

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Equity and Access Council

Design Group 1:
Payment Calculation (1C)
and Distribution (1D)

Workshop 1

February 17th, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comment	5 min
3. Overview of Design Group Process	5 min
4. Overview of Shared Savings	5 min
5. Payment Calculation	15 min
6. Payment Distribution	15 min
7. Synthesis of Payment Calculation & Distribution Initial Hypotheses	10 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
Group 1 - 1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2									
Group 2 - 1C-D: Performance-based payment calculation & distribution							M1			R1	M2	R2					
Group 3 - 2A-B-C: Rules, communication, enforcement							M1			R1	M2	R2					
Group 4 - 2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2							

Today



Report containing Phase I recommendations

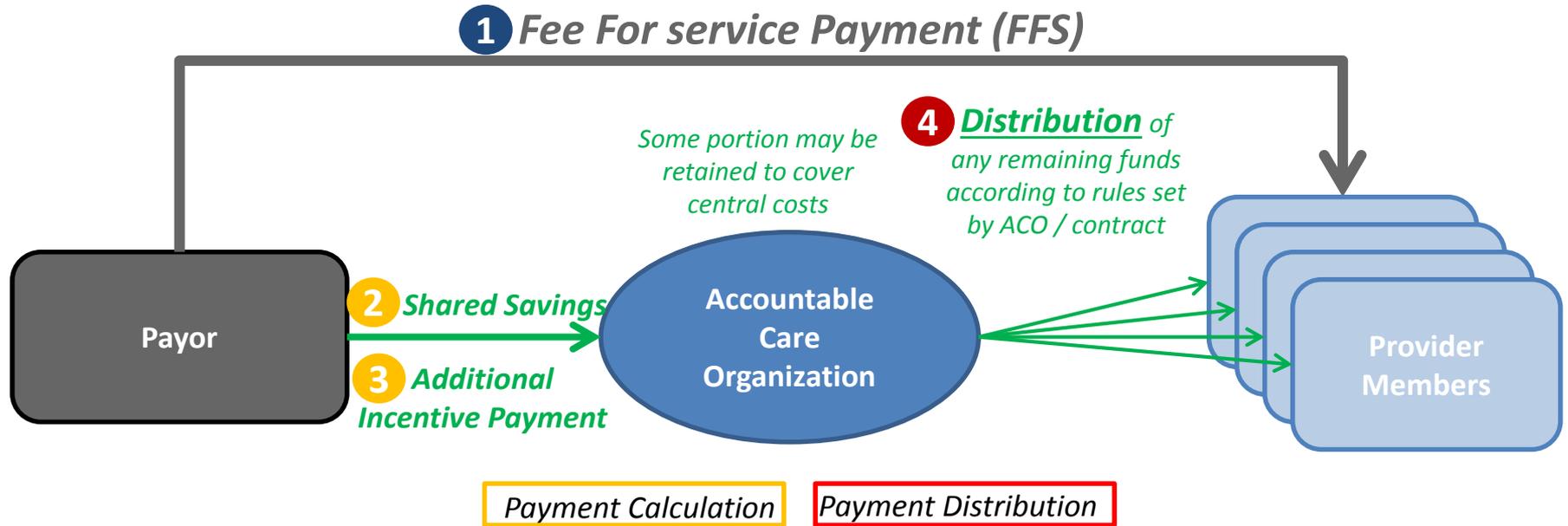
- M1 Design milestone/workshop 1 R1 EAC initial review/input
- M2 Design milestone/workshop 2 R2 EAC final review/input

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>	
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>	
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. Overview of a Shared Savings Program



#	Description
1	Providers will continue to receive FFS payments for the services provided within an ACO contract.
2	Incremental to the FFS payments, providers will receive a portion of shared savings assuming certain parameters have been met established by the contract (i.e.; minimum savings rate (MSR), performance reporting and targets). In some contracts there is downside risk, in which case an ACO that experiences higher than expected costs would be expected to pay back a portion of those costs to the payer.
3	In some contracts there also may be incremental payments that are paid if pre-determined targets are met (e.g.; quality targets) regardless of whether or not savings were achieved.
4	Once savings are paid to the ACO they need to be distributed amongst the provider members and in some cases are re-invested in the ACO itself to support central costs.



5. Shared Savings Program Payment Calculation



1C. Payment Calculation

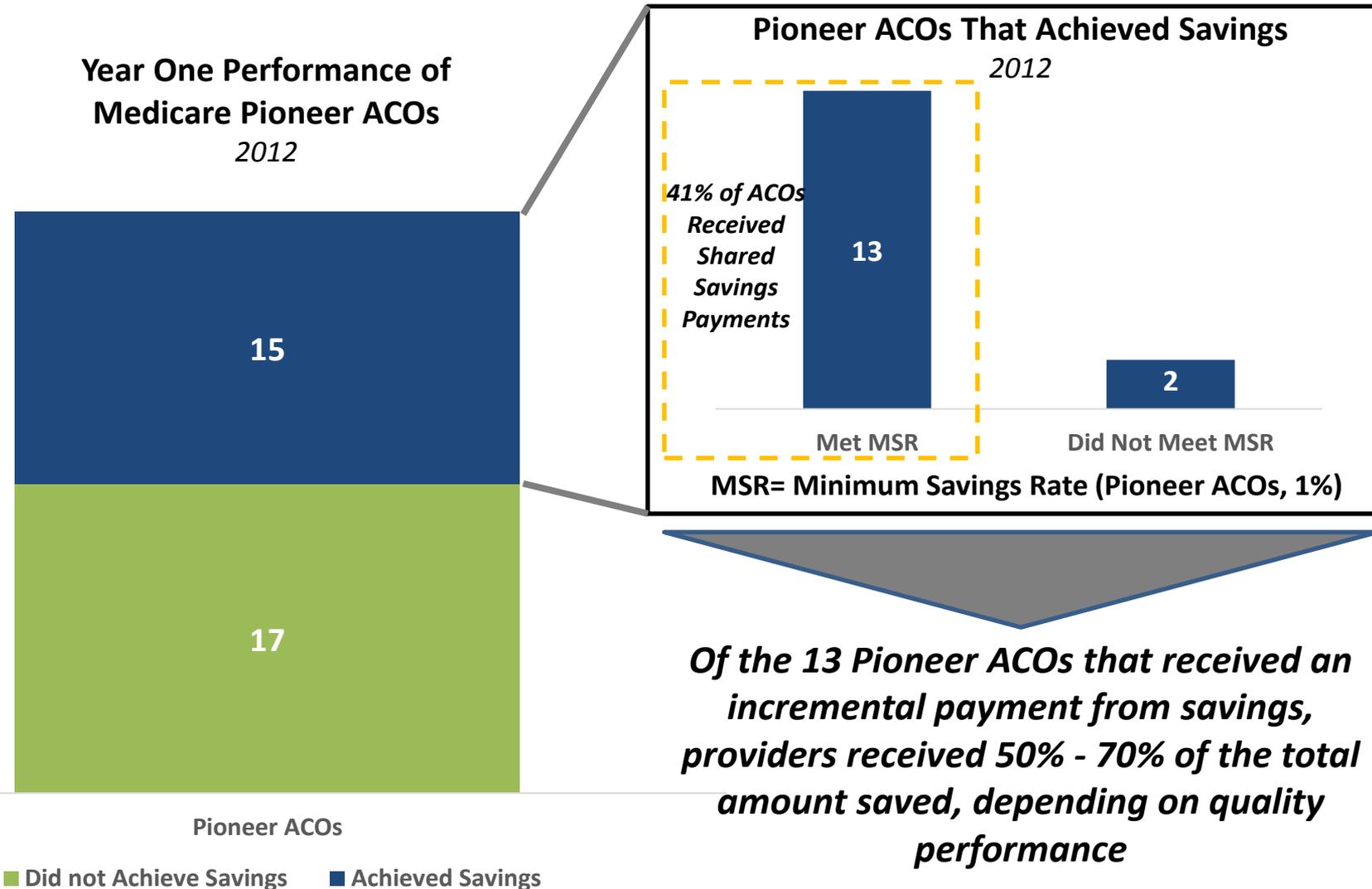
Elements of the incentive design that determine the amount of savings achieved for a given patient population for which a provider is eligible

Design Feature	Definition
Minimum Savings Rate (MSR)	The % of savings that must be achieved to receive a portion of the savings. The MSR is meant to account for random variation and will vary based on size of the ACO. For example, in CMS MSSP programs ACOs with 5,000 beneficiaries would have to reach 3.9% savings and a 60,000 beneficiary ACO would have to reach 2%
Percentage of Total Savings Shared with ACO	If an ACO achieves savings, it splits those savings with the payer. The percentage of savings the ACO receives can depend on a couple items: <ul style="list-style-type: none"> • Meeting performance measures (often 1st year requires reporting and 2nd year requires meeting targets) • If the ACO is partaking in downside risk (i.e.; if the ACO exceeds the cost benchmark, they are responsible for paying the payer for a portion of those costs)
Performance Incentive Unrelated to Savings	All shared savings programs are required to meet quality targets. Some programs will pay providers an additional payment for hitting their quality targets regardless of whether or not savings are achieved.



5. Shared Savings Program: Financial Impact

How might the feasibility of achieving savings and the relative financial benefit of the savings impact a providers interest in participation and prevent under-service and/or patient selection?





6. Payment Distribution

1D. Payment Distribution



The method by which providers share in the savings received

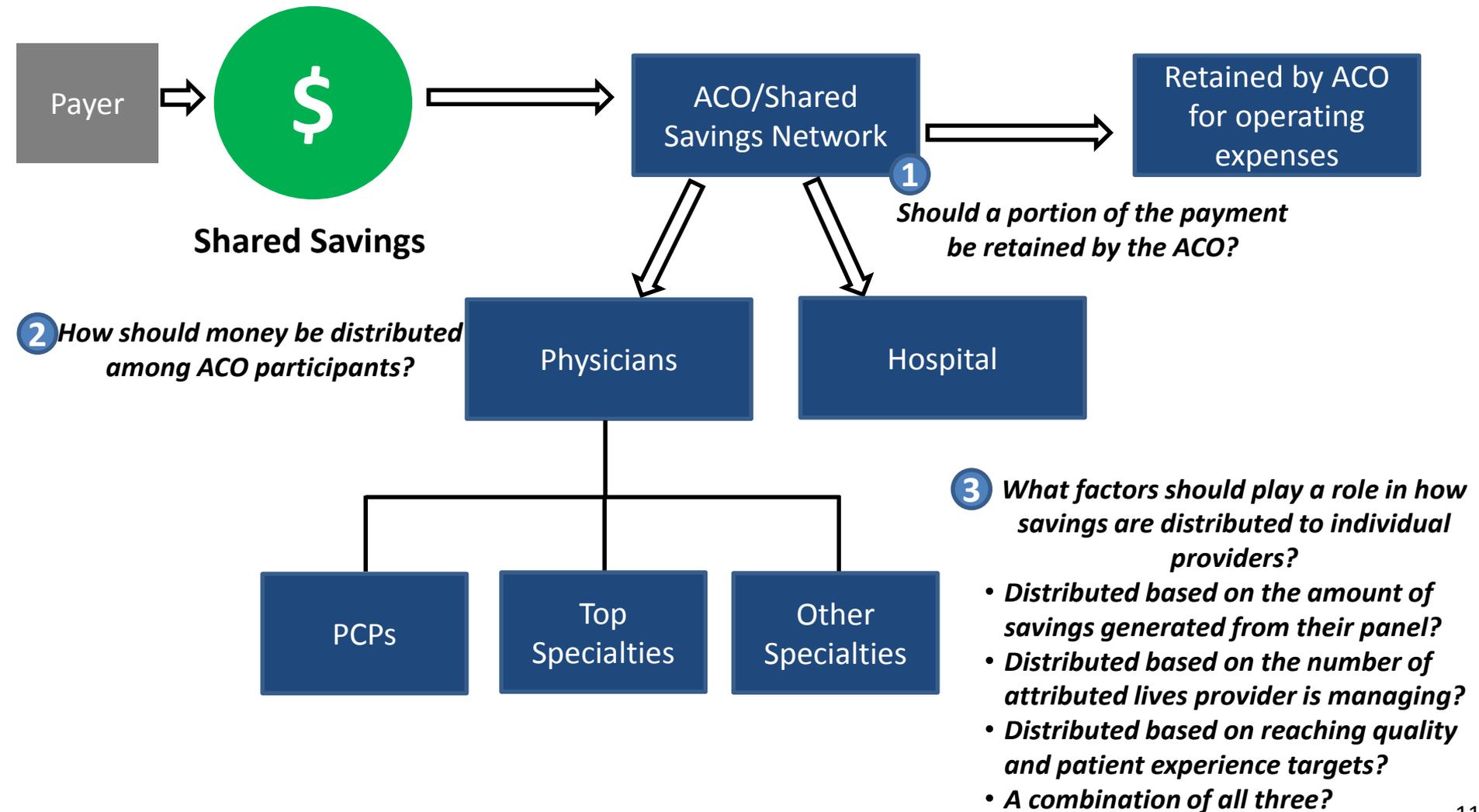
Design Options/Considerations

- 1 Are any savings retained** by the network, rather than distributed to providers? Can help to cover operating expenses or build reserves if program takes on risk in future
- 2 What are the distribution pools with in the shared savings program? And how do you distribute among these pools?** Hospitals vs physicians; PCPs vs specialists; practice level or individual level?
- 3 What role do performance metrics play?** Relative quality/cost of individuals or practices taken into account? Number of lives managed? Relative risk of patients seen by one practice or provider vs. others taken into consideration?



6. Payment Distribution

Will decisions made at each decision point impact the likelihood of patient selection or under-service? How will different decisions help safeguard against unwanted adverse outcomes?



7. Synthesis of Initial 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.....

1C. Payment Calculation	Patient Selection	Under-Service
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

1D. Payment Distribution	Patient Selection	Under-Service
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>