CPR Pilot Report to GMCB

June 30, 2018

Budget Order

No later than the end of the second quarter of 2018, OneCare must submit a payment differential report that describes its Comprehensive Payment Reform Pilot's payment methodology and analyzes how the capitated payments for primary care services under its program compare to the payments hospitals make to primary care providers that are not participating in the pilot. The report must also address how the Comprehensive Payment Reform pilot reduces administrative burden for primary care providers. At the end of the fourth quarter of 2018, OneCare must submit a quality report that includes a description of the measurement process and preliminary quality results comparing the outcomes of the Comprehensive Payment Reform Pilot cohort with the non-pilot cohort. A final report of quality results must be submitted in 2019 at a time to be determined by Board staff in consultation with OneCare.

Program Description

OneCare Vermont designed and developed a program intended to transition independent primary care practices away from fee-for-service (FFS) reimbursement to a payer-blended PMPM payment model for all attributed lives. The purpose of this initiative, known as the Comprehensive Payment Reform (CPR) pilot, is to implement a payment reform that results in a simpler and more predictable revenue stream, more financial resources, and a reimbursement model that allows for clinical flexibility and innovation. Three practices agreed to participate in the pilot year and work collaboratively with OneCare on the initial design and continued enhancement of the program.

Financial Model

To develop the financial model for the program, analysis first focused on the portion of the payment intended to replace the historical FFS, and the approach to allocate financial resources between practices in a way that recognized the individuality of each. Then, the model incorporated the supplemental payments that other attributing practices receive into the model to produce what is intended to be a comprehensive PMPM payment.

Financial Resources Breakdown

To produce a payment that fairly reflects and accounts for the unique characteristics of each practice, financial resources were segmented in two ways: adults vs. kids and "core" services vs. "non-core" services. The segmentation of adults vs. kids is important due to a PMPM gap between the populations. Resulting from a different frequency of visits pattern (as opposed to acuity), revenue earned on a PMPM basis for an attributed child is materially higher. By segmenting the payment model between adults and kids it ensures that payments are reflective of the patient mix of the practice. Next, spending was segmented between "core" primary care services, and other services that often vary by practice (referred to as "non-core" services). For example, non-core services may include performing in-office x-rays, blood lead screening, and other procedures. This segmentation is necessary to recognize that each practice is unique. A practice that has invested in specific technology or developed the capacity to provide additional services in a primary care setting should retain the ability to collect the corresponding reimbursement.

	Adults (>18 YOA)	Kids (<19 YOA)
Core Services	Claims involving specific CPT/HCPCS codes as designated by 2015/2016 GMCB Payment Reform Committee subgroup on primary care	Claims involving specific CPT?HCPCS codes as designated by 2015/2016 GMCB Payment Reform Committee subgroup on primary care
Non-Core Services	All other paid claims not meeting criteria above	All other paid claims not meeting criteria above

On top of the FFS replacement funding, the supplemental population health management (PHM) funding was added to the core services quadrants to create a combined pool of primary care funding. These supplemental PHM sources include the OCV PHM $3.25 PMPM, the Complex Care Coordination Level 2 payment ($15 PMPM for the high and very high risk lives), and a supplemental CPR investment that matched the previous two. Not included in the CPR payment model were the Complex Care Coordination Level 3 payments and the Value Based Incentive Fund estimated distribution. These were kept separate to maintain the financial incentives linked to active engagement in care coordination and quality. Any payments related to the UVMMC Self-Funded program were also excluded due in part to the timing of the program start date.

Risk Adjustment

The CPR model incorporates risk adjustment to the core service buckets to account for variation in the patient panel seen by each practice. For the adult core services quadrant, PMPMs were adjusted using relative risk score for the attributed lives. As a result, a practice with a comparatively higher average risk score would receive a higher PMPM rate for their adult population. The kids core services quadrant was risk adjusted using an age/gender approach. Because standard risk scores tend to place more weight on chronic disease, the risk scores for kids can be misleading. Using the age/gender mix results in an adjustment factor that relies more heavily on the frequency of visits, which evolves as a child ages.

There was no risk or age/gender adjustment applied to the non-core services. Rather, the historical PMPM experience in a FFS environment was carried forward (with the applicable trend rate) and left unaffected for each practice. This approach was utilized to maintain the historical non-core revenue discretely for each practice and ensure that revenue earned for practice-specific capabilities isn't altered by the CPR model.

Resulting PMPMs

To determine the final PMPMs for each practice, the risk-adjusted adult core code PMPM was combined with the practice-specific non-core code PMPM to yield the adult PMPM, and the age/gender adjusted core code PMPM was combined with the practice-specific non-core code PMPM to yield the kids PMPM. Each month, the attribution for each practice is multiplied by their specific PMPMs accordingly to determine their payment amount.

Modifications

The BCBS QHP program is paying providers on a FFS basis in 2018. This means that a FFS replacement amount could not be incorporated into the model and the practices will still receive payment from BCBS on a FFS basis. To accommodate this in the modeling, the expected BCBS QHP FFS the practices will receive was subtracted before calculating the final PMPMs. The BCBS QHP lives that each practice attributes are still in the model and the corresponding supplemental payment for these lives are in the PMPM, but the model does account for the fact that payment will continue to come in the form of FFS reimbursement directly from the payer.

Upon receipt of early Medicare attribution rosters, it was discovered that an error was made and one of the three participating practices was mistakenly excluded from the Medicare program due to a technicality. OneCare worked with Medicare to remedy the mistake and was able to restore the practice's participation in the program. However, due to the timing, the

practice technically does not attribute any lives and therefore cannot receive a fixed payment for the Medicare component. In this case the same methodology used with the BCBS QHP program was employed to subtract the expected FFS before calculating the PMPM.

Payment Differential Report

The following table displays the early financial results of the program and provides a comparison of the CPR program results to the hospital primary care revenue earned on a FFS equivalent basis. Attempts were made to provide a fair baseline and minimize variables that are outside of the scope of the CPR program. No patient share expectation or other OneCare revenue streams not included in the CPR mode are incorporated.

To provide a level comparison, only the two CPR practices able to attribute to all three programs were included in the analysis. The hospitals included in the analysis were those in all three payer-programs that also have hospital-owned primary care (five hospitals in total).

So that the data are reasonably complete, the results incorporate services delivered to patients in January and February and consists of the following paid-through periods:

- Medicare: 4/27/18
- Medicaid: 5/25/18
- BCBS QHP: 5/31/18

Perspective	PMPM
(1) CPR Practices - Non-OCV Model	$22.39
(2) CPR Practices - Std. OCV Model	$27.64
(3) CPR Practices - CPR Model	$37.48
(4) Hospital Primary Care Practices	$23.08

(1) The PMPM the CPR sites would have earned for the attributed lives if they didn't participate in OneCare programs.
(2) The PMPM the CPR sites would have earned for the attributed lives if they participated in OneCare programs but outside of the CPR model (i.e. they received FFS claims payments, the $3.25 PMPM and the CCC Level 2 payments).
(3) The PMPM the CPR sites experienced as part of the CPR model.
(4) The PMPM that hospital primary care would have earned for the attributed lives if they participated in OneCare programs but outside of a fixed payment model (i.e. they received FFS claims payments, the $3.25 PMPM and the CCC Level 2 payments).

The early results are encouraging, but there are a number of nuances to consider before drawing conclusions. One such nuance is the effect of seasonality on the payer-paid components. Due to dynamics related to patient-share obligations, the payer-paid portion tends to be lower early in the year for both BCBS and Medicare. The CPR model, however, blends this throughout the course of the program year, which contributes to the early CPR PMPM being substantially higher than the FFS equivalent. Also, ratio of adults to kids is different for the CPR sites than for the hospital primary care included in this analysis. 33% of the attributed lives to the CPR sites are kids while kids comprise 19% of the lives attributed to hospital primary care. This dynamic would be expected to result in a higher PMPM for the CPR sites with all else equal.

Combined Financial Performance Report

The CPR model incorporates the bulk of the reimbursement that the practices receive from OneCare, but there are others kept outside that should be considered when compiling the full financial perspective. The following builds upon the base CPR revenue and adds elements that are outside of the model but flow to the practices for their OneCare attributed lives:

Component	CPR Practices - CPR Model *
(1) Member Months of Attribution	22,298
(2) CPR Pilot Payments	$757,072
(3) FFS Paid	$78,748
(4) Supplemental OCV PHM Investments	$ -
Total CPR Revenue	**$835,820**
Total CPR Revenue PMPM	**$37.48**
Patient Share Revenue	$163,485
CCC Program Level 3 Estimate	$1,338
Medicaid PCCM	$25,510
VBIF Estimate	$51,676
Medicare Blueprint	$13,192
Combined Revenue	**$1,091,020**
Combined Revenue PMPM	**$48.93**

** All of the figures represent a two-month equivalent experience*

Administrative Burden on Providers

Early focus for all the CPR pilot sites has been heavily drawn to the financial performance and developing comfort with the fixed-payment model. However, now that there is enough claims and runout time to produce reports that provide confidence in the initial financial results, the focus is beginning to shift to clinical innovations. With a payment model that is unchained from a volume-based mechanism, practices are able to modify workflows and protocols to develop new and innovative care models. In the CPR pilot steering committee meetings, there is a strong focus on using the flexibility and resources afforded by the program incorporate behavioral health, psychiatric care, and a team-based care approach into the practices. While the primary motive for these changes is expressed as a way to provide better care for patients, hope remains that alleviating the pressure of FFS volume targets will results in a dynamic that is more satisfying for providers and results in better care for patients.

Also, there are no additional reporting requirements related to participation in the CPR pilot. There may be future opportunities to work with payers to allow for modifications that alleviate some existing burdens (such as prior authorization) since these practices are moving forward under a PMPM reimbursement model.

One additional step that OneCare is taking to address administrative burden is facilitating a practice-workflow engagement called Infinitum™ with Vermont Program for Quality in Health Care (VPQHC). This program aims to evaluate and measure workflow in healthcare in hope of finding efficiencies that can both enhance access and eliminate “waste” in processes. The intention is to begin the consultations in the second half of the year and help each practice maximize the benefits of the CPR payment model and minimize administrative burden through improved process efficiency.