Primary Care Capitation 101

John Freedman, MD, President
Mary Jo Condon, MPPA, Senior Consultant

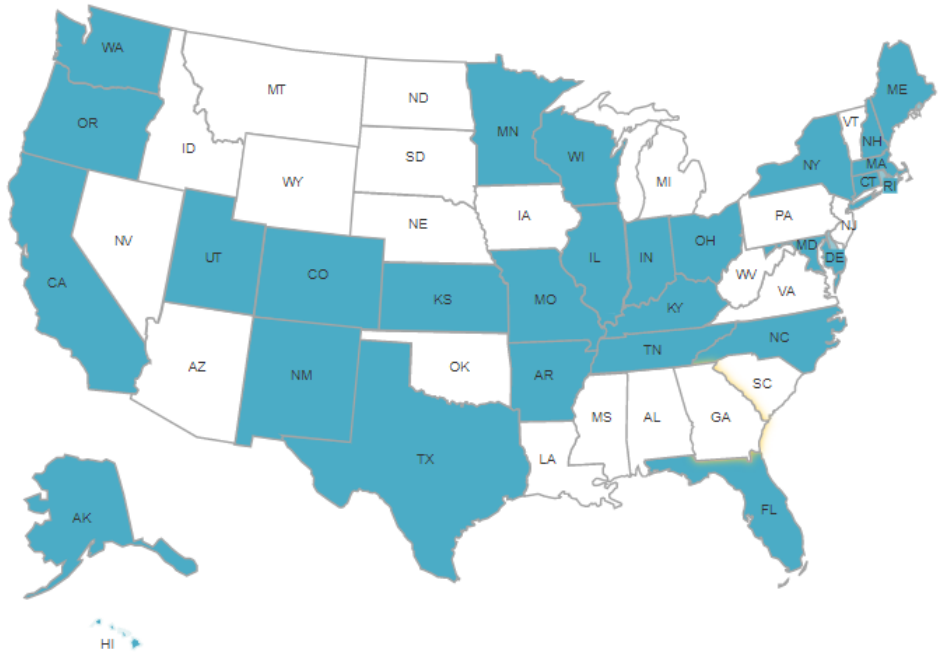
Today's Discussion

- Background and Context
  - Rhode Island Affordability Standards
  - Medicaid/OHIC Shared Goals to Increase Investment in Primary Care and Expand Primary Care Capitation
- What is and isn't Primary Care Capitation?
- Other Alternative Payment Models
- History of Capitation and Relevance to Today
- Resources

About Freedman HealthCare

- Founded in 2005
- Focus on government and nonprofit health data & performance initiatives
- Experienced with quality and cost measurement and improvement
- Assisting states to transform payment and care delivery

Freedman HealthCare States



FHC Team

John Freedman, President & CEO

Dr. Freedman has 25 years' experience in performance measurement and improvement, health information technology, care delivery, and health care reform. Before founding Freedman HealthCare in 2006, he held leadership roles at multiple innovative health care organizations from federally-qualified health centers to health insurers.

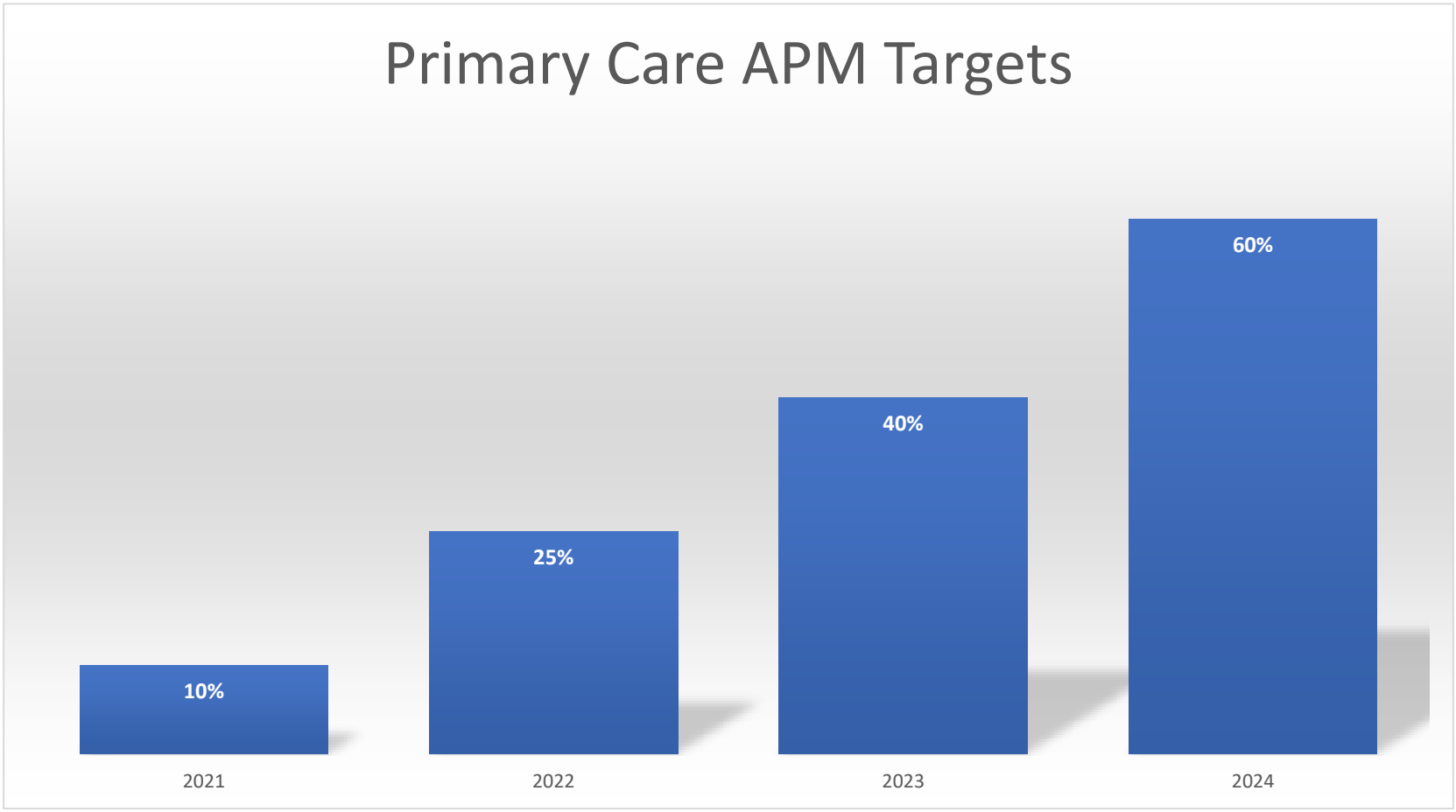
Mary Jo Condon, Senior Consultant

Ms. Condon has spent more than a decade guiding physicians, employers, hospital executives, payers, and other community leaders in collaborative action. Her recent engagement work has resulted in payment reform to increase primary care investment, reduce hospital price growth and expand alternative payment adoption.

Background and Context

- OHIC's Affordability Standards require insurers to dedicate at least 10.7% of their medical spending to primary care.
- Under OHIC regulations, primary care practices recognized a PCMHs are entitled to ongoing care management funding from insurers.
- OHIC is a co-convener of CTC-RI and has been an advocate for PCMH-Kids.
- The Affordability Standards encourage payment reform and require insurers to develop alternative payment models for primary care.

OHIC Primary Care APM Targets



Primary Care Capitation

It isn't…..

Primary Care Capitation

It also isn't.....

Primary Care Capitation

Nor does it have to be…..

Primary Care Capitation

What it is..

Capitation is a payment arrangement whereby a group of physicians receives a set amount for each enrolled person assigned to them, per period of time, ***whether or not*** that person seeks care, and ***regardless of the services provided***.

Primary care capitation refers to capitated payments for primary care clinical services only. It ***does not*** include payments for other professional, facility, or ancillary services.

A Few Other Key Terms

Alternative Payment Model (APM) – A payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:

- Improving quality of care
- Improving population health
- Reducing total cost of care growth
- Improving patient experience and engagement
- Improving access to care

APMs should define and evaluate cost performance relative to a "budget" that may be prospectively paid or retrospectively paid. Providers are rewarded for managing costs below the budget, should quality performance be acceptable by maintain some or all of the savings. Providers may also be responsible for some or all of the costs that exceed the budget.

A Few Other Key Terms

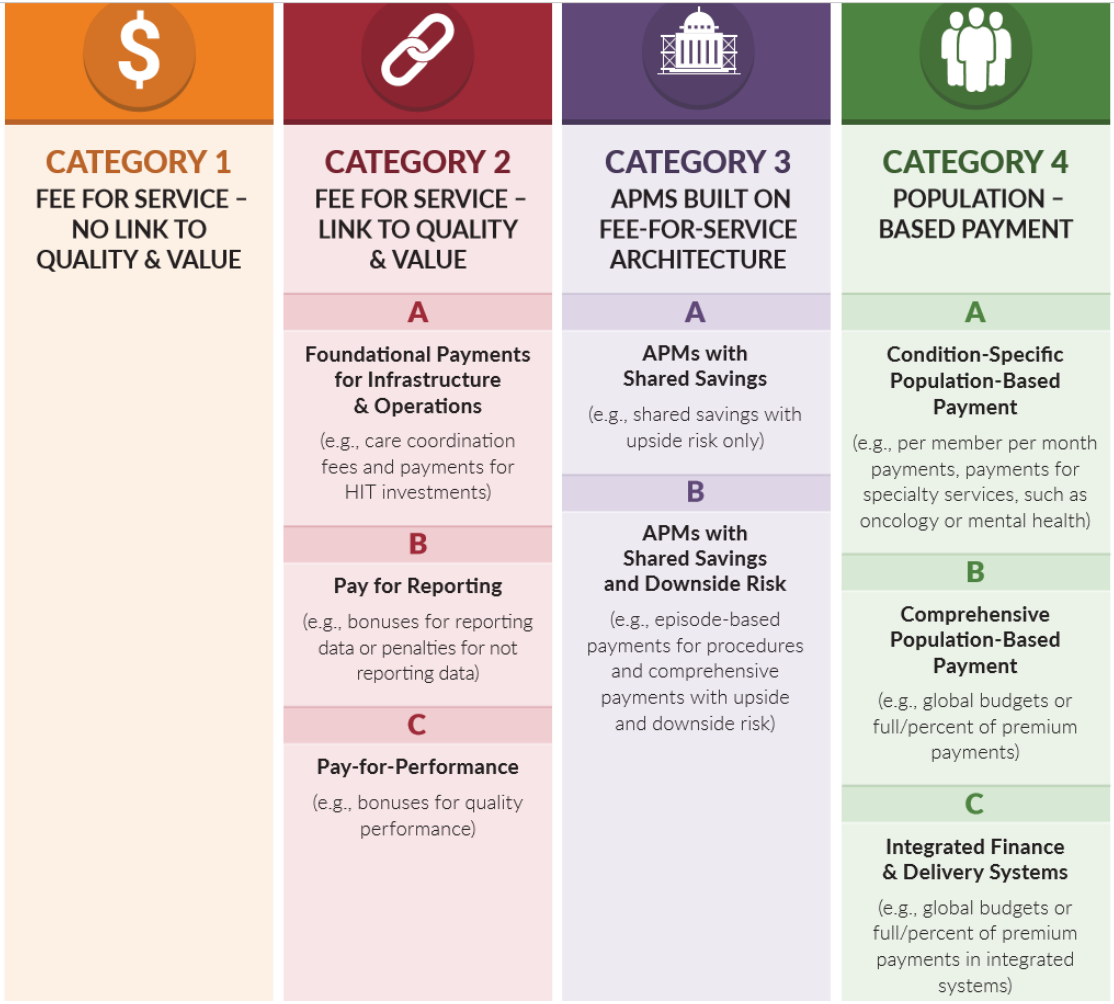
Integrated System of Care – This group of providers working together, sometimes referred to as an Accountable Care Organization, means one or more business entities consisting of physicians, other clinicians, hospitals and/or other providers that together provide care and share accountability for the cost and quality of care for a population of patients, and that enters into a Population-Based Contract, such as a Shared Savings Contract or Risk Sharing Contract or Global Capitation Contract, with one or more Health Insurers to care for a defined group of patients.

Attribution – The process of assigning patients to the provider entity that will be responsible for delivering their care and that will be held accountable for the cost and quality of that care.

Risk Adjustment - A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

American Academy of Pediatrics Practice Transformation Key Terms and Definitions

Alternative Payment Model Types



NOT MUTUALLY EXCLUSIVE

A contract between a payer and a System of Care might include several of these alternative payment models working together to produce a desired result.

Paying for All Other Services

How will all other services be paid?

Likely, fee-for-service **plus** some combination of the following…

- **Pay for performance** or additional reimbursement for meeting certain systemwide performance or utilization metrics.
- **Upside risk** or additional reimbursement if the **total cost of care** (all services, all care settings) across a population of patients is less than expected.
- **Downside risk** or financial penalties if the **total cost of care** (all services, all care settings) is more than expected.

Assessing the Trade Offs of Capitation

The headaches it may reduce….

- Pressure to fill appointments, "churn" patients
- Administrative billing burdens eased, not eliminated
- Fee for service requirements and constraints (e.g., valuable but non-traditional services, like check in phone calls, are unpaid)
- No loss of cash flow when not seeing patients due to vacation or pandemics
- Better organized to achieve population health and quality aims

Assessing the Trade Offs of Capitation

The headaches it may cause….

- Attribution will matter. It may feel opaque and may not always be timely.
- You'll likely manage other members of care team more and may spend less time seeing patients yourself
- Perfecting care team workflows, analytics and administrative processes all take time

The Case for Capitation

So why do it?

- **Flexibility** to provide the right care, at the right time and right place, by the right provider
- **Time** to focus on patients with the most complex needs
- **Opportunities** to manage the health of populations, not just the patient in front of you

Not a Return to the 90s

How will it be different from the old days?

- **Fairer budgeting:** Better data to risk-adjust payments
- **Clearer expectations:** More tracking of quality, access, patient satisfaction
- **Total cost of care accountability** makes it less financially advantageous to skimp on clinical management and oversight
- **Support** for care teams, integrated behavioral health, virtual care, connections to community-based services

2017 Consensus Model Principles

In spring 2017, OHIC convened a workgroup to develop recommendations on a multi-payer Primary Care Alternative Payment Model.

1. 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. Should complement Rhode Island's Primary Care Medical Home strategy.
3. Goal is not to reduce primary care spending or shift insurance risk to PCPs
4. Should lend itself to multi-payer alignment (including by public payers Medicaid and Medicare CPC+ Track 2).
5. Should preserve access for patients.

2017 Consensus Model Recommendations

- Full primary care capitation; providers still collect patient cost share;
- Rate largely based on past experience. Care management fees will be included. Total still may not fully reflect current thinking (e.g., IBH, nurse care manager, support for social needs)
- No requirements regarding provider size or readiness
- Included services: Office, virtual, and telephone visits; urinalysis; electrocardiogram, intralesional injections, removal of skin lesions and tags
- Insurers can use the risk adjustment tools of their choice and should be transparent about how the software is applied, including underlying parameters, assumptions, and the impact on payments.
- Insurers can use existing attribution policies and modify for this program.

Questions to Ask

Each insurer will implement the Consensus Model a little differently.

Here are a few questions you may want to ask…

Questions to Ask: Model Design

Model Design: Will participation, attribution, performance, and payment be defined by provider/practice/TIN/system of care?

***Why it matters*:**

- Will your system of care or a payer offer (or require) all a system of care's primary care practices to be paid via capitation if one is to be paid via capitation?
- Aggregation of performance may boost or diminish your opportunity for incentives.
- Internal compensation structures also may need to adjust to align with this new payment model.

Questions to Ask: Model Design

Real Life Example:

- Dr. Smith is unsure whether her practice can opt out of capitation if the system of care signs on?
- Her practice performs well on quality measures. Will that performance be aggregated with others?
- Her families tend to have social needs. Will she receive sufficient revenue to provide that care?
- Will the flexibility of the payments allow her to expand her care team and/or use more virtual care to better address these needs?

Model design, including who is the contracting entity, informs these questions.

Questions to Ask: Attribution

Attribution: What attribution method will be used? Will it be retrospective or prospective? Will patients be required to choose a PCP? What fraction of plan members will be attributed to PCPs?

***Why it matters*:**

- Understanding the rules allows providers to align patient outreach with attribution and clinical need.
- Pediatric providers with young, healthy patients may want a longer lookback (at least 24 months).
- If patients' coverage changes frequently, providers might prefer attribution that does not require continuous enrollment.
- Other rules to understand include handling of moms/newborns and whether virtual care or care provided by non-PCPs will count toward attribution

Questions to Ask: Attribution

Real Life Example:

- Annie, an 8 y/o girl, considers you to be her primary care provider.
- Her parent schedules her annual well visit with you in January.
- In February, Annie has a sore throat and fever, so her mother brings her in for an acute visit. Its last minute. Your SoC colleague in another office near Annie's home can see her right away.
- Is Annie still attributed to you? What if instead of seeing your colleague for her sore throat, Annie went to urgent care?

Attribution determines who receives payment for Annie as a patient each month.

Questions to Ask: Support

Support: What data analytics and administrative support will be offered?

***Why it matters*:**

- Data analysis is time consuming, benefits from a specific skillset and may require information not available to practices
- Accurate data on patient panels, population health and quality, and utilization will be more important than ever

Questions to Ask: Support

Real Life Example:

- Annie also has asthma. Sometimes her mom forgets to refill her medications and once she needed to visit the ED.
- Will the carrier provide data on when Annie refills her medications or when she visits an ED?
- Will the system of care assist you in reaching out to Annie following a missed refill or ED visit?

Support from your SoC and the carriers can improve your likelihood of success.

Questions to Ask: Services

Services: How do included services differ from consensus model?

***Why it matters*:**

- The consensus model recommends including preventive and well visits – this is particularly important to pediatrics
- It seems to be silent on hearing and vision screening
- It does not include vaccines or vaccine administration
- As practices evolve, they will likely want sufficient resources for integrated behavioral health, care coordination and nurse care managers, and addressing social needs

Questions to Ask: Services

Real Life Example:

- After her ED visit, Annie's mom began connecting with a recently hired nurse care manager on your care team.
- Sometimes they connect by text or phone.
- Every once in awhile, they do a video visit.

These are new services, not previously offered by your practice. Past billing experience may not be sufficient.

Questions to Ask: Risk Adjustment

Risk Adjustment: What risk adjustment method will be used?

***Why it matters*:**

- Most commercial risk adjusters are designed to predict the total cost of care for a patient – not a patient's primary care costs
- Most commercial risk adjusters are built based on the experience of a majority adult population
- Most commercial risk adjusters do not reflect patients' social needs

Questions to Ask: Risk Adjustment

Real Life Example:

- Annie also has a new baby brother, Jayden. He just turned 1.
- This year, Jayden will visit your office at least three times, just for well visits. This will drop to 1 well visit a year at age 3.
- Annie and Jayden's mom recently mentioned their house had a rodent problem.
- A community health worker from your office connected them with a non-profit that offers pest control services.

Pediatrics will need narrow age bands and ideally, risk adjustment methods designed to predict the primary care needs of patients.

Resources

Academic paper on the financial considerations for pediatric practices considering capitation.

Video presentation with clear, practical advice on implementation of pediatric primary care capitation.

White paper on risk adjustment considerations for pediatric populations.