CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Roadmap for Success Under PCP Capitation

Care Transformation Collaborative of R.I.

CLINICAL STRATEGY COMMITTEE MEETING
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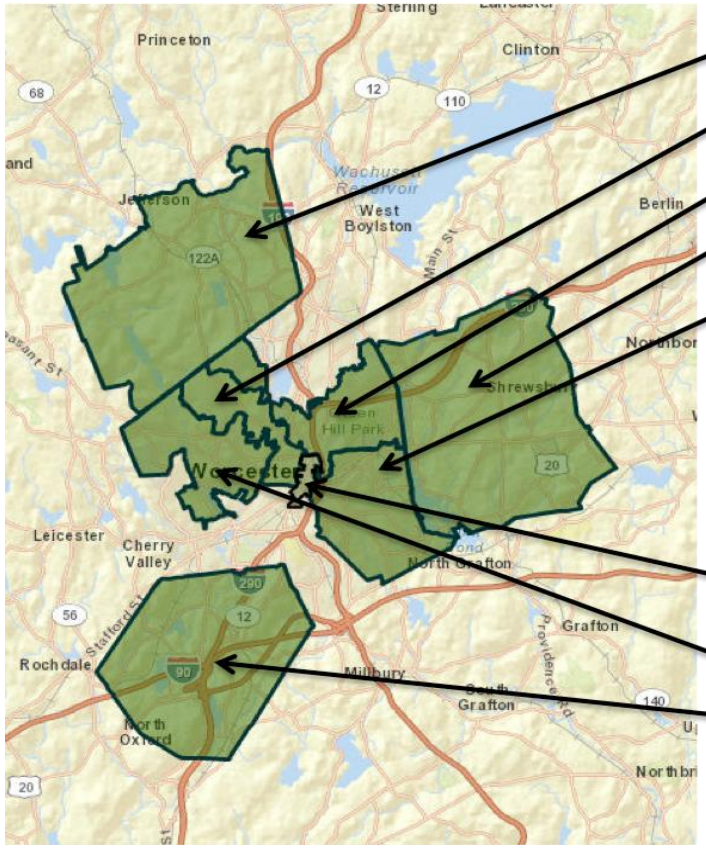
Brief Background

CMIPA was founded as an association located in Worcester, MA, with its primary focus as as contracting entity. Overtime, it was re-engineered into a care delivery system in response to regulatory and payor demands

Patients. Providing care for 50,000 risk sharing adult and pediatric patients primarily in Central Massachusetts

ACO Members 200 + physicians with 100 PCPs and 100 SCPs across 90 clinical sites



PCP Capitation Version 1.0

Why did we embark on PCP Capitation?

What was our state of preparedness for PCP Capitation?

- Experience Under Global Risk Contracts
- Financial Health
- Communication
- Technology
- Alignment with Partners

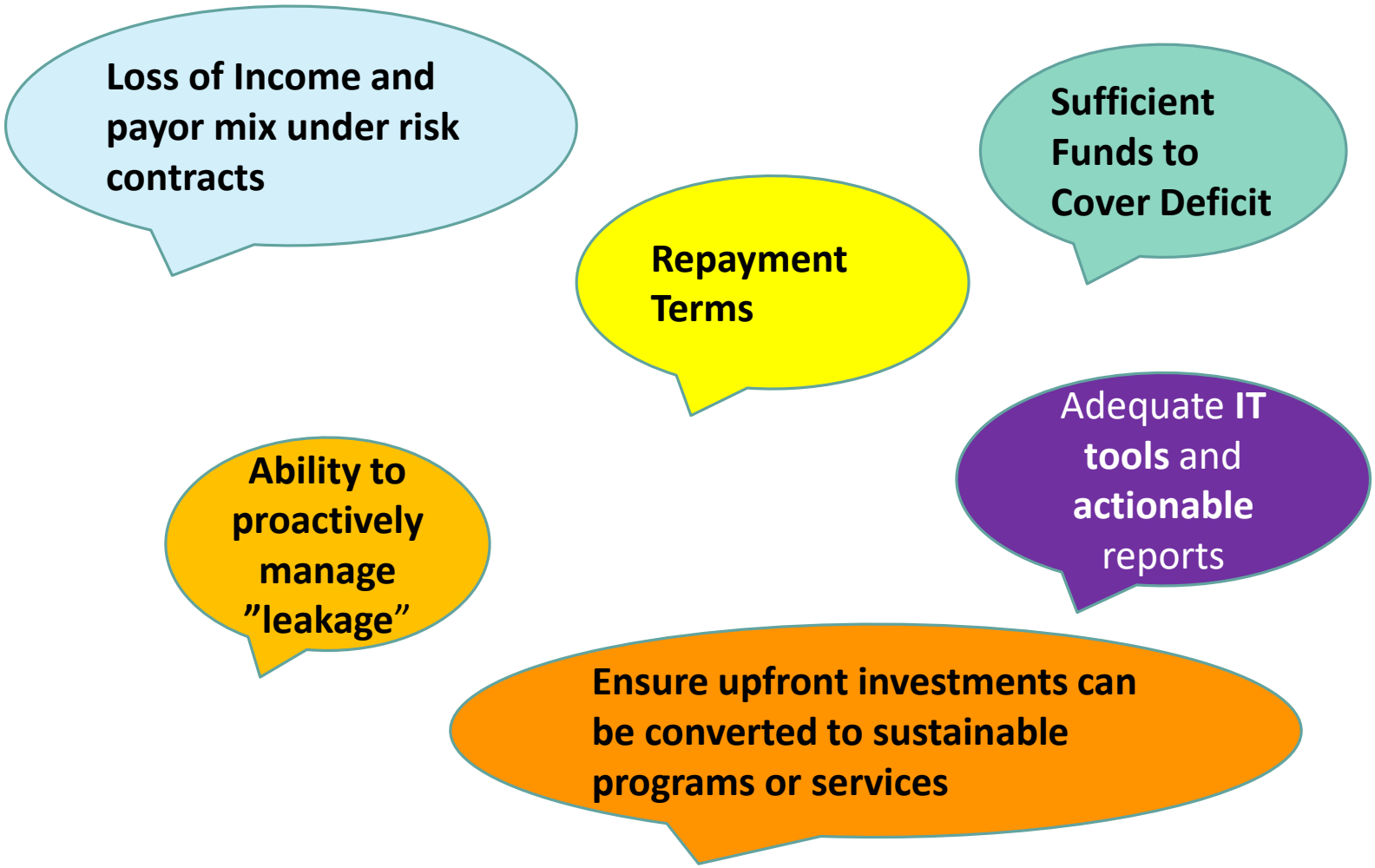
Reasons For Embarking On PCP Capitation

- Existing Partnership with pre-existing capitation contract terms
- Receive payment for services not currently being paid for
- Greater flexibility to collaborate with colleagues
- Greater flexibility to manage team
- Flexibility to determine services most appropriate for patients

Reasons For Embarking On PCP Capitation

- More Predictable cash flow
- Eliminate Documentation Burden
- More time for patient/beneficiary engagement
- More time to develop physician leadership skills
- Desire to be rewarded for reducing total healthcare costs

What Our Doctors Were Concerned About …



How do you manage under both a FFS and Capitation Environment and make your infrastructure investments sustainable?

How would PCP Capitation Payments be Calculated?

Discussion Questions:

Are there some services that should always be FFS in order to support quality or cost management goals?

What guardrails should be considered to ensure that beneficiaries get the care they need?

Code Set: What would be included/excluded in the PCP capitation calculations?

Office Based Visits
Immunizations/Laboratory Tests/injections and medications administered in the office
Preventative Medicine Visits
Annual Wellness Visits
Screening and Non-Office Based Visits
Home Care/SNF Rounding/Preventative Counseling
Care Management Activities (Transitional Care Management)

What was our "State of Preparedness" for PCP Capitation: Experience and Financial

- Experience under global risk sharing contracts
- Respected physician leadership and a medical management team
- A hospital partner with deep pockets to help with downside risk
- Cash reserves and appropriate reinsurance and risk corridors in our contracts
- Sufficient volume of patients to handle risks associated with random variation (i.e., high-cost claimants and population changes)

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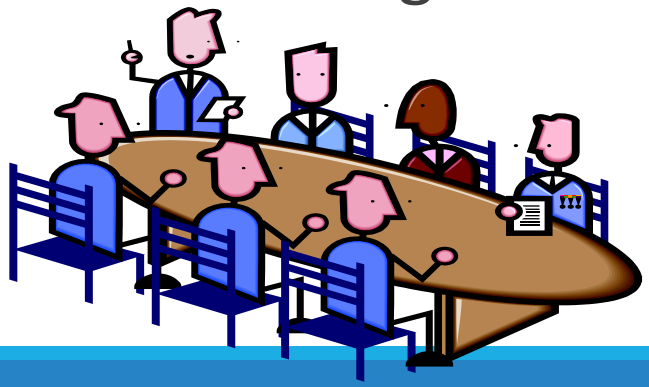
What was our "State of Preparedness" for PCP Capitation: Communication

- Culture of collaboration among PCPs & SCPs
- Board and physician members were very engaged in CMIPA activities and PCPs comprised 50% of the board
- PCPs had a strong voice in the operation of the organization, with alternating leadership of SCPs and PCPs
- PCPs & SCPs split the surplus earned 50%/50%
- PCPs and SCPs attended Regular POD meetings together



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What was our "State of Preparedness" for PCP Capitation: Technology

- Data Warehouse:
  - Integrated data from claims and lab feeds into DW
  - In development: Integrate Patient Generated Data in Physician's EMR that would connect to DW
- Population Health Management Tool
- PatientPing
- Real time Coding and Gaps of Care Platform
- Inpatient Admission Report
- Case Management Software Program

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What was our "State of Preparedness" for PCP Capitation: Miscellaneous

- Identification of Preferred Partners (SNF; Imaging Centers; Urgent Care Centers)
- SNF Rounding Program
  - Nurse Practitioner Employed by CMIPA Foundation
  - Preferred SNFs
- Alternative ER treatment options: Urgent Care Center
- In development: conversations with VNA for home visits and ambulance company to transport sick patients from home to office or urgent care center

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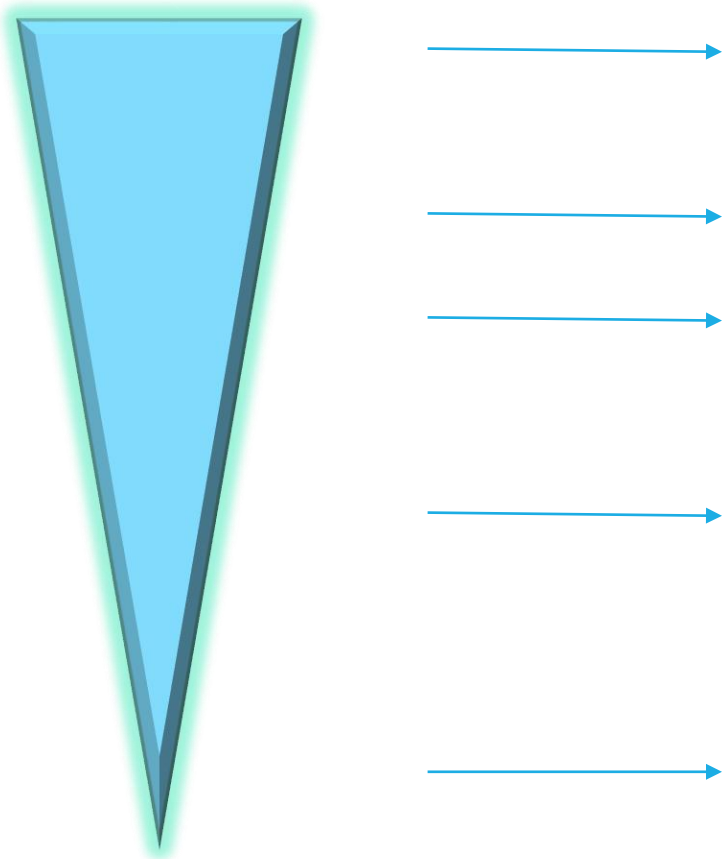
CHALLENGES

Willingness to collaborate with other small practices to deliver services cost effectively (i.e., Diabetic Educator)

Doctors reluctance to attend POD meetings in the evenings and how to make the meetings relevant to all specialties

CHALLENGES

Sophisticated IT platforms and extensive data analytics



- Lacked Single EHR System
- Remote Monitoring
- Robust Clinical Informatics
- Risk Stratification and Predictive Modeling tools
- Sophisticated Population Health Registries

CHALLENGES

- Inadequate Pharmacy Management Program

- Inadequate Patient Engagement strategy: engaging high-cost, high-need patients in care management

- Poaching of our PCPs by competitors and losing risk sharing contracts due to adequate covered lives

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ALIGNMENT CHALLENGES

HOSPITAL	PAYERS	PROVIDERS	PATIENTS
Access by Care Managers to patients in ER and on floors	Real time cost of service price comparison of providers in the community	Expensive Boston world class hospitals	Lack of demographic information
Proper incentives for hospital physician employees to have skin in the game		Lack of Specialty buy-in from outside the system	Coordinated approach to care management

Financial Strategy

STRATEGY	TACTICS
Developed Financial and Quality Dashboard for ongoing monitoring	▪ Review variance from previous years
Negotiate Contracts with adjustments of PCP Capitation Payments and Payment Withholds	▪ **Periodically adjust payments based on Network's overall performance** ▪ **Periodically adjust payments based upon PCP's individual performance**

Control Over Leakage and Referral Management

STRATEGY

Decrease referrals to costly Facilities and Specialists who did not adhere to cost/quality guidelines

Reports

POD Meetings

TACTICS

Specialty Engagement:

Specialty Directories

Specialty Affiliation Agreements

Surplus Share

PCP Report Cards/SCPs Report Cards
Reports on Cost and Quality of Services – show Dollar Value

Specialist Meet and Greet

Post-Acute Care Strategy

STRATEGY	TACTICS
Decrease total cost of care by decreasing inappropriate:	
SNF lengths of stay	**Preferred SNF Network** **SNF Rounders**
Emergency room transfers	**Urgent Care Centers/Web Site Notifications**
Re-hospitalizations	**Care Managers**

Other Strategies

STRATEGY	TACTICS
Patient Outreach programs to minimize patient no-shows and ensure regular PCP visits for chronically ill patients	Gift Cards
Set Expectations in Advance	API Plan
Academic Detailing in the PCP Offices	Meet with individual physicians every 6 weeks
Enroll High-Cost Patients in Case Management Program	Identify Patients from Payor list and at Office Meetings and enroll in Case Management Programs and enter into Database

LESSONS LEARNED

- Single HER among disparate practices
- Need a solid plan, in advance, to cover downside exposure or potential losses
- Reinvest in network – limit how much bonus and surplus money will be redistributed to physicians each year to cover future deficits
- Need good communication between PCPs and SCPs
- Develop directives for SCPs to follow for cost effective care and monitor their performance against such directives and reward them for following these directives
- Ensure new team base services can be converted to ongoing programs

LESSONS LEARNED

- Align incentives in physician contracts for hospital employees
- Separate Medical Management and/or Care Management Fee
- Base PCP Capitation Fee must be sufficient to allow for withhold or adjustment
- Adequate tools to monitor utilization and manage capitation
- Monitor monthly dashboards to review financial health of organization so you can self-correct during the year and not depend upon documentation from payers regarding financial performance