capitated arrangement.

When evaluating whether a practice is appropriate for primary care capitation, the work group noted that billing for preventive codes was a critical indicator, as specialists typically do not bill for these codes. Insurers can look at preventive code billing as an indicator of whether a practice is predominately providing primary care services. If this is not the case, the insurer should consider appropriateness on a case-by-case basis.

The work group then considered whether practices should be required to demonstrate other qualifications in order to contract on a capitated basis. Notably, the CPC+ program has an explicit set of delivery model requirements. The group agreed that the barriers to capitation participation should be low and that all primary care practices should be eligible to participate on a voluntary basis.

Consensus Model: Insurers should not adopt any additional practice model requirements (e.g. PCMH status) as a condition of participation.

The work group discussed some of the challenges in characterizing providers with respect to their practice specialty appropriateness for primary care capitation. The group believed that there were many case-by-case issues raised in identifying appropriate practices, and that it was difficult to establish broadly applicable standards.

Consensus Model: Insurers should use their existing policies – with modifications for the purposes of this program as appropriate – to designate individual providers and practices as PCPs.

The work group also discussed the variation in readiness and likelihood of successful implementation between various kinds of practices. Several work group members suggested that capitated primary care might work best when the provider is also responsible for total cost of care.

Consensus Model: Insurers may elect to introduce capitation-based primary care contracts first with practices they assess to be best positioned for capitation success. Insurers may use their discretion as to which practices are most promising for implementation.

2. Services Falling Under the Capitation Rate

The work group considered what services were appropriately included in a capitation rate. The group used the following criteria to guide the discussion:

Consider including services that are:

1) typical primary care services that are widely performed by primary care clinicians, and
2) low-value or prone to overuse.

Consider excluding (and paying based on pre-existing FFS rules) services that are:

1) valuable, but potentially underutilized. (e.g., tobacco screening and counseling);
2) valuable, but performed at widely varying rates among providers (e.g., pap smears, which are differentially offered by male and female clinicians). Including these codes in a capitated rate would disadvantage providers who provide them more frequently. Other reasons for wide variation may be differences in practice structure, patient mix, or available services (like a lab);[2]

[2] If the capitation rate is based on the *provider-specific* history (see section VII.1 below), this consideration is less important, and such services could be included.

3) important for tracking utilization, e.g., for quality reporting. Paying for these services on a FFS basis increases the likelihood that they will be reported accurately on claims, and
4) not used in the Rhode Island commercial market. Note that implementation of primary care capitation for Medicare or Medicaid programs will require adding additional codes that are not used in the commercial market.

Based on these principles, the work group established the following set of codes for primary care capitation. Under a primary care capitation contract, the provider would be paid prospectively for these codes and receive no additional payment when the service is actually delivered. Codes not on this list would continue to be paid in some other manner for all patients according to payer rules.

Consensus Model: The following commercial codes should be paid on a capitated basis:		
New or Established Patient Office or Other Outpatient Visit	New patient Established patient	99201-99205, 99211-99215
Prolonged Patient Service or Office or Other Outpatient Service		99354-99355
New or Established Patient Prevention and Wellness		99381-99387 99391-99397
Urinalysis		81000-81003, 81005, 81015, 81020,
Electrocardiogram		93000, 93005, 93010, 93040, 93268, 93270, 93272, G0403 - G0405
Consultation		99241-99245
Codes that are otherwise bundled into the office visit codes.	Telephone, and Online E&M Collection, blood Measure blood oxygen level	98966-98969, 99441-99444 36415-36416 94760-94761
Services that are typically not performed by a primary care physician, or subject to overuse.	Removal of skin lesions, skin tags Nail trim, debridement Intralesional Injection	11056, 11200-11201 11719-11721 11900-11901

Consensus Model: This code set is established as a minimum set to provide consistency for providers in Rhode Island. However, providers and payers may include additional services in the capitation payment as they mutually find appropriate.

The work group considered excluding the preventive service codes (e.g. 99391-99397) on the basis that preventive care should be encouraged and accurately measured. However, these codes make up a significant portion of primary care billing, particularly for pediatrics. The model *includes* these codes to increase the transformative potential of the capitation payment by broadening the clinical and financial scope of the methodology.

Similarly, there was a discussion about including primary care behavioral health screens (e.g., 96110, 96127) and other prevention codes (including vaccine administration and various other screening codes), but they made up a smaller portion of spending, and the group decided to *exclude* them to avoid discouraging their use (to the extent that they are currently separately paid). The behavioral health screening codes and other behavioral health service codes will be revisited in the future by an OHIC work group as part of consideration of payment strategies to promote behavioral health integration.

3. Special Considerations

Several additional special considerations were raised by the work group.

Pediatrics: Some codes have special importance to pediatric providers. The work group was unable to explore this topic in detail. Nonetheless, an insurer's capitation model should account for any high-volume pediatric-specific codes.

Care Management: There are codes that reflect care management services and related codes. If a practice is paid separately for care management (e.g., through the PCMH program), these codes should be bundled in the primary care capitation. However, if there is no separate care management payment, the codes should be excluded from the capitation. Codes that fall into this category include:

Prolonged patient service without direct patient contact	99358-99359
Transitional care management services	99495-99496
Chronic care management services (typically nurse care manager)	99487-99490
Physician supervision of a patient under care of home health agency; 30 minutes or more within a calendar month	99374-99375

Expanded Capitation: The group noted that there may be primary care codes that could be excluded in an initial capitation contract, but later included as providers and payers gain experience with the capitation model. By establishing this as a minimum set, OHIC recognizes the ability of contracts to add additional services initially or over time. In particular, OHIC has committed to considering how to include behavioral health services in the primary care capitation model (see below).

Behavioral Health Integration: There was strong interest in developing an integrated behavioral health option for capitated practices. However, the work group determined that developing a behavioral health capitation model will require its own sustained effort. OHIC has committed to facilitating a subsequent work group process to develop an approach to integrate behavioral health into this primary care capitation model for those practices delivering integrated primary and behavioral health services. Payers and providers may also independently develop a capitation model that includes such services.

Beyond these specific special circumstances, providers and payers may agree to adjust the included and excluded codes to reflect specific situations. For example, one payer noted an at-home care delivery model primarily directed towards Medicare beneficiaries that would require consideration of different codes.

Providers and payers may agree to change the list of included services during contract renegotiation, although not more than annually. The rate should be adjusted accordingly (see below).

VI. Patient Attribution

A primary care practice that contracts on a capitated basis will be paid prospectively for those patients who are attributed to the practice for capitated services. That practice will receive FFS payment for the care of other patients (including patients that may be attributed to other practices; see below), as well as for non-capitated services delivered to capitated patients.

Rhode Island insurers have previously established attribution methods used for medical home programs and for other purposes.

Consensus Model: Insurers should utilize an attribution methodology of their choosing, which may include attribution methodologies in current use.

Because it is important to accurately support practices that are responsible for a patient's care, attribution should be updated on a regular basis.

Consensus Model: Insurers should reattribute patients monthly, communicate these updates to practices in a timely manner, and use these updates when calculating capitation payments.

VII. Capitation Rate Development

1. General

Because the goal of the primary care APM is to support flexible delivery models and not to reduce primary care spending, capitation rates should be designed with the intention of maintaining or increasing the pre-existing level of practice revenue for a given panel size and composition. In general, the capitation rate should be set by looking at historic claims, while applying the program's parameters.

Both the CDPHP primary care capitation program and CPC+ included an overall increase in payment relative to historical payment levels. CDPHP explained that this increase was helpful to recruit practices into the new model, and that it was largely budget neutral due to resulting decreased hospital and specialist utilization.

Consensus Model: Insurers should develop the PMPM capitation rate by looking at 24 months of claim allowed amounts, applying the methodology of the capitation program (e.g., monthly attribution, included services), counting only payments made to the attributed practice. Insurers may increase the rate to pay more than historic amounts to reflect annual rate increases, to increase provider participation, and/or for other factors. Not more than annually, the rate should be updated when conditions change (e.g., different included services), or to account for observed changes in spending on other care, including specialists and emergency department use, as discussed in Section IX below.

Even for patients who are attributed to a practice, there are some primary care services delivered by providers outside the capitation (e.g., an urgent care center visit outside the attributed practice). The work group agreed that by counting only payments made to the attributed practice, the rate development would account for this 'natural' rate of services outside the attribution automatically. However, it is possible that a capitated provider would seek to increase the provision of primary care outside the attributed practice (thus shifting the cost of providing the care 'off-book') or the patient may seek care outside the capitated practice due to provider unavailability or for other reasons. The work group determined that this possibility was best handled through two means:

1) Insurers should apply monthly re-attribution (see above) to shift the prospective payment to a new primary care site as quickly as possible.
2) Insurers should monitor the rate of services delivered outside the attribution, and discuss trends in this regard with practices whenever appropriate.

Accordingly, if the provider is not getting paid capitation for a patient the provider should be paid based on other contractual arrangements (e.g., FFS), unless the provider is in the same practice as the provider receiving the capitation, or covering for her/him (also see the recommendation in Section V.2.c below to pay separately for after-hours codes).

Notably, the CPC+ demonstration includes a methodology for evaluating (and in the case of that program, adjusting for) the level of primary care services delivered outside the attribution. The work group opted not to adopt this somewhat complex CMS process.

There was further discussion regarding whether the analysis of historic PMPM spending should occur on a practice-specific or market-wide basis. Some providers expressed the belief that applying market-wide rates would disadvantage them; for instance, if a practice has a lower-than-average percentage of primary care being delivered outside the attributed practice, it would be financially harmed by a market-set rate. However, others pointed out that more efficient providers would be rewarded if their capitation rate was set based on peer practices who provided more visits per patient on average. Furthermore, capitation rate development based on historical utilization should not 'lock in' financial rewards for inefficient care.

Consensus Model: For larger providers, insurers and providers may agree to develop practice-specific rates on a case-by-case basis, or utilize a standard PMPM capitation rate based on a market-wide calculation. For smaller independent providers, insurers should offer a standard PMPM capitation rate based on a market-wide or small independent practice-only calculation.

Several work group members stressed the importance of transparency in rate development.

Consensus Model: Each insurer's rate development methodology should be highly transparent for contracting practices; insurers should provide sufficient documentation and data to allow a provider to understand how the capitation rate for that practice or provider was developed and the anticipated implications for the individual practice if adopted. OHIC may develop a common methodology description to help insurers communicate this process to providers.

2. Risk Adjustment – General

The work group agreed that the capitation payment should be adjusted for a practice panel's clinical risk to accurately pay providers for the management of more complex patients, but recognized that there are few commercially available products to risk adjust specifically for this purpose, and none in use in Rhode Island. Some providers expressed concern that existing risk adjustment models in Rhode Island have had significant financial implications in ways that were hard to connect to their observations of patient acuity. One provider also noted that in some cases, more effective patient management (e.g., reducing hospitalization) had the effect of reducing risk scores, and therefore lowering payment, even though the patient's underlying risk did not change.

The work group also acknowledged that standard risk adjustment tools are generally designed to predict cost, not primary care utilization (which is not typically a significant driver of overall

cost). However – at least for an adult population – cost may be the best available proxy for primary care utilization.

The work group was aware of only one risk adjustment tool specifically designed for primary care capitation: the PCAL, which is used by CDPHP and licensed by Versed Technologies. The PCAL is based on the DxCG risk adjustment model. Based on a conversation with Arlene Ash, who developed the PCAL, more effective patient management would not reduce the PCAL score, because it is based on diagnosis, and not site of service or episodes of care.

Neither the DxCG nor PCAL groupers is currently in use in the Rhode Island commercial insurance market.

Consensus Model: Insurers should risk adjust their capitation payments to account for variation in the health care conditions of different patient panels, age, and gender. Insurers may implement the risk adjustment tool of their choice, but should provide a high level of transparency to providers about how the software is applied, including underlying parameters, assumptions applied by the insurer, and the impact of risk adjustment on payments. Insurers are encouraged to investigate improved risk adjustment methods for primary care utilization specifically (such as the PCAL).

Recognizing provider concerns that the capitation model broadly, and risk adjustment specifically, may lead to undesirable volatility in provider payments, insurers are encouraged to prospectively model and concurrently monitor provider revenue and make modifications to the risk adjustment process if appropriate through the contract renewal process.

3. Risk Adjustment – Pediatric

Risk adjustment software is typically designed to predict spending for certain patients or populations based on diagnoses or past service utilization. Because most children have very low spending due to low rates of morbidity, hospitalization and other care, they tend to have low risk scores. However, because of annual wellness visits and other preventive care, children have disproportionately more primary care utilization relative to their risk scores (or total cost of care). Accordingly, the work group discussed the need to develop different adjustments for pediatric populations.

Consensus Model: Insurers should use age/sex adjustment *and/or* clinical risk adjustment tools for pediatric populations in order to reflect their distinct primary care utilization patterns.

Social determinants of health (SDOH) are particularly relevant to the future health status of pediatric populations. Therefore, insurers are encouraged to investigate how they might use SDOH indicators for risk adjustment.

VIII. Payment Adjustments

1. Cost-sharing reconciliation

As described above, the capitation rate should be developed based on the claim allowed amount. The work group discussed the best way to account for cost sharing. The goal of the work group was to minimize the impact of any changes on overall revenue.

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.

This methodology is designed to result in little change to current revenue and obligations. Today, providers do not receive payment for the full allowed amount; the claim is paid only after deducting cost-sharing. Under the consensus model, the capitation payment is based on the full allowed amount. The cost-sharing amounts are deducted retrospectively after the claims are received.

Notably, one of the goals of the primary care alternative payment model is to increase the flexibility of practices to deliver care outside of a traditional office visit setting. Accordingly, the provider may offer services without charge or cost sharing (patient liability), to the extent permitted by state and federal law.

IX. Incentives for Providing High Quality Care

1. In General

The work group acknowledged that Rhode Island already has a variety of initiatives for measuring primary care quality of care and rewarding high quality providers. The work group supported a quality incentive opportunity to complement capitation payments, but recommended that any performance measurement specific to primary care capitation be consistent with existing measure sets (e.g., SIM Aligned Measure Set for Primary Care).

Consensus model: Insurers should align any new quality measurement and incentives with existing quality programs and aligned measure sets.

Several work group members noted the experience of CDPHP and others that quality incentives should be sufficiently large as to motivate providers to change their behavior. CDPHP reported that primary care providers were eligible for up to a 20% payment increase based on their performance metrics. However, given the desire to align any quality incentives with other programs, the work group did not make a recommendation on the size of quality payments specific to primary care capitation.

2. Challenges raised by primary care capitation models

While a primary care capitation model is designed to alleviate some of the perverse incentives of fee-for-service contracting (e.g., high visit volume, lack of flexibility in care delivery), the model introduces at least five significant challenges of its own.

a. "Cherry-picking" and "Lemon-dropping." Providers may financially motivated to select or encourage a panel of healthier patients and/or to discourage practice selection by high morbidity patients. By doing so providers will produce low demand for services under the capitated rate. The adoption of risk adjustment is intended to address this challenge, because the capitated rate will reflect the relative risk of the panel. In theory, this should reduce the incentive for a practice to seek out healthier patients and discourage sicker patients.

b. Double payment for capitated services. Capitated providers may shift primary care services to other non-attributed providers outside the capitation, or patients may seek care at sites outside the capitation for other reasons. This would result in double-payment for primary care (i.e., once as a capitated payment, the second time as a FFS payment). Section VII above considers this challenge and defines an approach for addressing it.

c. Stinting on care. Providers may stint on care (i.e., inappropriately under-treat), either by reducing care delivered directly or by reducing access to care for their panel (e.g., making it difficult to obtain appointments, being slow to return telephone calls).

   Risk-adjusted capitation payments will provide additional resources to providers who treat patients with greater care needs. This will provide some offset to stinting concerns. However, there is no direct financial incentive to avoid stinting once a patient is attributed to a practice other than to retain the patient.

   The work group considered a variety of approaches to measuring possible stinting:
   - utilizing patient experience survey questions regarding access to care;
   - evaluating attributed patient voluntary turnover rates, and investigation of the reasons for patients exiting a practice, and
   - tracking trends in visit volume or patient 'touches' over time.

   The work group concluded that each of these options provided some information about stinting, but none was effective enough to warrant including as part of the consensus model. Therefore, identification of a means to counter the financial incentive for stinting remains an area requiring further developmental work.

Consensus model: Insurers should carefully monitor provider behavior to identify cases where access is decreasing or there are other signs of stinting on care. Insurers should use the data available to them to monitor this problem to the extent possible, and take corrective action when performance measures indicate the need to do so.

Capitated payment also reduces the incentive for providers to provide care outside normal care delivery hours. A coding subgroup discussed this issue and recommended that providers use existing codes to pay more for care delivered outside regular hours.

Consensus model: Insurers should pay separately for codes that indicate services delivered after regular office hours (e.g. 99050-99051). Insurers should also monitor the availability of care outside regular office hours and take additional action where appropriate to increase this kind of access.

d. Inappropriate over-referral to specialists. A capitated primary care practice may refer patients to specialist care who can be or are more appropriately treated in the primary care setting. By so doing, the practice shifts the cost of delivering care to the specialist and generates profit to the primary care practice. This can lead to another form of double-payment – and poor primary care.

   CDPHP reported that it captured this behavior in a relative resource utilization index measure and a) discussed the findings with outlier practices, and b) reduced the practice's bonus payment.

   The work group recommended that the SIM Measure Alignment Work Group consider measures that evaluate patterns of specialist referrals, and identify excessive use, for addition of one or more measures to the SIM Aligned Measure Set for primary care. This work will begin in August 2017 as part of the annual measure set review.

e. Inappropriate diversion to emergency departments. Primary care practices may actively (through referral) or passively (through limited availability) inappropriately divert patients to emergency departments for primary care services. This can lead to another form of double-payment for primary care, and also is likely to create a poor patient experience and increased cost.

   CDPHP described a similar process to address this problem as with practices with high specialist referral volume.

Consensus Model: Payers should adopt measures that give capitated primary care practices incentives to minimize inappropriate use of specialists and emergency departments. OHIC will pursue identification of such measures through the SIM Measure Alignment Work Group and identify one or more measures to the SIM Aligned Measure Set for primary care. This work will begin in August 2017 as part of the annual measure set review.

X. Data Sharing and Education

The work group noted on several occasions that high quality data exchange is necessary for payers and providers to make the most of a capitated arrangement.

Consensus Model: Payers should supply providers with timely, high-quality data to allow more effective management of their patient panel and their revenue under a capitated contract.

At a minimum, this requires:

- *payers* to provide high-quality, timely data to providers on their panel, risk scores, and associated payment calculations, and.
- *providers* to provide accurate accounting of services rendered, particularly with respect to services related to quality measurement.

In addition to this basic data exchange, payers should also provide additional performance information to providers (see discussion in the previous section), including:

- prevention and wellness visit rate;
- specialist utilization;
- emergency department visits (average rates and high-utilizers);
- non-capitated urgent care use, and
- measures of stinting.

In addition to data sharing expectations, some providers will benefit from education and coaching about how to delivery excellent patient care in a financially sustainable way in the context of a capitated payment methodology. OHIC will facilitate development of provider supports beginning in the summer of 2017.

Consensus Model: Insurers should provide appropriate technical assistance and educational support to facilitate the transition to capitated payments.

Appendix 1: Summary of Consensus Model Recommendations

Primary Care Capitation Model

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). 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.

Definition of Primary Care – Providers

Insurers should not establish a fixed minimum size requirement, unless it would be administratively impractical to contract with very small attributed panels. Insurers may prioritize contracting with larger groups, and may decline to contract with a provider who has demonstrated an inability to manage under a capitated arrangement.

Insurers should not adopt any additional practice model requirements (e.g., PCMH status) as a condition of participation to participate.

Insurers should use their existing policies – with modifications for the purposes of this program as appropriate – to designate individual providers and practices as PCPs.

Insurers may elect to introduce capitation-based primary care contracts first with practices they assess to be best positioned for capitation success. Insurers may use their discretion as to which practices are most promising for implementation.

Definition of Primary Care – Services

The following commercial codes should be paid on a capitated basis:		
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Consultation		99241-99245

Codes that are otherwise bundled into the office visit codes.	Telephone, and Online E&M Collection, blood Measure blood oxygen level	98966-98969, 99441-99444 36415-36416 94760-94761
Services that are typically not performed by a primary care physician, or subject to overuse.	Removal of skin lesions, skin tags Nail trim, debridement Intralesional Injection	11056, 11200-11201 11719-11721 11900-11901

This code set is established as a minimum set to provide consistency for providers in Rhode Island. However, providers and payers may include additional services in the capitation payment as they mutually find appropriate.

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Patient Attribution

Insurers should utilize an attribution methodology of their choosing, which may include attribution methodologies in current use.

Insurers should reattribute patients monthly, communicate these updates to practices in a timely manner, and use these updates when calculating capitation payments.

Capitation Rate Development – General

Insurers should develop the PMPM capitation rate by looking at 24 months of claim allowed amounts, applying the methodology of the capitation program (e.g., monthly attribution, included services), counting only payments made to the attributed practice. Insurers may increase the rate to pay more than historic amounts to reflect annual rate increases, to increase provider participation, and/or for other factors. Not more than annually, the rate should be updated when conditions change (e.g. different included services), or to account for observed changes in spending on other care, including specialists and emergency department use.

For larger providers, insurers and providers may agree to develop practice-specific rates on a case-by-case basis, or can offer a standard PMPM capitation rate based on a market-wide calculation. For smaller independent providers, insurers should offer a standard PMPM capitation rate based on a market-wide calculation or a calculation specific to smaller independent practices.

Each insurer's rate development methodology should be highly transparent for contracting practices; insurers should provide sufficient documentation and data to allow a provider to understand how the capitation rate for that practice or provider was developed and the anticipated implications for the individual practice if adopted. OHIC may develop a common methodology description to help insurers communicate this process to providers.

Capitation Rate Development – Risk Adjustment
Insurers should risk adjust their capitation payments to account for variation in the health care conditions of different patient panels, age, and gender. Insurers may implement the risk adjustment tool of their choice, but should provide a high level of transparency to providers about how the software is applied in this program, including underlying parameters, assumptions applied by the insurer, and the impact of risk adjustment on payments. Insurers are encouraged to investigate improved risk adjustment methods specifically for primary care utilization (e.g., PCAL).

Insurers should use age/sex adjustment and/or clinical risk adjustment tools for pediatric populations in order to reflect their distinct primary care utilization patterns.

Payment Adjustments – Cost Sharing Reconciliation
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.

Incentives for Providing High Quality Care
Insurers should align any new quality measurement and incentives with existing quality programs and aligned measure sets.

Insurers should closely monitor provider behavior to identify cases where access is decreasing or there are other signs of stinting on care. Insurers should use the data available to them to monitor this problem to the extent possible, and take corrective action when performance measures indicate the need to do so.

Insurers should pay separately for codes that indicate services delivered after regular office hours (e.g., 99050-99051). Insurers should also monitor the availability of care outside regular office hours and take additional action where appropriate to increase this kind of access.

Payers should adopt measures that give capitated primary care practices incentives to minimize inappropriate use of specialists and emergency departments. OHIC will pursue identification of such measures through the SIM Measure Alignment Work Group and identify one or more measures to the SIM Aligned Measure Set for primary care. This work will begin in August 2017 as part of the annual measure set review.

Data Sharing and Education

Payers should supply providers with timely, high-quality data to allow more effective management of their patient panel and their revenue under a capitated contract.

Insurers should provide appropriate technical assistance and educational support to facilitate the transition to capitated payments.

Appendix 2: Comparison of the Rhode Island Model and the Medicare CPC+ program

There are a variety of differences between the Medicare CPC+ program and the model outlined in this report. This appendix highlights some of the major differences, but does not discuss every aspect of both program designs. The third column indicates the inclusion of the topic in the CPC+ MOU commercial payers executed with CMS.

Topic	**Medicare CPC+**	**Rhode Island Model**	**CPC+ Payer MOU**
Participation Qualification	Requires specific practice delivery model competencies and minimum size. (*31 participating RI practices*)	No explicit panel size or practice competencies. Insurer discretion in contracting priorities.	Different requirements for Track 1 and Track 2 providers. "Common Approach Towards Care Delivery Requirements and Accountability"
Capitation model	Only "Track 2" includes a capitation component. In Track 2, services are paid partially on prospective capitation, partially on retrospective FFS	The standard model is full, prospective capitation. Some payers and providers may agree to modify the approach.	"Non-visit-based financial support"
Included services	Non-prevention office visits only.	Prevention and regular office visits and other services.	Track 2 "Alternative to Visit-Based Reimbursement Methodology"
Capitation Rate Development	Historical experience, practice-specific.	Historical experience, practice-specific or community rate.	
Risk Adjustment	Capitation rate not risk adjusted.	Risk-adjusted using plan-administered methodology.	
Services delivered by non-capitated providers to attributed members.	Partial reconciliation methodology based on analysis of experience.	Observe trends and adjust annually if appropriate.	

Topic	Medicare CPC+	Rhode Island Model	CPC+ Payer MOU
Performance-Based Incentive Payments	Specific methodology.	Largely based on other existing performance incentive programs; new measure for ED and specialist use.	"Performance-Based Incentive Payments" and "Commitment to Aligning Quality Measures"
Data Sharing and Education	Yes	Yes	"Commitment to Sharing Data with Participating Practices"