Alternative Payment Methodology Advisory Committee

SECOND MEETING – NOVEMBER 2ND 2016

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

Agenda

- Introductions
- Presentation & Discussion: Proposed Recommendations for the 2017-18 Alternative Payment Methodology Plan
  - Commonly Defined Episodes of Care
  - Primary Care APMs
  - Minimum Downside Risk
- Public Comment

Commonly Defined Episodes of Care: Recap of 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: Feedback from Meeting #1

- General support for the concept from most providers.
  - Some concern that episode-based payment will reduce ACO savings.
- Some insurer interest, especially for contracting with independent specialist groups.
  - Some concern that OHIC not define episodes that insurers can't operationalize.
- Some felt that OHIC should focus its efforts only on common episode definition, and not on implementation of episode-based payment.

Commonly Defined Episodes of Care: Feedback from Meeting #1

- **Policy questions raised:**
  - How should episode-based payment relate to total cost of care arrangements, including dealing with episode savings and deficits?
  - Should episode-based payment be organized by ACOs, insurers or both?
  - Who should be the "bundler"?
  - How should the price get set?
  - How do we avoid obscuring information from primary care physicians?

OHIC Proposal for 2017-18 APM Activity Re: Episode-Based Payment

- Have the APM Advisory Committee **identify episodes of highest priority** for development of aligned payment models. Possible candidates include, but are not limited to, maternity care, joint replacement and cardiac procedures.

- **Convene episode-specific subcommittees** of the APM Advisory Committee beginning in January 2017 to participate in a structured process to define the parameters of each episode, with a goal of completing this process for three episodes during calendar year 2017.
  - Invite participation from interested specialty practices, as well as the membership of the APM Advisory Committee.

OHIC Proposal for 2017-18 APM Activity Re: Episode-Based Payment

- **Consider the parameters of episodes currently in place** between RI payers and providers, as well as other publicly available resources including the episode definitions from CMS, HCP-LAN, the NY DSRIP program and other sources.

- **Utilize the SIM Measure Alignment Work Group** to identify the quality measures that should be tied to the episode-based payment models. (During 2016 that work group identified maternity and behavioral health measures.)

- **Publish the agreed-upon episode definitions and distribute them** through payers and the appropriate medical specialty societies.

OHIC Proposal for 2017-18 APM Activity Re: Episode-Based Payment

- Establish a process for **periodic and/or ad hoc review** of episode definitions.

- Discuss the **policy issues related to payment** identified during Meeting #1 in 1-3 ad hoc meetings of the APM Advisory Committee during 2017.

Commonly Defined Episodes of Care: Proposed First Steps

1. **APM Advisory Committee members identify episodes** – procedural, acute or chronic – that they recommend for prioritization, and the supporting rationale, by *11-21-16*.
   - e.g., area of great practice pattern variation, area of high spending, interested and ready providers, topic of interest to ACOs, provider and/or insurer experience in the area

2. **Bailit Health perform initial research** on the episodes of interest to help prepare for an informed discussion at Meeting #3 (the final meeting of 2016).

Commonly Defined Episodes of Care: Advisory Committee Feedback & Discussion

- What are your thoughts on the proposal?
- What modifications would you like to make?

Primary Care Alternative Payment Model: Recap of Rationale

- 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 pa**yments." – 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 Alternative Payment Model: Feedback from Meeting #1

- Wide support for the strategy.
  - Consistent with CTC-RI vision from the start
  - Desire for Medicaid to be a participant in the activity

- Insurers anticipate some challenges with implementation, including:
  - Explaining the concept to practices
  - Operationalizing payment systems
  - Risk adjustment

Primary Care Alternative Payment Model: Feedback from Meeting #1

- During and subsequent to Meeting #1, work group members expressed interest in learning more about the following:
  - What has been the experience of insurers elsewhere in the U.S. that have implemented some form of primary care capitation?
  - How can payment models avoid having capitated PCPs referring a higher number of patients to specialists than they otherwise would have under a traditional FFS model?
  - What services should and should not be included in primary care capitation?

OHIC Proposal for 2017-18 APM Activity Re: Primary Care Payment

- **Convene a work group** of insurers and interested primary care organizations, coordinating with CTC-RI in January 2017.
- **Define principles and objectives** for the model before commencing design work.
- Invite **presentations by representatives from organizations with implementation experience** and ask them to address questions pre-identified by the work group.
  - *CDPHP has already confirmed willingness to present.*

OHIC Proposal for 2017-18 APM Activity Re: Primary Care Payment

- **Study the CPC+ hybrid model** and identify attractive and unattractive design elements.

- Start design work with definitions of primary care capitation and **complete design work by 6-30-17**.

Primary Care Alternative Payment Model: Advisory Committee Feedback & Discussion

- What are your thoughts on the proposal?
- What modifications would you like to make?

Minimum Downside Risk: Initial Recommendations from Meeting #1

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 Proposal: Feedback from Meeting #1

- General agreement on need to move to risk sharing.

- Concerns voiced by different members regarding the following:
  - Having different recommendations for physician vs. hospital-affiliated ACOs
  - Required provider risk level in Year 5
  - Lack of standards for risk contracts below 10,000 lives
  - Need for certification of providers' ability to take on risk

Minimum Downside Risk Proposal: Proposed Changes

To respond to some of the concerns voiced by Advisory Committee members during Meeting #1, OHIC has made the following modifications to its draft minimum downside risk requirement:

1. Begin with 1-year and 3-year minimum requirements, and remove the 5-year minimum requirement
2. Create a 3-year minimum downside risk level that is below that of the proposed 5-year level
3. Evaluate experience after each year and revisit levels

Minimum Downside Risk: Revised 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 3: net risk >/= 2.5%	Between 10,000 and 20,000 commercial lives, as % of physician org's ACO contract revenue: Year 1: net risk >/= 3% By Year 3: net risk >/= 5%
Over 20,000 commercial lives, as % of projected total cost of care: Year 1: net risk >/= 2% By Year 3: net risk >/= 4%	Over 20,000 commercial lives, as % of physician org's ACO contract revenue: Year 1: net risk >/= 10% By Year 3: net risk >/= 15%

Public Comment and Next Meeting

Wednesday December 7th 8 AM – 11 AM