Alternative Payment Methodology Advisory Committee

FIRST MEETING – OCTOBER 18TH 2016

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

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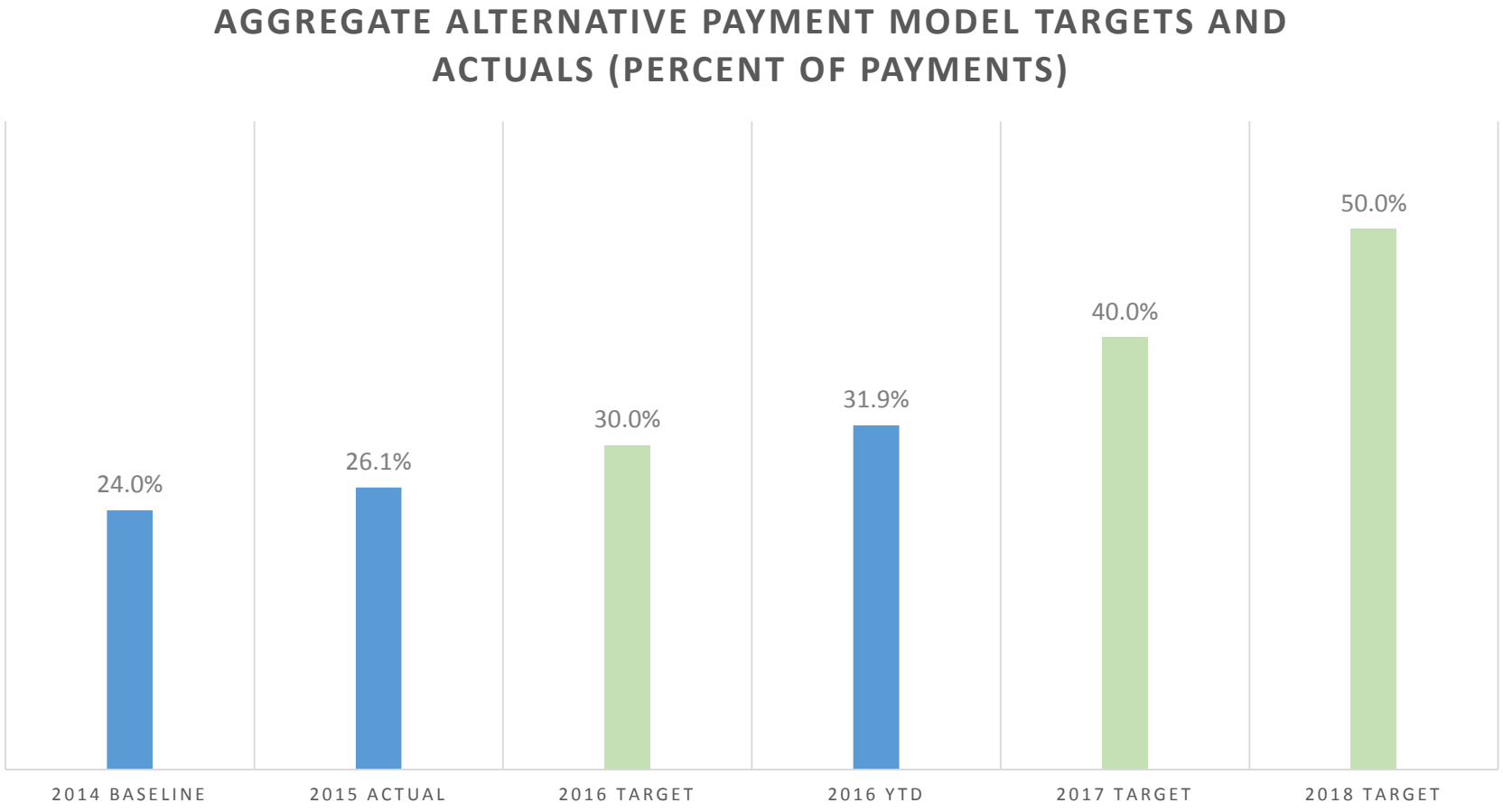
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

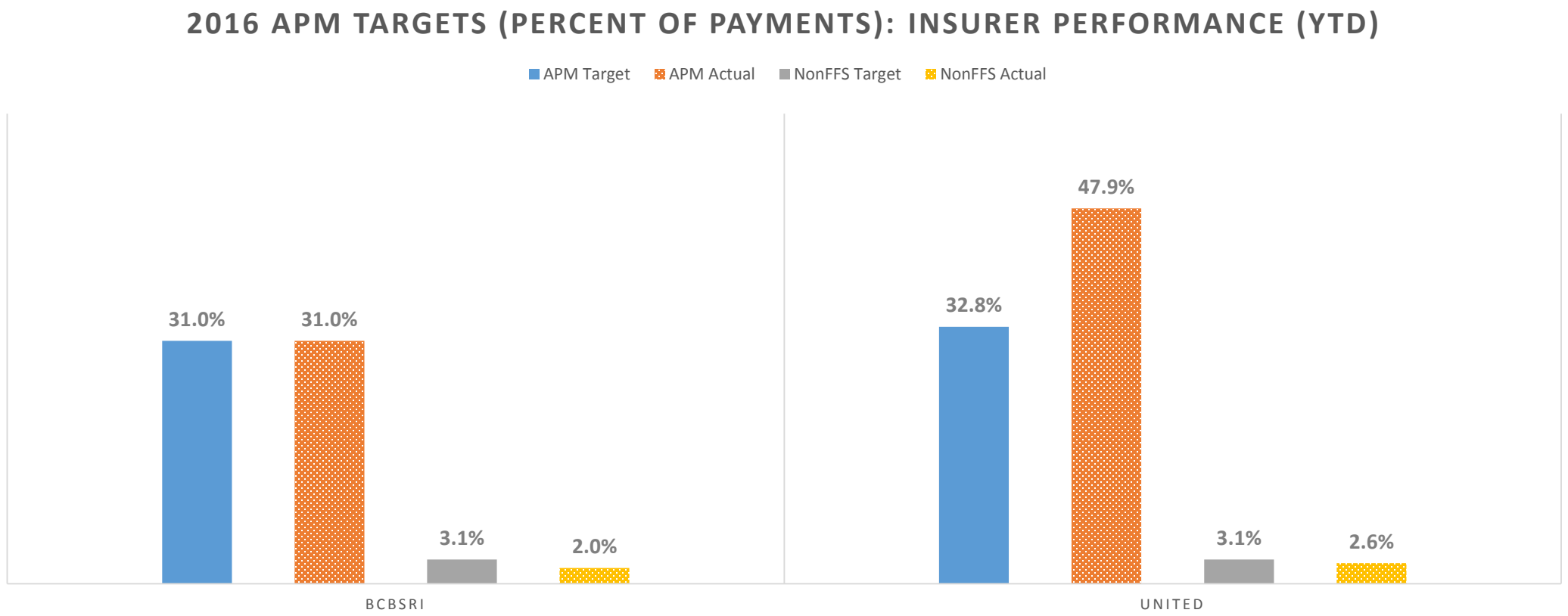
Agenda

- Introductions
- Review of APM Data
- Minimum Downside Risk
- Commonly Defined Episodes of Care
- Primary Care APMs
- Conclusion
- Public Comment

APM Data Review



APM Data Review



Discussion

- The current APM measure specifications include payments for all fully insured covered lives (regardless of state of residence) and regardless of where the services were delivered.
- Question: Should OHIC consider modifying the APM measure specifications to capture payments for RI resident covered lives only?

Minimum Downside Risk: Regulatory Requirement

- After studying the impact of Rule 2 Affordability Standards and a robust public process, OHIC amended Section 10 of Regulation 2 in 2015 to include a payment reform requirement that insurers over time **increase the percentage of covered lives that are attributed to provider total cost of care contracts that include risk sharing**.
  - Specifically, Regulation 2 requires that by the end of 2016 at least 10% of insured covered lives be attributed to either:
    - a Population-based Risk Contract that includes risk sharing, or
    - a Global Capitation Contract which places 100% of the risk on providers.

Minimum Downside Risk: Purpose of Study

- During the fall 2015 meeting OHIC presented a proposed definition of “minimum downside risk” to qualify an insurer shared risk provider contract as meeting the OHIC APM standard. The Advisory Committee did not support the proposal and recommended additional work by OHIC.
- As a result, the 2016/2017 OHIC Alternative Payment Model Plan includes a requirement that OHIC study options for setting a minimum downside risk threshold for medical service or ACO contracts. Bailit Health performed this study for OHIC.

Minimum Downside Risk Report: Study Approach

1. Understand current market practice
   - CMS-initiated payment models
     - Medicare ACO models: Pioneer, MSSP and Next Gen, and MACRA then-draft regulation
   - Gathered information from two large commercial payers in Massachusetts
   - Considered contractual arrangements among RI insurers and major RI provider organizations

2. Model different levels of risk assumption on RI ACOs
   - Percentage of total cost of care
   - Percentage of cash reserves and total reserves for two hospital-based ACOs and one physician organization-based ACO

Minimum Downside Risk Report: Study Findings

- General approaches to defining risk
  - Most often defined as a percentage of PMPM total cost of care budget
    - Example: Downside risk capped at 5% of $400 PMPM or $20 PMPM
    - Often risk is mitigated by risk sharing, insurer and provider share losses on a 50:50 basis, in above example would limit provider risk to $10 PMPM.
  - Can be defined as Minimum Loss Rate (MLR)
    - Establishes a minimum loss (or gain (MSR)) that must be realized before risk sharing is applied
    - Example: 2% MLR and 50:50 risk sharing and 5% cap on losses, if provider realized 5% loss ($20 PMPM) would not be responsible for first 2% ($8 PMPM), would share the remaining $12 PMPM loss 50:50 ($6 PMPM)
  - Providers also mitigate assumed risk by using reinsurance and/or by carving out selected services

Minimum Downside Risk Report: "Net Risk"

Risk Arrangement	Calculation of Maximum Possible Loss	Net Risk Assumption
Risk capped at 5% of $400 total cost of care PMPM	Loss: $400 x 0.05 = $20 PMPM, which is equal to the loss cap	5.0%
Risk capped at 5% of $400 total cost of care PMPM and shared 50/50 with insurer	Loss: $20 PMPM Loss After Risk Sharing: $20 x 0.5 = $10 PMPM, which is below the loss cap	2.5%
Risk capped at 5% of $400 total cost of care PMPM; risk beyond 2% is shared 50/50 with insurer	Loss: $20 PMPM Risk Corridor: $400 x 0.02 = $8 PMPM Total Provider Loss: ($20 - $8) x 0.5 = $6 PMPM, which is below the loss cap	1.5%

Minimum Downside Risk Report-Study Findings –Medicare Risk Arrangements

Model	Risk Arrangement		Net Risk Over Time (TCOC)
Pioneer	Risk sharing (provider/Medicare): ranges from 50/50 – 75/25 MLR = 1% Risk cap: ranges from 5% -15%		2.0-10.5%
MSSP	Risk sharing (provider/Medicare): 60/40 MLR = 2% Risk cap: ranges from 5% -10%		1.8-4.8%
Next Generation	Risk sharing (provider/Medicare): ranges from 0 – 85/15 MLR: ranges from 0 – 4.5% Risk cap: 15%		8.4-15.0%
MACRA "Other Advanced APMs" (final rule)	ACOs: (2017-2018) 8% of the estimated average total A and B revenue, OR Risk sharing: 30% MLR: 4% Risk cap: 8%	Medical Home Models: Total risk: 2017: 2.5% (A+B revenue) 2018: 3% 2019: 4% 2020: 5%	1.2%+

Minimum Downside Risk Report: Views from RI Providers and MA Insurers

- RI providers view risk in terms of % of revenue for services delivered under ACO contract.
  - They capture a very small percentage of the total cost of care through their own service delivery (PCP-based ACO: 10-11%; hospital-based ACO: 30-40%).

- MA risk contracts
  - Plans generally do not use risk MLRs and MSRs (risk corridors).
  - A few very mature provider organizations assume 100% of the risk with no loss cap. Most other provider organizations have risk sharing arrangements with net risk levels of between 5% and 8% of total cost of care PMPM.
  - Losses, when they occur, are substantially below the cap.

Minimum Downside Risk Report: Research Conclusions

1. Rhode Island ACOs, both hospital- and provider-based, expressed lower risk tolerance than is reflected in what their Massachusetts counterparts with more experience are assuming and successfully managing. This suggests that OHIC should consider setting relatively low risk levels initially.
2. The Massachusetts experience also indicates that over time providers can successfully manage increasing levels of risk. However, the level of risk may not need to be as high some CMS initiatives based on the successful evaluation findings for BCBSMA's risk contracts.

Minimum Downside Risk Report: Financial Modeling

- Bailit Health modeled potential Rhode Island ACO losses and their impact on total assets and cash reserves for two hospital-based ACOs and one physician organization-based ACO.
- This was done to assess the feasibility of providers assuming varying levels of risk.
- The results of this analysis are not being shared to protect the confidential nature of some of the financial data used for the analysis.

Minimum Downside Risk Report: Study Recommendations

1. Vary minimum downside risk requirements based on whether the ACO includes hospitals, or is solely physician-based.
   - **ACOs including hospital systems:** Express risk assumption expectations as net risk as a *% of total cost of care*.
   - **Physician-based ACOs:** Express risk assumption expectation as net risk as a *% of the physician organization ACO contract revenue*.

2. Expectations for insurer risk contracts should be modified for insurer ACO contracts for somewhat smaller populations.
   - This recommendation is informed by the growing appreciation of the difficulty in assessing total cost of care financial performance when covered lives are small due to the effect of random variation in service utilization.

Minimum Downside Risk Report: Study Recommendations

ACOs including Hospital Systems	Physician-based ACOs
Between 10,000 and 20,000 commercial lives, as % of projected total cost of care: Year 1: net risk >/= 1% By Year 5: net risk >/= 5%	Between 10,000 and 20,000 commercial lives, as % of physician org's ACO contract revenue: Year 1: net risk >/= 3% By Year 5: net risk >/= 10%
Over 20,000 commercial lives, as % of projected total cost of care: Year 1: net risk >/= 2% By Year 5: net risk >/= 6%	Over 20,000 commercial lives, as % of physician org's ACO contract revenue: Year 1: net risk >/= 10% By Year 5: net risk >/= 20%

Minimum Downside Risk Report: Discussion of Report Recommendations

- Do you agree with the recommendations?
- What modifications, if any, would you recommend the Commissioner consider?

Commonly Defined Episodes of Care: Rationale and Approach

- Multiple Rhode Island insurers have expressed interest in employing episode-based payment as a means of extending value-based payment to specialist physicians.
- The design and application of payer-specific episode-based payment methodologies will complicate implementation, increase provider administrative costs and detract from the impact of the strategy.
- Pursuit of commonly defined episodes of care in Rhode Island must recognize existing non-Rhode Island episode definitions:
  - Medicare: Bundled Payments Care Improvement (BPCI), Comprehensive Care for Joint Replacement (not in RI yet), and a proposal for cardiac care and for non-joint replacement hip surgeries
  - Prometheus: episode definition for more than 90 conditions
  - HCP-LAN: maternity episode definition

Commonly Defined Episodes of Care: Issues to Explore

1. What are the pros and cons of an OHIC-facilitated, collaborative insurer and provider effort to establish and implement common episode definitions?

2. How do episode-based payments fit within total cost of care contracts?

3. What are the procedures and/or conditions that represent the best opportunity?

4. Should the payment strategy be complemented with a care transformation strategy?

What are the pros and cons of an OHIC-facilitated, collaborative insurer and provider effort to establish and implement common episode definitions?

Pros	Cons
1.	1.
2.	2.
3.	3.

How do episode-based payments fit within total cost of care contracts?

Four options…

1. Exclude members attributed to an ACO.
2. Include members attributed to an ACO if the episode participants and ACO sign collaborative agreements about how to share any savings.
3. Include members attributed to an ACO, and back out the episode savings from the ACO savings so they aren't paid twice.
4. Exclude episodes from payer contracts altogether and let ACOs negotiate arrangements for their attributed members.

What are the procedures and/or conditions that represent the best opportunity for episodes?

Four options…

1. Specialties representing the most independent contracted dollars
2. Specialties with the largest percentage and/or absolute dollar value of potentially avoidable complications
3. Specialties with related BPCI experience
4. Specialties with providers who are eager and well-positioned to participate

Other ideas?

Commonly Defined Episodes of Care: Next Steps

- What additional steps should be taken prior to our next meeting on 11-2-16 relative to this potential APM strategy?

Primary Care APMs

- There appears to be growing recognition that fee-for-service payment is a poor fit for transformed primary care.
  - Forces practices to generate visit volume
  - Doesn't support more efficient and patient-centric treatment modalities and workforce configurations
- "It seems unlikely to be able to fulfill the major goals of PCMH transformation through a fee-for-service approach…There was really a very large separation in how much more capitated payments would support PCMH functions than fee-for-service payments." – S.Basu (re: *Annals of Family Medicine* paper, Oct, 2016)

Primary Care APMs

Two options:

1. Primary care capitation
2. Primary care capitation/fee-for-service hybrid

Primary Care APMs: Primary Care Capitation

- Primary care capitation was a common payment model in the early days of managed care. It was discontinued in many instances when managed care moved away from HMOs and towards PPOs.
- Still, its use has continued in pockets across the country.
- There has been a resurgence of interest in primary care capitation, e.g., Vermont's new all-payer model will use primary care capitation, initially as a voluntary option.
- There is also some evidence that primary care capitation can yield impressive performance results, e.g., www.cdphp.com/providers/programs/enhanced-primary-care.

Primary Care APMs: Primary Care Capitation/FFS Hybrid

- The CPC+ Track 2 payment model is a primary care capitation/FFS hybrid:
  - Track 2 practices continue to bill as usual, but the FFS payment will be reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which will be paid in a lump sum on a quarterly basis absent a claim.
  - CMS expects that Track 2 practices will increase the comprehensiveness of care delivered. Therefore, the CPCP amounts will be larger than the FFS payment amounts they are intended to replace.

What are the pros and cons of an OHIC-facilitated, collaborative insurer and provider effort to establish and implement a common episode primary care APM?

Pros	Cons
1.	1.
2.	2.
3.	3.

Primary Care APMs: Next Steps

- What additional steps should be taken prior to our next meeting on 11-2-16 relative to this potential APM strategy?

Next Meetings & Public Comment

Wednesday November 2nd 8 AM – 11 AM