ADVANCING INTEGRATED HEALTHCARE

Accelerating Primary Care Capitation in Rhode Island

CTC-RI Clinical Strategy Workgroup Recommendations as of April 2021

Report By:

Care Transformation Collaborative of RI / PCMH Kids

Pano Yeracaris, MD, MPH, Chief Clinical Strategist
Debra Hurwitz, MBA, BSN, RN, Executive Director
Susanne Campbell, RN, MS, PCMH CCE, Senior Program Director
Linda Cabral, MM, SBIRT/CHT Project Manager
Care Transformation Collaborative of Rhode Island

Mary Jo Condon, MPPA, Senior Consultant
John Freedman, MD, President and CEO
Freedman HealthCare

Craig Jones, MD, Partner
Capitol Health Associates

Somava Saha, MD, MS, Executive Lead
Well-being and Equity (WE) in the World Faculty
Harvard Medical School Center for Primary Care

May 2021

INTRODUCTION

As a public/private partnership, the mission of the Care Transformation Collaborative of Rhode Island (CTC-RI) is to *lead the transformation of primary care in Rhode Island in the context of an integrated health care system, to improve the quality of care, the patient experience of care, the affordability of care, and the populations we serve*. CTC-RI brings together critical stakeholders to implement, evaluate, and spread effective models to deliver high-quality and accountable comprehensive primary care, which improves health equity and meets the quadruple aim.

The RI primary care community mounted a strong, organized and collaborative response to the COVID-19 pandemic. The care transformation work of several important projects is outlined in the COVID Relief Fund Summary report. The pandemic exposed the vulnerability of primary care practices operating under Fee-for-Service (FFS) and many primary care providers reported an interruption in cash flow that jeopardized their financial viability. In April, 2020 CTC-RI was charged by OHIC and Medicaid to assist in accelerating the adoption of comprehensive primary care capitation. This White Paper describes the work of the CTC-RI Clinical Strategy Committee and provides detailed recommendations. At the time of this writing (May, 2021), there have been fewer capitation contracts executed compared to interest expressed from Systems of Care (SOC). Working in collaboration with the RI Health Plans and SOC, OHIC, and Medicaid, RI has an unprecedented opportunity to more closely align primary care capitation efforts in order to accelerate adoption.

An important new report just released by the National Academy of Science, Engineering and Medicine, entitled Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care, identifies the need to shift from FFS to hybrid payment (part FFS, part capitated) models, making them the default method for paying for primary care teams over time. For risk-bearing contracts with population based health and cost accountabilities, such as those with accountable care organizations, payers should ensure that sufficient resources and incentives flow to primary care. Hybrid reimbursement models should:

> a. pay prospectively for inter professional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations;
>
> b. be risk-adjusted for medical and social complexity;
>
> c. allow for investment in team development, practice transformation, and the infrastructure to design, use, and maintain necessary digital health technology; and
>
> d. align with incentives for measuring and improving outcomes for attributed populations.[1]

---

[1] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

BACKGROUND

In the summer of 2020, CTC-RI assembled a team of national experts with local, statewide/regional, and national experience in the areas of design and implementation of comprehensive primary care. As part of broader initiatives responding to the pandemic, CTC-RI sponsored an accelerated four-month effort to define critical factors of Care Delivery Design to “maximize success in Comprehensive Primary Care Capitation (CPCC) within Total Cost of Care (TCOC) risk.” Those efforts identified “must have” and “nice to have” components for successful performance in capitation and TCOC risk for both adult and pediatric care. Core components for success also included Integrated Behavioral Health (IBH) and several further expansions of “extended care team capabilities.” Meeting the social needs of patients and families through community health team services was also identified as a “must have.”

Key recommendations to foster success in CPCC include:

- A common approach to defining core competencies in CPCC that ensure accountability, adequate funding, and aligned incentives to support success
- Support for ongoing performance improvement (PI) at the primary care practice level, with attention to workforce well-being and development, to reduce burnout and administrative burden, build skills, and improve work-life for all staff
- Consider establishing a “consensus capitation methodology” led by Medicaid and OHIC. A “reasonable” PMPM can be calculated based on identified competencies and team members. Current experience with PCMH functions, as well as analysis of RI Medicaid primary care spend, can be used to inform final actuarial estimates
- Percent of membership targets for the MCOs should align with, if not exceed, the OHIC affordability standards
- Continue shared learning among broad stakeholders to improve execution of comprehensive primary care at the practice level and within “accountable” Systems of Care (SOC)

SPECIFIC RECOMMENDATIONS REGARDING PRIMARY CARE CAPITATION

The "State of Rhode Island Office of the Health Insurance Commissioner Primary Care Alternative Payment Model Work Group Consensus Model" ("RI Consensus Model" Spring, 2017) offers a strong foundation for developing a primary care capitation model. Since its release, primary care practices in Rhode Island have expanded their care teams, identified new ways to engage patients in the office and beyond, and increased their use of data at the patient and population levels. Four years later, in response to the pandemic and other factors, RI has accelerated efforts towards CPCC, however many challenges remain.
Recognizing this continued evolution, the CTC-RI recommends that the following update to the RI Consensus Model be considered.

Recommendation #1: Work Jointly to Assure Adequate and Sustainable Funding for Comprehensive Primary Care Capitation in RI

At the request of OHIC and Medicaid, CTC-RI convened primary care providers, system of care leaders, payers, and employer representatives in the second half of 2020. Participants worked collaboratively to prioritize recommended care delivery components for comprehensive adult and pediatric primary care. The list included "must have" and "nice to have" components of comprehensive primary care under capitation and total cost of care accountability models. Care delivery components in *italics* were deemed "nice to have" but not necessarily a "must have" for success.

Adult and Pediatric Components of Care Delivery Models for Comprehensive Primary Care Capitation/Total Cost of Care

- Expanded Care Teams
  - Integrated Behavioral Health
  - Care management (pharmacist, nurse care manager, care coordinator)
  - Health/wellness support
  - Community Health Teams (working with HEZ, CBOs)
- Specialist referral network (*e-consults*)
- Remote clinical care (video visits, phone, text, email, *remote patient monitoring*)
- National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)
- Specialized practices (e.g. geriatric care, substance use disorder treatment)
- Open access scheduling
- Group medical appointments (pediatrics only)
- Infant home visits (pediatrics only)

Recommendation #2: Align Financial Support with Enhanced Care Delivery

Some models have contemplated paying practices a PMPM based on historical total claims and non-claims payments. However, the list of recommended care delivery components outlined by stakeholders and listed above may require additional resources. RI has benefited from building a strong and cohesive system for primary care. At the same time, there are ongoing challenges in quality and financial performance at the practice and system of care level, and continued issues impacting workforce well-being and development.

Payments to RI PCMH practices and SOC have generally covered care management, QI, data reporting, and performance incentives. Payments should also recognize the expanded care team, such as pharmacists, IBH clinicians, and CHWs to also strengthen CPCC. Risk-adjusted costs for some of these added functions can be estimated based on RI and national experience. For example, a practice-based CHW (per 3000-5000 patients, based on available risk adjusters) to assist with population health efforts might also be included with an estimated $1 (one per 5000) - $1.67 PMPM (one per 3000). Data compiled for recent The New England States Consortium Systems Organization (NESCSO) primary care analysis could be compared to estimates of the cost of providing comprehensive primary care and inform the process. Incorporating these "non-claims-based payments" into the estimates is important.

The RI Consensus Model also encouraged insurers to apply a broad lens when determining what to include in the payment. Generally, it recommended including services that are 1) typical primary care services that are widely performed by primary care clinicians, 2) low-value or prone to overuse. It also recommended including care management services if the practice was currently paid a care management fee. Further, it suggested excluding from capitation (and paying based on pre-existing FFS rules) services that are 1) valuable, but potentially underutilized (e.g., tobacco screening and counseling), 2) valuable, but performed at widely varying rates among providers, 3) not used in the Rhode Island commercial market.

Excluding high value, underutilized services from the capitation rate, and offering fee for service payment, may result in a positive increase in utilization. However, many of these could also be provided by non-physician members of an extended care team, or through virtual care settings. In paying for these valuable, underutilized services, either fee for service or part of the capitation rate, Medicaid and OHIC may want to encourage insurers to offer flexibility regarding who performs the service (e.g., primary care provider, behavioral health clinician, certain non-billing providers), and how the services are delivered (e.g., in office). This would maximize providers' ability to offer these services in an efficient way that is aligned with the flexible workflows necessary for successful capitation, rather than be tethered to the constraints of traditional fee-for-service.

Recommendation #3: Attribution Method to Reward Practices that Redesign Workflows and Expand Access

Practices are more likely to be successful at capitation and total cost of care risk contracting when they redesign workflows to ensure patients receive the right care, at the right time, from the right provider, in the right setting. The expansion of telehealth visits during the COVID pandemic has demonstrated the advantages and convenience of virtual care, and many expect it will remain a core part of regular care after the crisis has passed. Traditional attribution methods conflict with this vision. Basing attribution solely on face-to-face visits between primary care providers and patients can financially harm practices seeking to expand access to other members of the care team or through virtual care delivery.

While large-scale redesigns of attribution models may not be possible immediately, Medicaid and OHIC should encourage insurers to review their attribution methods through the lens of capitation and refine them, as reasonable, to align with current care delivery goals.

The Rhode Island HIT Steering Committee identified patient-provider attribution as an issue needing further discussion as part of its Strategic Roadmap development process. Capturing other types of patient interactions and engagements appears to be an important goal of the Roadmap. When available, Medicaid and OHIC should encourage insurers to utilize this information as a component of defining attribution.

Recommendation #4: Risk adjustment

Risk adjustment is complex, often misunderstood, and may disadvantage providers who lack resources for documentation and coding. Further, risk adjustment methodologies specifically targeted to predict primary care costs are less commonly utilized. Therefore, when risk adjusting primary care payments, insurers often turn to total cost of care methodologies. This can lead providers to question the accuracy of the method, and add to fears regarding whether the capitation payments will be equitable and sufficient.

Others have approached primary care risk adjustment slightly differently. Independent Health Association in Western New York, for example, has developed a layered approach combining elements of traditional risk adjusters and groupers with information they already know about their members including social determinants of health. Their approach utilizes narrow age bands, especially for pediatrics, with information on patients' chronic condition status, expected physician costs, and whether they live in an urban or rural area. Commercially insured patients with high-deductible health plans are another component. Insurers willing to explore risk adjustment methods more attuned to the needs and perspectives of primary care may find these approaches more accurate at predicting the cost of primary care services, and may help strengthen trust with providers.

NEXT STEPS

The Clinical Strategy Committee will continue its focus on improving care delivery design and execution through its integrated learning plan. At the same time, OHIC and Medicaid might consider working with current engaged stakeholders to better align payment methodologies for the broad functions necessary for successful performance in CPCC.