

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Equity and Access Council

Design Group 2: Payment
Calculation (1C) and
Distribution (1D)

Workshop 2

March 19th, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comment	5 min
3. Overview of Design Group Process	5 min
4. Discussion of Payment Calculation and Distribution	35 min
5. Synthesis of Initial Hypotheses	10 min
Appendix	

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 Timing

The agenda of upcoming EAC meetings will be organized around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January				February				March					April				May			
		Week of:		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	4	11	18	25
1	Healthcare Innovation Steering Committee (HISC)	8				5						12			9						14	
2	Equity and Access Council Meetings			22		5			26	12			26	9		23					28	
4	Group 1 - 1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2			R2	M3	R3										
5	Group 2 - 1C-D: Performance-based payment calculation & distribution							M1					M2	R1	R2							
6	Group 3 - 2A-B-C: Rules, communication, enforcement							M1						R1	M2	R2						
7	Group 4 - 2D-E: Retrospective & concurrent monitoring						M1				M2	R1		R2								
8	EAC deliberate on draft report, adopt full slate of recommendations																					
9	HISC review, feedback on EAC report																					

↑
Today

- M1 Design milestone/workshop 1 R1 EAC initial review/input
- M2 Design milestone/workshop 2 R2 EAC final review/input
- M2 Design milestone/workshop 3 (if needed) R3 EAC final review/input – continuation (if needed)

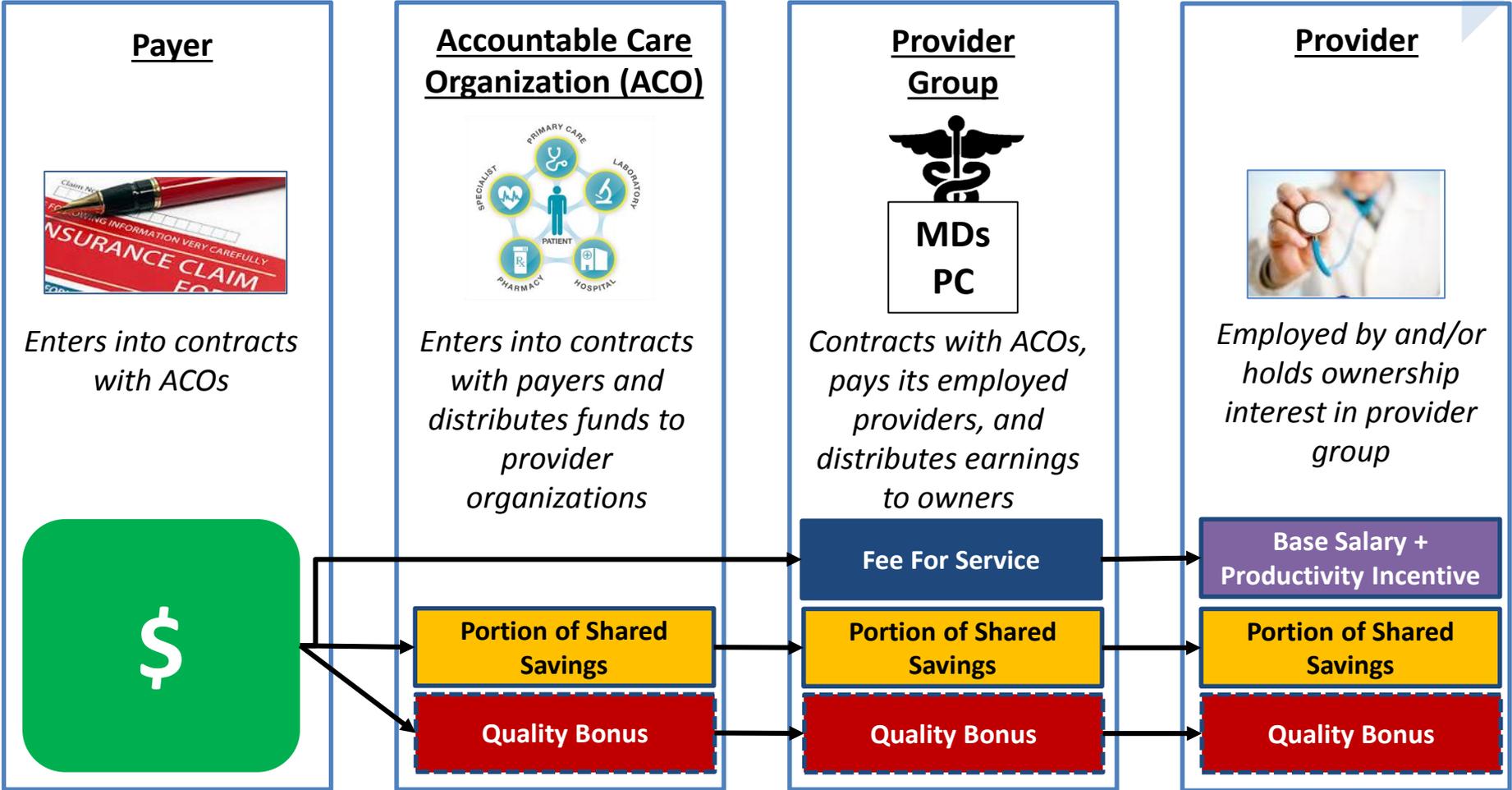
3. Design Group Process

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>	
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. Payment Terminology and Structure

Flow of Funds



Key
 = Typical ACO practice
 = Less Typical ACO practice

An ACO may include one provider group or many



4. Design Group 2: Payment Calculation

Proposed hypothesis:

Assuming all else is equal, the greater the financial pressure on a provider to hit a given cost target, the higher the potential risk for inappropriate under-service.

1

Quality Gate

Providers can only receive shared savings if quality and other performance measures are met.

2

Quality Incentive

Provide an incentive payment when quality and other performance targets are met regardless of whether savings are achieved.

3

Minimum Savings Rate (MSR)

There should not be an MSR in the early years of a shared savings program. Any savings achieved should be shared with providers (assuming the quality/performance targets are met). If there is an MSR it should be low (e.g.; 1%) to make achieving savings more attainable, reducing the “all or nothing” aspect of reaching an MSR target.

4

Reinvestment

When savings are achieved, but the ACO is not eligible to receive the savings (either because the MSR was not met or because quality/performance targets were not met), the money should be reinvested back either (a) into the delivery system as a whole or (b) into the ACO (following a set of guidelines to support the ACO’s future ability to deliver high performance)

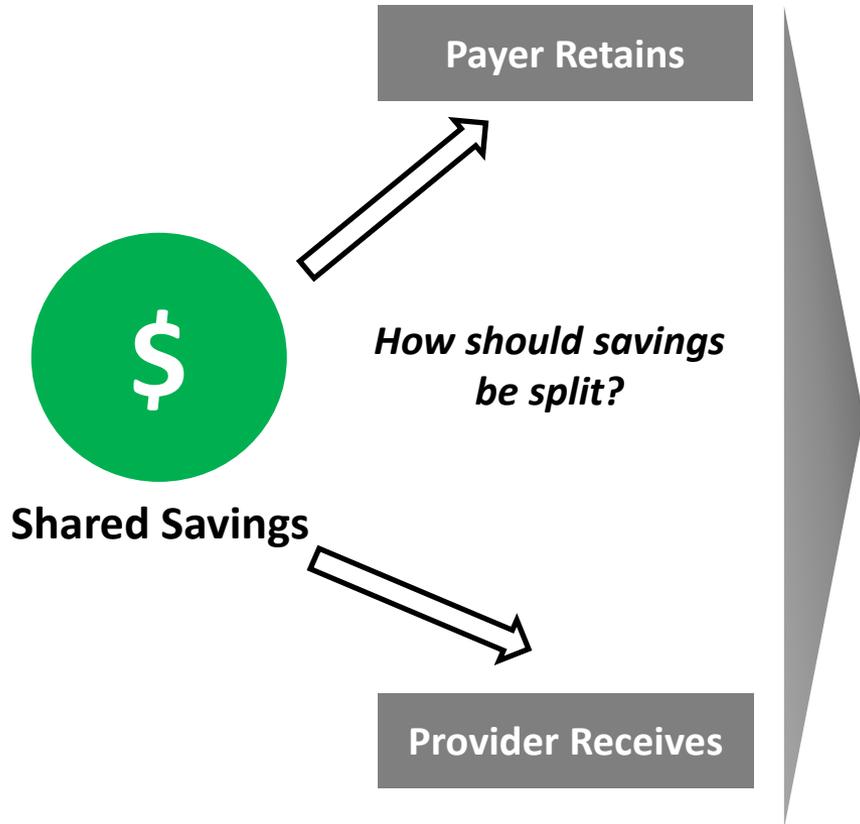
The group also discussed providing an advanced payment to ACOs to support building the necessary infrastructure outside of shared savings or performance incentive payments.

- *This is similar to the CMS’ ACO Advanced payment model and ACO Investment model.*
- *Would an advanced payment have an equity and access implication?*
- *How would this be funded?*



4. Design Group 2: Payment Calculation

Are there additional considerations for how the payment calculation is determined that will impact under-service or patient selection?



Decision Points (all assume quality thresholds are met):

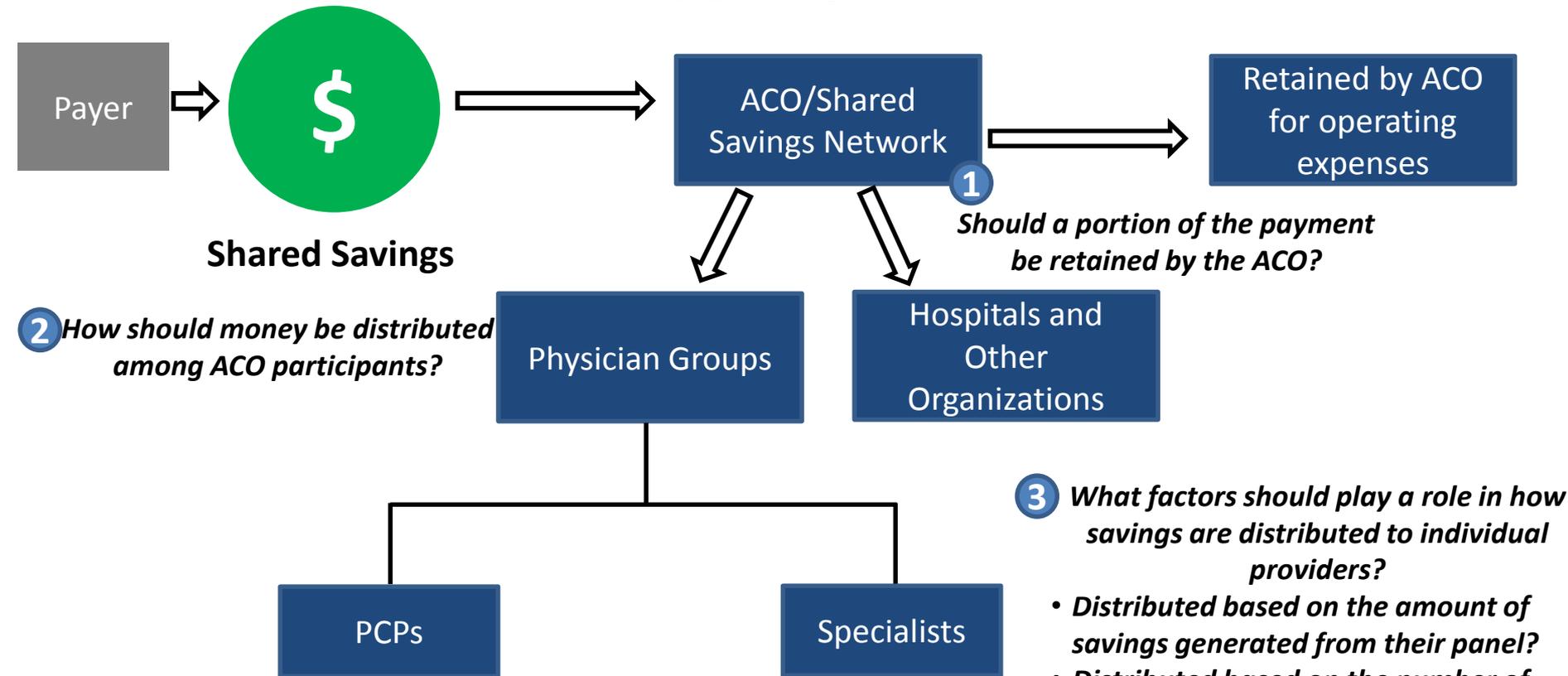
<p><i>Should the savings amount be fixed or varied?</i></p>	<p>Fixed: the % of savings will be the same as long as threshold quality targets are met, but will not increase with improved performance.</p> <p>Varied: the % of savings the ACO receives will increase with quality performance that exceeds the quality threshold targets.</p>
<p><i>How should quality performance be assessed?</i></p>	<p>Benchmark: Based on performance relative to others (i.e.; %ile rank).</p> <p>Improvement: Based on the ACO's prior performance.</p> <p>Combined: Blend of the benchmark and the improvement methods. Improvement helps to bring along lower performers while benchmark rewards high performers.</p>

The EAC should also consider how quality measures are risk adjusted when overall quality performance is assessed.



4. Design Group 2: 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?



3 *What factors should play a role in how savings are distributed to individual providers?*

- *Distributed based on the amount of savings generated from their panel?*
- *Distributed based on the number of attributed lives provider is managing?*
- *Distributed based on reaching quality and patient experience targets?*
- *A combination of all three?*

Workshop One Summary of Ideas:

- ACOs should determine independently how to distribute savings, within parameters. The EAC should recommend how to monitor the manner in which savings are distributed to ensure the distribution methodology in use does not lead to perverse incentives for providers.
- Distribution should provide sufficient financial incentives to individual providers in order to promote buy-in.

5. 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 the next EAC meeting*

Applies to.....

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

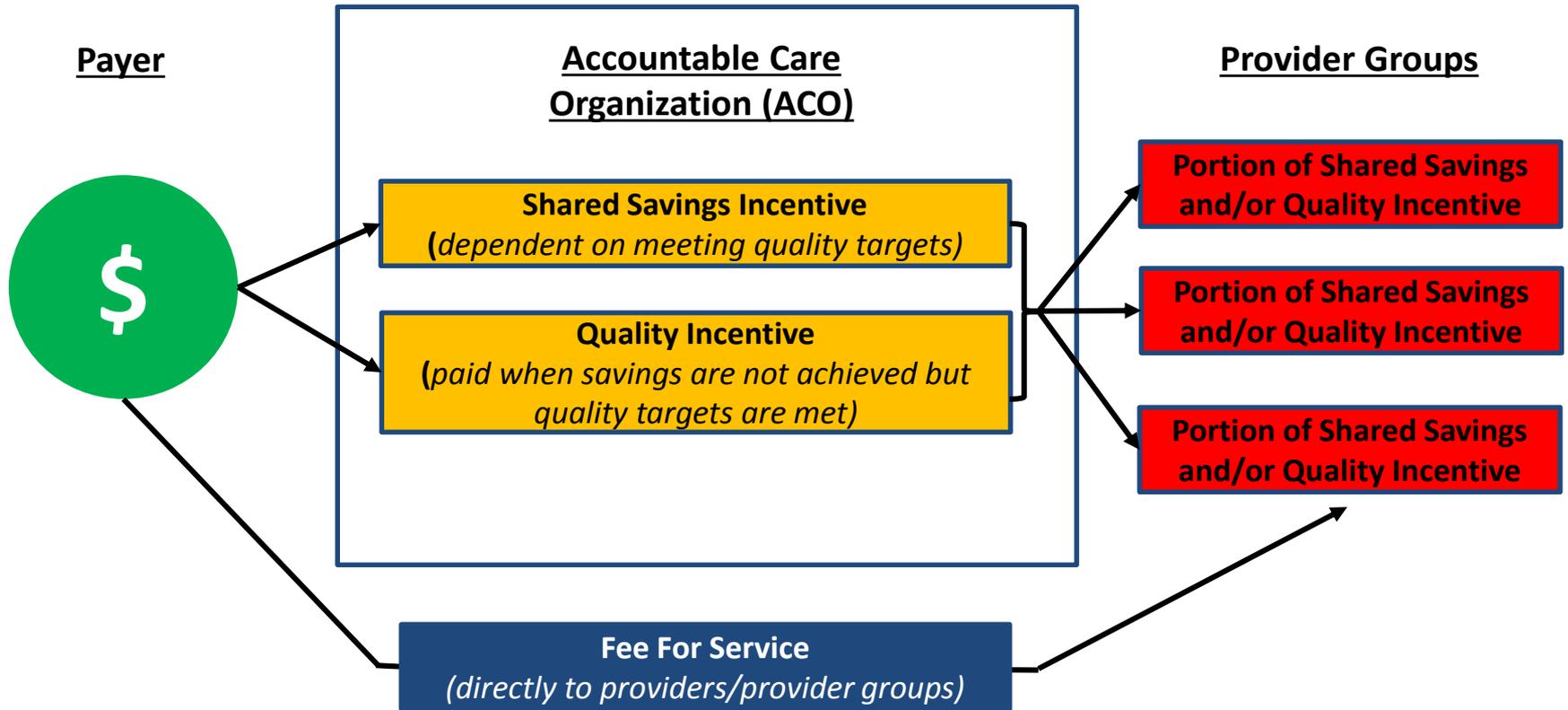
1D. Payment Distribution	Patient Selection	Under-Service
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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Appendix: Overview of a Shared Savings Program



Fee For Service	Providers will continue to receive FFS payments for the services provided within an ACO contract.
Shared Savings Incentive	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.; MSR, performance reporting and targets).
Quality Incentive	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.
Portion of Shared Savings and/or Quality Incentive	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.