

# Risk Adjustment and Year End Reconciliation: *Office Hours*

## Virtual Session

*Primary Care Payer Action Collaborative*

**February 7, 2018**

3:00-4:30 pm (EST)

### 1. Session Objectives

- Build a deeper understanding of payer operations relating to CPC+ Track 2 Alternative to FFS Payment.
- Provide an overview of Independent Health’s Primary Value Model, with a specific emphasis on risk adjustment.

2. **Speaker Panel:** Melinda Walter, MHA CPC – Manager, Provider Network Analytics, Independent Health; Brian Keane, Actuarial Analysis Manager, Independent Health

### I. Introduction:

- Independent Health is a non-for-profit health plan headquartered in Buffalo, New York (one of four CPC+ regions commencing in 2018). Currently, Independent Health is serving nearly 400,000 members. It offers commercial, Medicare Advantage, Medicaid and self-funded products in eight counties of the Western New York area.
- Independent Health launched its Primary Value program in January 2018 with approximately 130 practices. A wide variety of practices were eligible including family medicine, internal medicine, pediatrics, with practices sizes ranging from large groups to solo practitioners. The self-insured and institutional lines of business (LOBs) are excluded from the model. Independent Health decided that having to sell the model both to practitioner and employer groups would add too much complexity in the first instance; however, employer groups are interested in tracking cost and other outcomes from the model to evaluate whether they would join later. The participating practices manage care for approximately 90% of members within the participating LOBs.
- Primary Value includes a global payment design. The aim of the program is to transition eligible practices from fee-for-service (FFS) to value based reimbursement, rewarding PCPs for providing value in the changing healthcare environment. Primary Value was designed to help PCPs by trying to address concerns over cash flow; providing flexibility in care delivery; increasing member access in PCP offices; supporting a provider care management component; and allowing providers to practice at the top of their licenses.
  - **Q:** What critical mass do providers need at the practice level of the Global Payment to see the alleviation of the “stressors”?  
**A:** Independent Health did hear feedback from providers that it is difficult to manage both global payments and FFS. The other major local payer in the area recently switched to a global payment model, which is helpful.
- Global Payment had been in place for a subset of Independent Health’s network practices for a number of years. Independent Health refined the previous model based on provider feedback, including by simplifying the rate structure, making it easier for practices to understand. All PCPs were invited to attend meetings during the roll-out. Independent Health produced a video that

spoke to experience in the model from the viewpoint of physicians, the chief medical officer (CMO), and staff. One lesson learned is that it's critical for the plan CMO or other clinicians to take a leadership role in the model rollout to providers.

- **Q:** is there a difference in clinical performance and cost between the roughly 1/3 of your network practices in CPC Plus vs. the other 2/3?

**A:** There hasn't been any analysis yet, but the more advanced practices are likely to be involved in the CPC+ and Primary Value models by definition.

## II. Payment Model Overview:

- **Minimum practice size:** Independent Health put criteria around membership minimums to ensure the practices were stable enough. The thresholds are 400+ members across all LOBs or 200+ members across one LOB.
  - **Q:** Was there a consideration for actuarial risk credibility in setting of minimum membership levels?
 

**A:** Yes. It was set up to only capture membership that could be appropriately predicted. For example, some practices are primarily serving Medicaid patients, but will have a handful of commercial patients also, and they get a default (plan average PMPM) rate for their commercial patients.
- **Code set:** Primary Value aims to encompass the majority of the services rendered in a primary care office. Some services, such as select preventive services and new patient visits were both excluded from the code set to ensure no disincentive to provide these services; drugs and immunizations were also left out due to fluctuating pricing. A provider focus group was involved in the selection of included/excluded codes.
  - **Q:** What about inpatient admissions and high cost radiographic procedures?
 

**A:** The code set is limited to paying for only the typical in-office primary care services. High cost radiographic procedures could be an opportunity for a cost or quality metric associated with the bonus, but wouldn't be included in the applicable code-set for the global payment.
  - **Q:** Are practices billing normally, or are they submitting dummy claims?
 

**A:** They submit normal claims processed by the system, but the system flags them for "global." The only difference is that the claim line has a paid amount of \$0 and a reason code specific to the global payment. If a single claim includes a line that is covered by global payment and one that is not, the system processes them together, but the line that is global will process as such and the line that is FFS will pay (as appropriate). Practices are being encouraged to submit dummy claims for services like e-visits, which are not currently reimbursable on the fee schedule but are increasingly being tested by practices (this is a new initiative so it is still too soon to conclude whether there is an uptick in e-visits).
  - **Q:** What percentage of fee schedule services end up being included in the global payments?
 

**A:** It varies from practice to practice. Pediatric practices might do more immunizations (excluded), whereas practices with adults might be doing more established office visits (included). Independent Health looks to see if there is a consistent volume across the

practices to determine if it could be part of the global payment model, meaning that most of the PCP providers perform the specific service at a high frequency.

- **Methodology:** The calculation begins with a per member per month (PMPM) calculation for each LOB for the specific PCP claims defined based on the code set and the doctors/ practices providing the services. The group of claims are trended forward. Some practices earn a tiered “add on” – e.g. extended hours, and having an EKG machine. Adjusters are applied as detailed below. The global payment is made retrospectively, so it occurs on or about the first of the month for the prior month.
- **Attribution:** Attribution is run monthly at the TIN/ NPI level; however, member selection trumps attribution. The goal is to capture the most current PCP for each member. If the member has a PCP on record, that is the PCP who is paid the global payment. Practices are paid FFS if someone who isn’t associated with them comes into their office. The PCP can appeal if they feel a member should not be on their panel. Independent Health tries to assign PCPs to members that do not have one: members have a co-pay incentive to choose a PCP.
- **Member cost share:** Member liability for copays, co-insurance and deductibles does not change under the model.
- **Quality incentive opportunity:** Payments are NOT being adjusted for quality and efficiency in the first year, but practices were made aware that the data would be used at a later time for performance metrics potentially including: patient experience of care, transformation opportunities, gaps in care, access, clinical quality and total cost of care.

### III. Risk adjusters applied to the Global Payment:

- **Components:**
  - I. **Benefit Adjuster** to handle utilization variance by type of member coverage
  - II. **Chronic Conditions Hierarchical Groups (CCHGs)** to handle variance in chronic conditions burden
  - III. **Utilization Adjuster** to handle variance in acute visit burden
- **Benefit adjuster:** The benefit adjuster adjusts for the relative difference in service use between health plan products. As Independent Health had expected, high deductibles have the largest effect on decreasing member utilization; otherwise, differences tend to be correlated to chronic conditions and/or age.
- **Modified CCHGs:** The CCHG model was developed by Milliman. CCHGs are used to bucket chronic conditions. Independent Health does not leverage their hierarchical nature, and they found that CCHGs did not always meet their needs in instances such as splitting out chronic conditions by age. The model also gave too much weight to expensive diseases typically managed by specialists. In response, Independent Health created its own risk adjuster for each LOB based on the CCHGs. Each LOB has a similar methodology but there are slight differences. Independent Health has also broken some CCHGs into smaller groupings to account for different patient groups: for example, pediatric asthma is chronically underscored, which especially impacts on practices with higher asthma incidences.

Independent Health broke up asthma groups by age – including age 10 and under – which improved how well the CCHG reflects risk.

- **Q:** What questions or concerns did you hear from providers on the CCHG approach?  
**A:** In this area, we haven’t heard a lot of concern.

- **Q:** What data are you using for the risk adjustment, and is it dependent on accurate provider coding?

**A:** The basis of the CCHG is all members’ claims data; it goes through diagnoses codes and buckets the members. It does use any coding that comes in from a hospital visit or specialist, as well as the PCP. Independent Health continues to stress the importance of providers accurately coding on their claims. Independent Health believes that there should not be a big difference in the way primary care providers are billing under the model since they submit claims for both Primary Value members and members/visits not in Primary Value.

- **Utilization adjuster:** The utilization adjuster is important because there is variance with the chronic CCHG buckets in level of acute disease requiring visits. Independent Health wanted to reflect this, while being careful not to go too far and replicate fee for service volume incentives. To take this effect into account, the utilization adjuster uses the “Work” portion of Medicare RVUs model to capture effort. The inclusion of the RVUs tripled the number of groups whose predicted expense was within an acceptable margin of their actual spend.

#### IV. Reports Available to Practices

- **Reports to Support Payments:** Independent Health has built five reports to support the Primary Value program:
  - I. Member roster report;
  - II. Payment summary report;
  - III. Member liability report;
  - IV. Out-of-practice claims report (limited to primary care services and providers) –i.e. “leakage” – will begin to flow in April 2018;
  - V. Adjustment score update report.

Plans for reports were shared publicly, and provider feedback was welcomed through community presentations.

- **Q:** what level of granularity are you thinking of including in the leakage reports?  
**A:** They will include enough detail so that practices have a good idea of what services were rendered by another site and where the dollars came from. The idea is to let practices know what is happening so that they can make corrections as they see fit. There is a process for documentation and notification regarding dismissal of members. There are many factors that drive leakage, so Independent Health just wants to make sure it is not paying too much for services rendered FFS in addition to the global payments.

- **New Performance Reporting Tool:** Separately, Independent Health launched an interactive tool in summer 2017 that shows annual visits; gaps in care; non-preferred drugs; specialty care; site of service; HCC drops; and high utilizers. The tool has easy-to-read, dashboard style visuals.
  - **Q:** What has the usage of the performance tool looked like?  
**A:** Of the 130 practices, all but 5 have been actively engaged on the portal.
- **Additional one-time Transition reports:** Independent Health also produced a practice- specific report for every practice transitioning to Primary Value, estimating the impact of the transition from FFS to the Global Payment. This was time intensive for Independent Health, but it was critical for practices to understand the model. There were some negatively impacted groups through this transition (though the majority were positively impacted), so Independent Health provided this level of detail to enable practices to make a fully informed decision to participate. There was also a dedicated web page, an email box, and formal presentations.

**Session recording:** <https://cc.readytalk.com/cc/playback/Playback.do>

**Link to previous session:**

**Link to following session:**