Constructing the Alternative-to-Fee for Service Payment: *Office Hours*

Virtual Session

Primary Care Payer Action Collaborative

February 28, 2018

3:00-4:30 pm (EST)

1. **Session Objectives**
   - Build a deeper understanding of payer operations relating to CPC+ Track 2 Alternative to fee-for-service (FFS) payment
   - Provide an overview of Capital District Physicians' Health Plan (CDPHP)'s Enhanced Primary Care model, addressing specific aspects of constructing this alternative to fee-for-service payment
2. **Speaker Panel**: Vincent Speenburgh, MPH, PCMH CCE Manager, Practice Transformation Capital District Physicians' Health Plan, Albany NY

I. Introduction

- **CDPHP:** Capital District Physician Health Plan, is a local, non-for-profit health plan headquartered in upstate New York. They have approximately 40% of the market share in their service area, which includes the "core four" counties – Albany and the surrounding counties. There are approximately 400,000 members and over 10,000 practitioners.

- **Enhanced Primary Care (EPC) Model:** The EPC program launched in 2008 with an existing model and network, prior to CPC Classic and CPC+. When EPC transitioned to CPC+ Track 2, CDPHP was able to grandfather all of their practices into Track 2. EPC is designated as a Track 2 payment in alignment with CPC+. The goal of the EPC model is to pay for value rather than volume, represented by the Triple Aim. EPC also aims to provide sustainable enhanced payments to primary care practices. The aggregate savings associated with improved outcomes and reduced utilization will be sufficient to sustain the enhanced payments. The EPC Model has 184 practices, 836 network clinicians, and approximately 235,000 members.

- **Comprehensive Payment:** The EPC Model's comprehensive payment includes a risk adjusted comprehensive global payment, paid prospectively, monthly, across all lines of business, excluding select ASO groups and coordination of benefits (where CDPHP is secondary). By 2016, CDPHP had assembled enough outcome data on the EPC model to show the value to ASO clients and gain their participation in the payment model. FFS reimbursement is used for anything not captured in the EPC service codes and also for those patients who are not attributed to the practice. The third component of the payment is a retrospective bonus payment, based on the Triple Aim. This performance-based incentive is driven by membership and panel risk. Relative to the overall payment to the primary care provider (PCP), Track 2 is paying 85% prospectively, with less than 15% remaining in FFS. This does not include the bonus opportunity. The payment is, on average, 174% of FFS for Medicare patients.
  - **Q:** How does CDPHP handle reports provided to the ASO groups with the capitated payment as opposed to FFS?
    A: CDPHP has an internal team that work closely with the ASO groups to provide reporting. Vince can look into this offline.

- **Q:** Have you done any return on investment analysis on paying PCPs 40% above FFS? Is the total cost of care needle moving in the right direction?
  A: There was an independent analysis published in 2014; it projected $20.7 million in savings, with some caveats. Vince would be happy to share the report upon request. (Report Here)
- **Q:** What was the reasoning for excluding ASO groups at the launch of the program?
  A: CDPHP needed a couple of years to assemble outcome data from the EPC model and then share it with individual ASO clients in an effort to get them to participate.

II. Payment Model Overview

- **Minimum Practice Size and Demographics:** To be eligible for the EPC Model, the practice must be accepting all lines of business (LOB) including commercial, Medicaid, and Medicare Advantage with a minimum of 150 members across all LOB. CDPHP is open to discussing with practices that do not quite meet the minimum threshold, and provides a financial simulation to ensure it is mutually beneficial. In 2017, 184 practices were contracted in the EPC model, and, of that, 94 were contracted for CPC+, with 36 in Track 1 and 58 in Track 2. CDPHP has independent, multi-specialty, and facility owned practices. From CDPHP's experience, having more resources available has not determined success for the practices. CDPHP offers a product where there is no copay for visits to EPC practices to provide better access and promote their network.
  - **Q:** What is the percentage of commercial HMO vs. non-HMO products in your area?
    A: Vince would have to circle back on the overall makeup by percentage of business. Generally, practices are transforming irrespective of LOB or payer type to improve outcomes of their entire population.

- **Methodology:** The three components to the bonus include:
  - Patient experience: includes 22 Consumer Assessment of Healthcare Providers and Systems (CAHPS) questions administered by an independent company. CDPHP carves out questions around access to care, communication, coordination of care and self-management support.
  - Effectiveness: uses 16 Healthcare Effectiveness Data and Information Set (HEDIS) questions across four domains.
  - Efficiency: looks at the total cost of care (ED/Hospital/Lab/Radiology/Rx/Specialists).

  The bonus methodology utilizes a quality scorecard that takes into account competing programs that practices might be participating in and creates alignment with those quality measures.
  - **Q:** What is the methodology for effectiveness and efficiency index? What factors are incorporated?
    A: The indices are calculated as an aggregate through the patient experience data, their quality data, and the HCC reporting. It is a sum of the data points that then provides a quality index, which is ranked among the network. The efficiency is also ranked with respect to their peer group and performance. It is risk adjusted with a normalized cost. 1.0 is the average utilization. Anything below that is considered to be more efficient.
  - **Q:** Does the efficiency measure use a cohort average cost as the touchpoint in looking at percentile ranking versus the averages?
    A: Practices establish a total cost of care score. There are different weights to each of the six profile service categories with their own efficiency score that sums to the total cost of care (1.0 being the average). It is a percentile of how they scored within the network.

- **Q:** Does the efficiency score methodology relate to the specialty providers, patient panel, etc.?
  A: It is not a direct causation – it's strictly claims data; however, there is a correlation. CDPHP provides reports to help address the trends (e.g., where the patient panel is seeking services). It informs decision making, but practices cannot yet open efficiency scores to specifically see the driving factors.

- **Code Set:** EPC model aims to include commonly used codes for the primary care setting and the health plan conducts an analysis based on codes submitted. Some examples of those included are E&M visits, physician office labs, and testing (e.g., strep or urine), while excluded codes are medications and vaccines (due to the cost of housing and administering).

- **Fee Schedules:** Multiple fee schedules do not impact the global risk-adjusted prospective payment, but the simulations and quarterly reports do account for any fee schedule changes. CDPHP utilizes FACETS as the claims processing system and updates fee schedules through the SQL process, automated with a robot tool. Practices are notified if adjustments are made to the fee schedule.
  - **Q:** What fee schedule methodologies are used for payment outside of the global payment?
    A: The fee schedule would be as prescribed by the LOB, rate schedules set by the state, and how CDPHP integrates into the claims system.

- **Attribution:** Members are attributed based on encounters and E&M visits using a hierarchical, claims based methodology. Patients can impute to an MD, DO, PA, and NP. Per Medicaid requirements, CDPHP does auto-assign members to a PCP if they do not select one; however, imputation does not actually occur until members have a visit with the practice. Auto-assigned members are included in the practice's quality data reports and patient roster.
  - **Q:** If a specialist is driving care for the patient, would the attribution move away from primary care?
    A: Attribution is established monthly and looks at claims in the hierarchy as well as E&M visits. The specialist would have to assume all care for the patient to look like a non-utilizer in that practice. If there is no claims data for that patient in the past 12 months, there is an additional 12 month look back to establish the imputation.
  - **Q:** CDPHP claims seem HMO-like, and members are selecting the PCP. In a market without a lot of HMO products where claims based attribution tends to change frequently, what kind of reconciliation process is in place if practices raise concern over having a member that is missing or not their own?
    A: If a patient is imputing to a practitioner, but payments are still going to the practice, CDPHP would leave this in place. If a practice reports that a member does not belong to the practice, CDPHP would do claims research to see when the encounters happened that led to the imputation. Some practices may discharge a patient, but imputation may still take place. CDPHP encourages practices to help facilitate that the patient gets a new PCP. This is not a major pain point for CDPHP.

- **Member Cost Share:** CDPHP provides a report to the practices that includes any adjustments. Services rendered with a cost share are represented in the following month to avoid duplication of payment. CDPHP will retroactively adjust plan payments as needed.

- **Outcomes:** CDPHP found that practices improved with time, and those in the model or one similar, adapted and outperformed others. They also found that after the first year, the aggregate investment of the additional payments is covered by the savings in the reduction of health care spend. Practices in the model achieved higher quality and efficiency. In 2016, 41 practices achieved the triple aim – 25 of which are CPC practices, and 20 of those are Track 2. Additionally, the highest performing practices tend to have over 40% of patients in Track 2, strong physician leadership, and an ability to embrace change.
    - **Q:** You mentioned that members benefit from more time with their doctor/ care team and extended hours. Can you give a little more detail on that?
      A: A physician engagement team works to support practices in the model, and practices are surveyed with respect to patient access. Results are used to draw correlations around total cost of care and profile service categories. CDPHP has seen practices block out additional hours (e.g., 8 am-12 pm and 2-5 pm on weekdays and on weekend mornings) or bring on additional staff to take urgent visits. While there is variation with respect to open access, telephonic access and portal communication are promoted across practices.
    - **Q:** Have you done any analysis to see if a correlation can be drawn between the risk corridors and the MLR?
      A: No, but Vince can look into this offline. CDPHP has escalated concerns from practices on a case by case basis when they feel that risk adjustment does not reflect acuity. The quarterly reports are used to ensure adequate payments to practices as a whole.
    - **Q:** How do you address the cohort average being a zero sum game, and that it does not necessarily tie to the MLR of the plan? Have you considered moving from a comparative measure to one that is tied to percent of premium or something of that nature?
      A: CDPHP has not done that, but always welcomes feedback to make it a better process for the plan and the practice.

III. Risk Adjusters Applied to the Global Payment

- **Risk Score:** Verisk Health calculates risk scores, or the primary care activity level (PCAL) on a monthly basis. It is claims based and calculated on a rolling 12 months of claims data. The pediatric model differs to account for the higher frequency of primary care visits at younger age. It is based on age and gender. A care management payment is layered on top of the global payment driven by the patient's PCAL score. CDPHP calculates the risk score at the member level. On a case by case basis, CDPHP works with providers to review challenges to their PCAL if it is not felt to be representative. There are 13 bands for the PCAL that range from 0 to 22.
    - **Q:** How many levels of risk adjustment are there?
      A: the PCAL ranges from .9 to 22, at which point there is a stop loss for members who would then likely primarily be seeing a specialist. CDPHP has quarterly reports for practices to compare their compensation to what it would have been under FFS (on average paying between 20 and 40% above). Changes to payment are relayed to practices and are updated annually in the contract.
    - **Q:** Do you also measure HCC as a risk score?
      A: No, CDPHP provides reporting along with HCCs to practices to give a better sense of the risk severity of their patients that would contribute to the PCAL. CDPHP also provides a gap in care report. CDPHP directs practices to treat patients as clinically appropriate and shares the claims with Verisk to adequately represent the risk.
    - **Q:** How does CDPHP adjust expectations for utilization within the efficiency score based on the risk for the panel?

A: All claims are used for risk adjustment, not just primary care encounter claims, which include the diagnoses. The efficiency score is a risk adjusted and normalized cost when calculating the scores for utilization. It controls for geography along with other factors and compares practices to peer groups with similar makeups.

- **Q:** Does the PCAL risk data follow the patient as that person is admitted to the hospital, or do you have a sense of if practices might make the PCAL available for use in the EHR by providers?
  A: No, but practices can utilize the PCAL as a component to how they risk stratify their patients. However, CDPHP does not push information about the PCAL to others settings of care (hospital, specialist, etc.).

IV. Reports Available to Practices

- CDPHP uses a number of reports, available through the portal, to support the practices:
  - The Patient Roster: a monthly report that provides the LOB, imputed provider (based on claims and encounters), the PCAL, and case management. It helps practices to know what their panel is and who is attributed.
  - Gap in Quality Report: allows practices to reconcile gaps by providing evidence that care was provided, but maybe have been under a different insurer. CDPHP allows practices to provide additional information to support their position.
  - ED Utilization Report: a quarterly report that shows the top ED utilizers, where they went, and the diagnoses.
  - Specialty Report: provides the top five specialties and top ten specialists within the quarter. If possible, CDPHP will provide the efficiency score and the effectiveness score.
  - Pharmacy Report: looks at patients with complex medication regimens (including the total number of drugs a patient might be on). Provides a picture of medication reconciliation or those individuals at risk.