

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Equity and Access Council

Design Group 1: Patient
Attribution (1A) and Cost
Calculation (1B)

Workshop 2

February 13th, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comment	5 min
3. Overview of Design Group Process	5 min
4. Synthesis of Attribution Recommendations	15 min
5. Cost Benchmark: Council Questions & Discussion	15 min
6. Synthesis of Cost Benchmark Initial Hypotheses	15 min

3. Two Categories of Safeguards

CT's Process

1. **Evaluate evidence** for the hypothesized risks and options for preventive safeguards
2. **Establish safeguards** (incentives, policies, and processes) that prevent under-service and patient selection
3. **Implement** safeguards
4. **Monitor** and analyze results
5. **Adjust** safeguards based on lessons learned

What types of safeguards can be built into the proposed payment reforms?

We propose two categories of safeguards:



1. Payment design features

Concept:

Design new payment methods in a way that, taken together, do not create incentives for under-service and patient selection



2. Supplemental safeguards

Concept:

Establish additional rules and processes to deter and detect under-service and patient selection

3. Design Elements of Safeguards



1. Payment Design Features

Safeguard Type		Description	Hypothesis
A	<i>Attribution of patients</i>	The method by which patients are assigned to a provider	How patients are assigned to an ACO will impact the ability to conduct improper patient selection
B	<i>Cost target calculation (cost benchmarks & risk adjustments)</i>	The method by which a patient's benchmark (expected) cost of care is determined and adjusted for clinical and other risk factors	Creating benchmarks that accurately reflect patients' expected cost of care – or that exceed expected cost of care for patients at greatest risk of being selected against – will minimize improper patient selection
C	<i>Provider payment calculation</i>	Other elements of the formula that defines the amount of incentive payments generated for a given patient population	Balanced financial incentives that make providers financially indifferent to providing more care vs less care will lead providers to provide the right care, minimizing the risk that medically appropriate services will be withheld
D	<i>Payment Distribution</i>	The method by which individual providers share in savings achieved	Rewarding providers based on ACO performance, rather than individual performance, will minimize any incentive for a provider to withhold appropriate services, while facilitating monitoring for improper behavior

3. Design Group Milestones and Proposed Timing

We propose to organize the agenda of upcoming EAC meetings around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January				February				March					April						
		Week of:				Week of:				Week of:					Week of:						
		5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27			
3. Equity and Access Council (EAC)																					
1	Healthcare Innovation Steering Committee (HISC)	8				5								12				9			
2	Equity and Access Council Meetings			22		5			26					12		26		9		23	
3	Equity and Access Council Exec Team Meetings		15					19						19					16		
4	1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2												
5	1C-D: Performance-based payment calculation & distribution							M1						R1	M2	R2					
6	2A-B-C: Rules, communication, enforcement							M1						R1	M2	R2					
7	2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2										

Today

Report containing Phase I recommendations

- M1 Design milestone/workshop 1 R1 EAC initial review/input
- M2 Design milestone/workshop 2 R2 EAC final review/input

3. Design Group Process

Design Phase	All Design Groups	Progress
Workshop 1	<p><u>Goal:</u> Evaluate existing research and evidence and establish initial hypotheses</p> <p><u>Content:</u> Synthesis of research on topic and input from experts for group to discuss, provide input, and establish a point of view</p>	X
Review 1	<p><u>Goal:</u> Feedback and reactions from EAC on initial hypotheses and suggestions on areas of further exploration and/or revision</p> <p><u>Content:</u> Present initial hypotheses from design group, review relevant materials, and pose any questions/concerns from the design group where EAC input was desired</p>	X
Workshop 2	<p><u>Goal:</u> Develop draft recommendations based on additional research and EAC feedback</p> <p><u>Content:</u> Synthesis of feedback from EAC and additional research required for group to provide input and establish a final recommendation</p>	
Review 2	<p><u>Goal:</u> EAC to adopt recommendations</p> <p><u>Content:</u> Present revised recommendations from design group and pose any final questions for EAC input</p>	



4. Patient Attribution: Summary of Recommendations

EAC Council Patient Attribution Recommendation

Prospective attribution will provide the necessary level of provider and patient awareness, will allow for the most effective care management and coordination, will protect against patient discontinuation, and will outweigh any potential risk of under-service that might accompany prospective assignment.

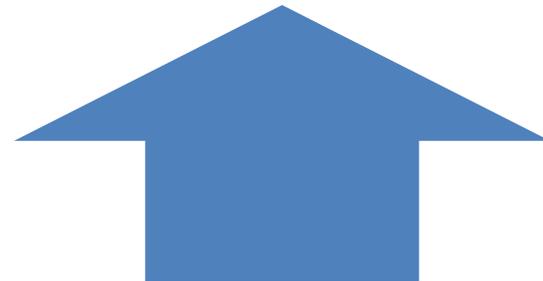
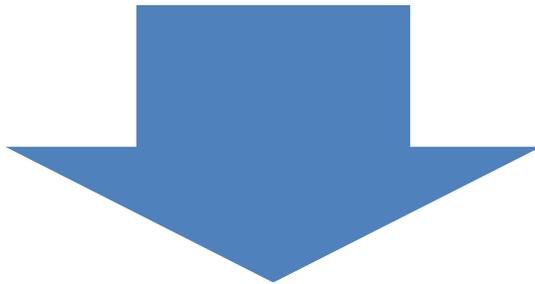
Additional Attribution Safeguards to Consider

1 Perform Reconciliation at End of Performance Year

*Mechanism to remove prospectively attributed patients who switched providers throughout the course of the year due to personal circumstance
(e.g.; moved away)*

2 Protect Against Inappropriate Patient Discontinuation

Balance patient reconciliation post performance year with method to protect against providers discontinuing difficult patients



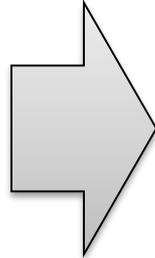


4. Patient Attribution: Summary of Recommendations

Additional Attribution Safeguards

1

Perform Reconciliation at End of Year

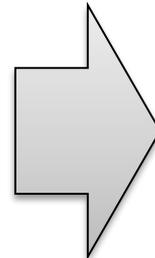


Potential Solutions

- Attribute patients to a provider at the outset of the performance year
- Reassess attribution at end of performance year and exclude patients who, based on the past year, would no longer be attributed to that provider
- This is method used in CMS MSSP Track 3

2

Protect Against Inappropriate Patient Discontinuation



- Address as a Supplemental Safeguard
- Rules around documentation required for discontinuing a patient
- Monitoring/detection of practice circumstances that might lead to supposed non-compliance (e.g.; excessive appointment wait times, patient complaints about access, etc.)



4. Patient Attribution: Additional Recommendations

1. When Are Patients Attributed?

Prospective Assignment

Patients assigned to providers at outset of performance year



2. How Are Patients Attributed?



- Where the patient received care in prior year(s) (plurality of visits)
- Patient designates provider
- Insurer designates provider
- Geographic area dictates provider

(See pgs 7-8 for discussion of prospective attribution)

Proposed Recommendation: *in order to preserve patient choice, attribution should utilize patient history and/or patient designation to assign patients to providers*

3. To Whom Can Patients Be Attributed?



PCPs

Do we believe that this design decision is likely to affect under-service or patient selection, or otherwise have access implications?



Specialists

The choice to use EDs for secondary attribution (i.e. for a patient who does not visit a PCP) may have the greatest relevance to the EAC's present inquiry. Potential hypotheses include:



UCC & Retail

- +** Use of EDs for secondary attribution would **render futile any attempt by an integrated ACO to cherry-pick patients**, since patients will end up attributed via the ED even if excluded from physician panels
- +** Use of EDs for secondary attribution would provide a **means for patients who don't see a PCP to get into an ACO model**, where they will receive more coordinated care, rather than "falling through the cracks"



EDs

- Use of EDs for attribution could provide an **unwanted incentive for an ACO to unnecessarily serve patients in the ED** in order to "capture" the patient lives for the ACO



5. Cost Benchmark: Overview

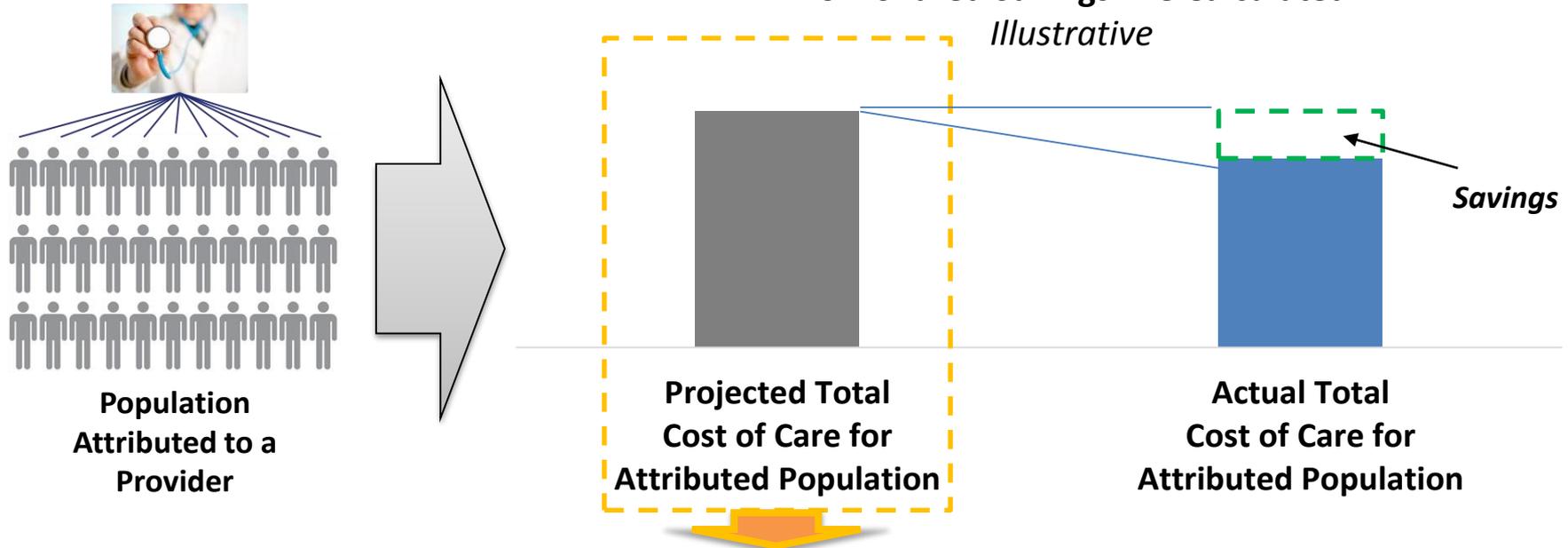
1B. Cost Calculation (cost benchmark & risk adjustment)



Future cost estimation for population of patients attributed to a provider, from which shared savings calculations are determined

How Shared Savings Are Calculated

Illustrative



How is the projected cost for the attributed population determined?

Step 1: Define population used to determine cost benchmark

Step 2: Risk adjust cost benchmark



5. Cost Benchmark: Overview

1B. Cost Calculation (cost benchmark)



Population of patients used to determine cost benchmark for shared savings program

Step 1: Define population used to determine cost benchmark

1 Historical Costs:

Uses past patient experiences of population attributed a provider to project future expenses for that population.

2 Control Group Costs:

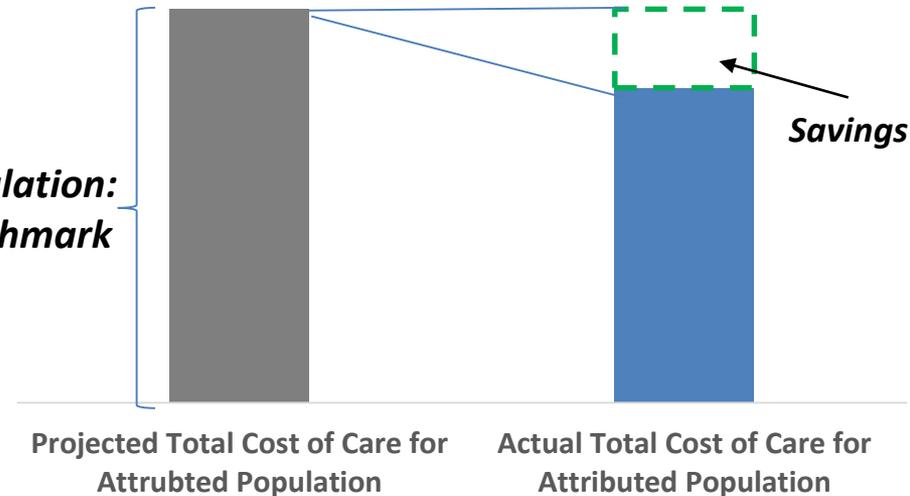
A comparator group that *is not* based on the past experiences of the patients in the shared savings program. Control groups can be based on:

- What is considered to be best practice in the region
- The broader regional provider network, or
- A comparator group that is deemed to be similar

How Shared Savings Are Calculated

Illustrative

**Cost Calculation:
Cost Benchmark**





5. Risk Adjustment: Overview



1B. Cost Calculation (risk adjustment)

Additional method used to adjust future shared savings cost projections that accounts for the overall risk of the population as part of the cost projection. Risk adjustment takes into consideration demographics and the diagnoses of the population.

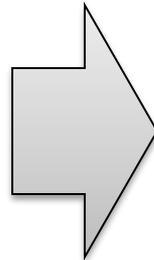
Step 2: Risk adjust the cost benchmark

Will the need for risk adjustment vary depending on the cost benchmark method?

Cost Benchmark Method

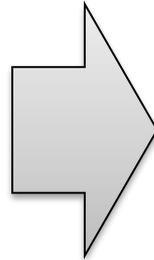
Role of Risk Adjustment

Historical Costs



- A historical cost benchmark will **inherently account for risk** as it is based on the actual prior care experiences of the attributed population.
- However, adjustment can be valuable as a way to more accurately predict how future costs are likely to vary from the historical snapshot.

Control Group Costs



- Unlike the historical cost benchmark, the control benchmark is based off of a population that is **not part** of the shared savings program and will **not inherently account** for the attributed population's level of risk.
- **Risk adjustment provides an essential method** to reflect the impact of risk on the cost benchmark, providing for an "apples to apples" comparison.

Beyond the risk adjustment method used, the timing of the adjustment (i.e.; concurrent vs prospective) and supplemental methods (e.g.; cost outlier adjustments, enhanced payments and service exclusions) should be considered



5. Cost Calculation: Additional Topics

At the 2/5 EAC meeting, several additional topics were suggested for further exploration by Design Group 1 or by the full Council.

#	Topic Suggested for Design Group Exploration	Disposition
1	Explore methods for focusing value-based payment methodologies on care management for the highest-users (e.g. enhanced PMPM) and on reducing use of the highest-cost settings (e.g. ED)	For discussion today
2	Explore level of specificity of risk stratification for purposes of providing enhanced payments for high risk patients – are two tiers sufficient or should there be multiple risk tiers?	For discussion today
3	Review how CMS is doing risk adjustment for the MSSP	See p14 and supplemental material on CMS-1461-P (Dec 2014 Proposed New ACO Rules) and NAACOS comments
4	Evaluate the use of “quality gates” that require providers to meet clinical quality thresholds in order to qualify for shared savings payments	Referred to Design Group 2 – Payment Calculation & Distribution
5	Evaluate the use of minimum savings rates (MSRs) for defining shared savings distributions to providers	Referred to Design Group 2 – Payment Calculation & Distribution
6	Review what other SIM states are doing to address issues concerning cost benchmarking and risk adjustment	To be included in broader discussion at an EAC meeting

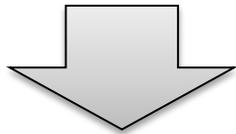


5. Cost Calculation: CMS Methods

CMS risk adjustment methodologies are likely to continue to evolve as the MSSP matures.

Dec 2014

CMS issues new proposed rules for the Medicare Shared Savings Program (MSSP)



Feb 2015

National Association of ACOs (NAACOS) submits comments to CMS

“... we urge CMS to consider **additional changes to increase the accuracy of the risk adjustment methodology**. For the continuously enrolled population, the CMS **Hierarchical Condition Categories (HCC)** scores are capped at the ACO’s baseline risk. CMS only allows an increase in the risk adjustment based on **demographic changes** (e.g., the aging of the population), not on changes in the acuity of the population. On the other hand, CMS allows reductions in the risk adjustment based on demographic factors or HCC scores for the continuously enrolled. **We are concerned that by only counting HCC scores that work against the ACO for the continuously enrolled population, the current policy actually disadvantages ACOs that take on the management of the sickest populations with greater medical need.**

... this artificial cap applies a perverse incentive in which those ACOs that meet the goal of improved patient health, reduced costs through coordinated care management, and other long-term strategies will be penalized. These organizations will see a decrease in acuity for well-managed patients that will count against them, while they will not receive credit for caring for patients whose acuity intensifies. *...In addition, CMS should continue researching alternative risk adjustment models.”*

5. Cost Calculation: Discussion Questions



Discussion Questions

1. **How important** is the cost benchmark methodology on influencing the opportunity or incentive for patient selection and under-service? The risk adjustment methods?
2. Would the cost benchmark alone ever be enough to protect against under-service and patient selection or **is risk adjustment always necessary**?
3. **What impact will the different methodologies** for cost benchmark definition have on patient selection and under-service? The impact of the risk adjustment methodologies?
4. Which methods (cost benchmark and risk adjustment) will create the **highest level of provider confidence** that the projected costs reflect the actual costs? How much confidence do providers and payers have in the methods in use today?
5. **Which additional methods** (i.e.; cost outliers, enhanced payments and service exclusions) should be considered? How will they impact under-service and patient selection?
6. Will the same cost benchmarking and risk adjustment methodologies be **applicable across all payers**?

6. Synthesis of Initial Cost Calculation Hypotheses

Objectives:

1. *Summarize initial hypotheses to share with the EAC on what its recommendations should say about design of patient attribution methods and cost calculation benchmarks to safeguard against patient selection and under-service.*
2. *Recommend discussion topics and material to support the EAC's discussion on these topics at its 2/5 meeting*

Applies to.....

1B. Cost Calculation (Cost Benchmark & Risk Adjustment)	Patient Selection	Under-Service
	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX



Design Group 1: Patient Attribution Overview

1A. Patient Attribution



Method used to assign a patient to a provider in a shared savings model

Is the timing of patient attribution likely to have an impact on patient selection and under-service? If so, how?

Shared Savings
Program Contract Start
Jan 1

End of First
Performance Year
Dec 31

Performance Year 1

When Are Patients Assigned?

Prospective Assignment

Patients assigned to providers at outset of performance year

Methods Include:

- Where the patient received care in prior year(s) (plurality of visits)
- Patient designates provider
- Insurer designates provider
- Geographic area dictates provider

How does it work?

Retrospective Assignment

Patients assigned to providers at end of performance year

Methods Include:

- Where the patient actually received care during the performance year (plurality of visits)



Design Group 1: Patient Attribution Overview

1A. Patient Attribution



Method used to assign a patient to a provider in a shared savings model

Will the provider type a patient can be assigned to in a shared savings program impact under-service or patient selection?



For a **physician group ACO**, the use of access points other than physician practices for attribution may not have a material impact on patient selection



Primary Care Providers



Specialists



Urgent Care / Retail Providers



Emergency Departments



For a **vertically integrated network ACO**, including “mandatory” access points like the ED in an attribution methodology may obviate any hypothesized incentive to select against patients perceived to be high utilizers – since these patients can end up attributed in any event through their use of the ED



Design Group 1: Cost Projection Impact

1B. Cost Calculation (cost benchmark) 	Potential Hypothesis About Impact on Equity and Access		
	Under-Service		A cost benchmark that is perceived to be appropriately adjusted for the complexity of the patients will help prevent under-service
	Patient Selection		Does not address directly

	Potential Equity & Access Risks/Benefits	All-Payer Applicability
1 Historical Costs	<ul style="list-style-type: none">  Does not predict for uncontrollable/unexpected factors (e.g.; bad flu season or poor economy); does not adjust for practices that had higher than average costs at outset  Less sensitivity around risk assessment 	<p>More applicable to population likely to have few variations in cost/care patterns (e.g.; SCHIP)</p>
2 Control Group	<ul style="list-style-type: none">  Difficult to accurately account for the risk of the population, which may lead to unintended under-service  Adjusts for providers who are starting with higher than average costs 	<p>Applicable to any plan that wants to control for over-service or large variations in care</p>



Design Group 1: Risk Adjustment Impact

1B. Cost Calculation (risk adjustment) 	Potential Hypotheses About Impact on Equity and Access	
	Under-Service	 A cost benchmark that is perceived to be appropriately adjusted for risk will minimize incentives for under-service
	Patient Selection	 Higher-risk patients will provide greater opportunity for savings if risk adjustment is done appropriately

Potential Equity & Access Risks/Benefits		All-Payer Applicability
1 Risk-Assessment Methodology	<ul style="list-style-type: none"> If the risk assessment methodology is not perceived to reflect the risk of a clinically and/or socially complex patient population, providers may be prone to underservice An appropriate risk assessment methodology should account for social factors and other demographics that are not directly related to, but impact, an individual's health and health behavior 	Will be of particular importance for patients who are relatively difficult to manage (e.g. low-income with chronic conditions)
2 Cost Outlier Threshold	<ul style="list-style-type: none"> The size of the shared savings program (# of beneficiaries) and the threshold for excluding high cost claimants will impact a provider's willingness to take on high-risk patients. Cost outlier adjustment should strike a balance between encouraging providers to take on high-risk/high-cost patients and the concern that the savings pool will be skewed. 	Applicable for all payers, but threshold level-setting will be more sensitive for higher-risk patient populations
3 Additional Payment for High Risk Patients	<ul style="list-style-type: none"> An additional payment for high-risk groups beyond what can be earned through shared savings will encourage providers to accept complex patients There is an added expense to coordinating complex patients; an enhanced FFS payment or a separate PMPM will lower the cost barrier for providers 	Applicable for all payers, but would be most impactful for complex patients