

Lab 2: Implementation

Virtual Meeting 3 of 5

Primary Care Payer Action Collaborative

September 28, 2017

1:00-2:30 pm (EST)

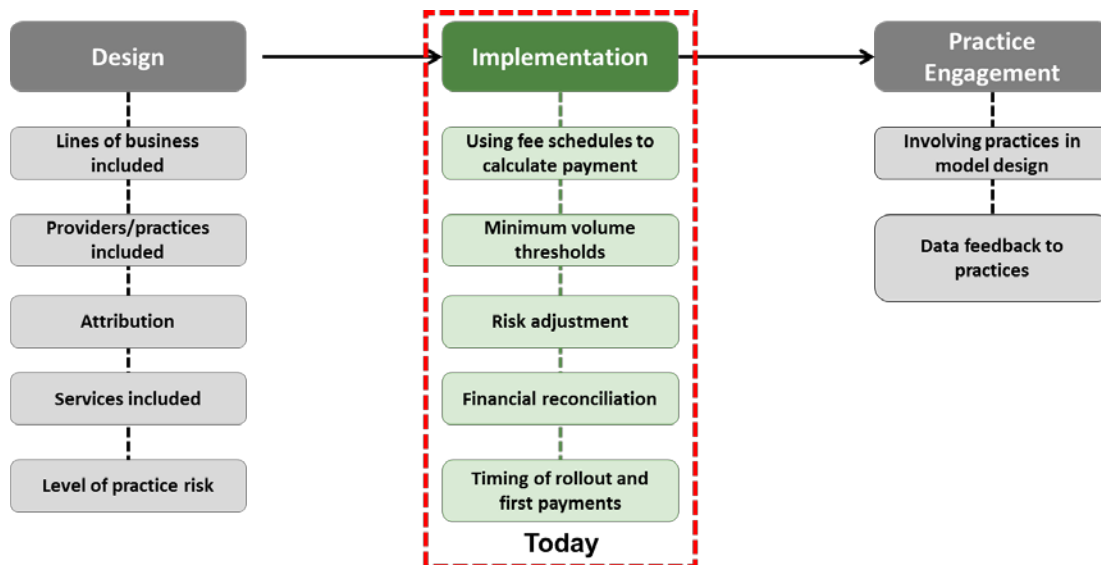
1. Session Objectives

- Define each of the key implementation steps involved in developing any alternative-to-FFS payment for primary care practices, and highlight options around risk adjustment.
- Identify problems and peer solutions at each step.

2. Speaker Panel

- Christiane Labonte, Payment Policy and Operations Lead for CPC+ at CMMI
- Melinda Walter, MHA, CPC Manager, Provider Network Analytics, Independent Health, Buffalo, New York
- Brian Keane, Actuarial Analysis Manager, Independent Health, Buffalo, New York
- Vince Speenburgh, Manager, Practice Transformation, Capital District Physicians' Health Plan (CDPHP), Albany, New York

3. Alternative-to-FFS Work Flow



Using Fee Schedules to Calculate Payment:

- How does your health plan align its Track 2 payment to multiple fee schedules? Does this vary by line of business? Do you have practice-specific fee schedules (e.g., large multi-specialty, rural providers), and how do you manage the crosswalk with these fee schedules?

- i. Independent Health has developed a PMPM rate specific to each of its lines of business (Medicare Advantage, Medicaid and commercial). Though some participating practices have their own fee schedules, the plan has tried to eliminate 'one-off' exceptions.
 - ii. CDPHP pays providers via a global risk-adjusted prospective payment system. As a result, providers' global payments are not directly impacted by the plan's fee schedule. The global payment covers a set of primary care claims codes, which are modified as needed. Any services rendered outside the global risk-adjusted prospective payment claims codes are impacted by fee schedules (e.g. immunizations).
- b. Is the alignment with multiple fee schedules a manual process or handled by your claims processing system? What claims processing system configurations have your organization made to automate processing?**
- i. Both Independent Health and CDPHP automatically process their alternative to fee-for-service (FFS) claims payments. Independent Health utilizes HealthRules, a HealthEdge product, and CDPHP uses Facets.
 - 1. Independent Health's claims processing system is tailored to the plan's capitation model. Initial development took time, but the platform is now aligned with the plan's needs.
 - 2. CDPHP's system can automatically implement fee schedule updates and notify practices of changes. The plan updates its fee schedule via a SQL process implemented by a developer, and then it is automated into Facets. An IBM Robot tool is used to automate any required provider payment adjustments. Any adjustments made are documented and provided in writing to impacted practices. In some circumstances, emails and phone calls are made as well.
 - ii. CMS' comprehensive primary care payment (CPCP) and FFS reduction involve a two part-process. To make CPCP payments, CMS uses outside operations contractors to calculate payment amounts, and then distributes those payments outside of its FFS claims processing system. The FFS reduction is both automated and manual. For the automated part, CMS incorporated new code into its FFS claims processing system that reduces the appropriate claims. To know which claims to reduce, CMS' operations contractor provides the CMS FFS claims processing system lists (i.e., this is the manual part of the reduction process) of CPC+ participants.
- c. How does CMS handle calculation of Track 2 payments for practices also participating in Medicare ACOs?**
- i. Practices participating in both CPC+ and a Medicare ACO receive the same CPCP payment. However, practices participating in both programs are not eligible to receive the CPC+ performance-based incentive payment (PBIP). Those practices would share in savings that the ACO earns.
 - ii. The CMS CPC+ Payment Methodology paper is available [here](#).

Minimum Volume Thresholds

- a. Does your health plan have a member attribution threshold for Track 2 payments? Is this inclusive of lines of business or vary by each LOB?**
 - i. The CDPHP threshold for Track 2 payments is 150 member lives across all lines of business, excluding coordination of benefits-only and select Administrative Services Only (ASO) groups. Participating providers receive rosters identifying ASO members and population health management reports for tracking purposes.
 - ii. Independent Health requires practices to serve 200 lives in any one line of business, or 400 lives overall, to receive Track 2 payments.
- b. How does your health plan work with and/or modify Track 2 payments for practices that have small member counts?**
 - i. CDPHP does not generally contract with small practices that see fewer than 150 CDPHP members. However, if a practice is near that number, CDPHP is open to working with it on a case-by-case basis.
 - ii. By setting minimum practice size at 200 lives in any one line of business or 400 lives overall, Independent Health can work with practices that have varying patient population sizes across different lines of business. Practices that have 400 patients total receive Independent Health’s default rate for non-qualifying lines of business (i.e., those with fewer than 200 patients).
- c. What is Medicare’s minimum volume threshold for CPC+ practices? Does this vary between Tracks 1 and 2?**
 - i. CMS requires practices to have a cumulative annual unique count of 125 beneficiaries to be eligible to participate in the model. This number was determined based on the sample size needed to calculate the performance-based incentive payment, not the sample size to calculate a CPCP.

Risk Adjustment

- a. How does CMS risk adjust the CPCP for Medicare?**
 - i. CMS did not see a compelling reason to add an explicit risk adjustment provision to the CPCP. Risk adjustment is inherently included in evaluation and management (E&M) billing. Payment to providers billing a higher number of Levels 4 and 5 E&M codes will reflect a population with more needs, for example. CMS does not expect the upcoming changes to the CPC+ attribution methodology to affect risk adjustment.
- b. Does your health plan risk adjust any portion of the Track 2 payment? What vendor or product does your plan use for risk adjustment?**
 - i. Independent Health has developed a custom risk adjustment solution to capture a customized primary care code set. The risk adjustment model is based on a Milliman solution, and reviews 18 months of rolling claims and adjusts payment quarterly.
 - 1. The risk adjustment model focuses primarily on chronic care burden and members’ age, sex, and diagnosis. Pharmacy claims are not included but instead built into a bonus component of the plan’s VBP model, which is addressed in utilization review.

2. To ensure that pediatric providers are appropriately compensated, certain chronic conditions are stratified by age band and gender to account for severity of diagnosis. For example, asthma in children is more costly than asthma in adults.
 - ii. CDPHP works with Verisk Health to calculate risk scores based on providers' primary care activity level (PCAL). Risk scores are calculated monthly with a rolling 12 month look back. All claims processed are used to determine the member's PCAL.
 1. CDPHP structures pediatric global payments so that providers are paid based on patients' age and sex. CDPHP utilizes an inverse model to account for the higher frequency of primary care visits for younger patients. Additionally, for the pediatric population, CDPHP provides a care management payment per member per month driven by the PCAL risk score. In sum, there is a global prospective base payment (age and gender) with an additional care management payment.
- c. How often do you report risk adjustment information to practices?**
- i. CDPHP distributes patient-level risk adjustment information to practices monthly, via patient rosters.
 - ii. Independent Health rolls risk score information up to the practice level. Providers receive quarterly reports identifying factors (utilization, pattern shifts, etc.) that impact practice risk scores so they can better understand how changes in risk patterns affected their PMPM payments.
- d. What are the pitfalls or implementation considerations for risk adjustment of Track 2 payments (i.e., pediatrics, other)?**
- i. CDPHP noted that explaining risk adjustment scores to providers can be challenging due to the complexity and proprietary nature of the risk adjustment algorithm. Providers sometimes feel their risk scores are not representative of their patients' acuity. In those cases, the CDPHP has worked with providers to review and explain diagnoses captured on CDPHP's end via claims and ensure they match what the practice has documented. CDPHP calculates risk scores at the member level and does not roll up risk scores to a provider and practice site level.
 - ii. Independent Health calculates a prospective risk score rolled up to the primary care clinician. The health plan provides quarterly reports to the clinician noting adjustments to the risk score based upon claims submitted and comparison to target for the full year.
 - iii. CDPHP has implemented a stop-loss process for risk scoring. Once patients exceed the plan's highest PCAL band, they are no longer eligible for prospective global risk-adjusted payments and are paid FFS for any primary care services rendered.

Financial Reconciliation

- a. **At what frequency does your health plan reconcile and/or check the adequacy of Track 2 payments (annually, semi-annually, quarterly, other)?**

Please provide a high-level explanation of how your health plan undertakes reconciliation. What reports are needed? What red flags are you looking for?

- i. CMS was concerned about payment adequacy and potential leakage of E&M services outside the CPC+ practice. To address payment adequacy, CMS inflated historical payments by 10% when calculating the CPCP. To address concerns about leakage, CMS will perform an annual limited partial reconciliation that compares out-of-practice E&M services in the historical period with out-of-practice E&M services in the payment year. If the difference falls outside a certain range, CMS will adjust future CPCP payments as needed. Data has shown that between 75-80% of office visits have been performed within a CPC practice, so CMS does not anticipate a large need for reconciliation.
 - 1. Beginning next year, CMS will separately and annually reconcile performance-based incentive payments. Because the PBIP is paid ahead of time, CMS will recoup PBIPs that are owed back.
 - ii. Similarly, Independent Health sees very little (5%) leakage. The plan shares historical utilization and leakage rates with providers and reconciles leakage annually.
 - iii. CDPHP provides practices with quarterly reports comparing their global risk-adjusted payments to the FFS equivalent. This provides the practice with a look at what it is earning above and beyond what it would be reimbursed in the FFS model.
- b. How do practices know whether they are likely to see an adjustment? How do you work with practices if an adjustment is necessary or there are concerns about inadequate payment?**
- i. Generally, Independent Health tries to avoid reconciling provider payments where possible to avoid provider recoupment, but must reconcile out-of-practice (leakage) claims. Should Independent Health need to recoup, the plan provides timely and transparent reporting to providers to mitigate impact and aid in budgetary planning.
- c. Are there special considerations for member cost sharing if applicable?**
- i. Independent Health noted that provider communication around member cost sharing can be challenging, as providers sometimes feel that member cost sharing is a takeaway from their payment. Independent Health has prioritized implementing real-time claims processing so providers have an immediate and accurate understanding of member cost sharing.
 - ii. Similarly, CDPHP emphasizes timely and transparent practice reporting, and issues a monthly payment report so practices can see adjustments made for member cost sharing. Since CDPHP utilizes a prospective payment system, one month's adjustments will be effectuated in the following month. CDPHP will retroactively adjust plan payments for member cost sharing if needed.
 - iii. For CMS, there are no changes to beneficiary cost sharing.
- d. Other**
- i. Both Independent Health and CDPHP provide total cost of care reporting for global risk-adjusted payments.
 - ii. CMS quarterly practice feedback reports include fields for CPC+ practice primary care expenditures, primary care expenditures outside the practice, total cost of care

expenditures, and expenditures by type of service, among other fields. These reports are meant to give practices a signal about how they are doing for tracking purposes, but not intended to be definitive for reconciliation.

Timing of Rollout and First Payments

Due to time constraints, this discussion topic was laid over to the next [PAC webinar](#) to be held on October 10, 2017.

Session Recording: <http://hcp-lan.org/workproducts/pac/PAC-Lab-2-Recording.mp4>

Link to previous session: http://hcp-lan.org/workproducts/pac/PAC-Lab1_Model-Design.mp4

Link to following session: <https://protect-us.mimecast.com/s/enkRBdFeNppocr?domain=hcp-lan.org>