

# Primary Care Payer Action Collaborative (PAC) Risk Adjustment and Year-End Reconciliation



**Office Hours**



If you require technical assistance, please contact  
***Kristian Motta*** at [kmotta@rippleeffect.com](mailto:kmotta@rippleeffect.com).

**February 7, 2018**  
3:00 – 4:30 PM ET

# Welcome and Introductions

# Welcome

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**Edith Coakley Stowe**  
**Senior Manager**  
**Manatt Health (DC)**



**Susan Stuard**  
**Independent Consultant (NY)**



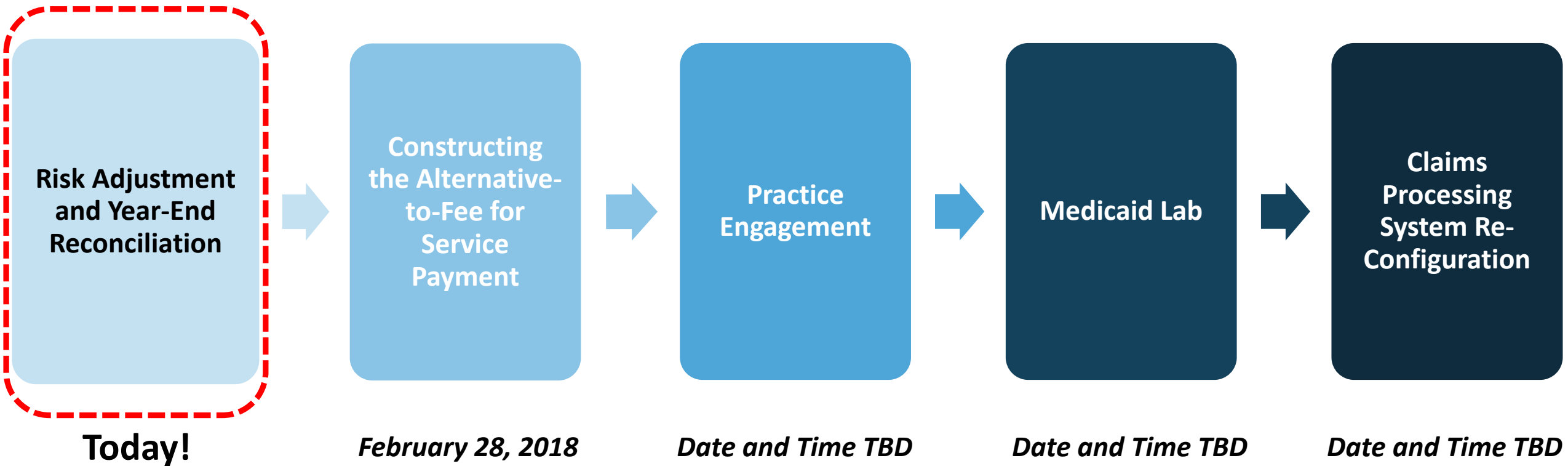
**Dori Glanz Reyneri**  
**Senior Manager**  
**Manatt Health (DC)**



**Kaylee O'Connor**  
**Consultant**  
**Manatt Health**  
**(DC)**

# Curriculum, Topics and Calendar

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# Today's Agenda

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Timeframe (EST)		Topic	Facilitators/Presenters
1	3:00-3:05	Reminder of PAC and Purpose	<b><i>Edith Stowe</i></b>
2	3:05-3:10	Interactive Polling and Today's Objective	<b><i>Edith Stowe</i></b>
3	3:10-4:55	Risk Adjustment and Year-End Reconciliation <i>(in the context of Independent Health)</i> <ul style="list-style-type: none"> <li>• Primary Value Introduction</li> <li>• Payment model overview</li> <li>• Risk adjustment</li> <li>• Reporting to practices</li> </ul>	<b><i>Melinda Walter &amp; Brian Keane, Ind</i></b>
4	4:55-4:00	Interactive Polling	<b><i>Edith Stowe</i></b>
5	4:00-4:30	<b>Optional</b> additional Q&A	<b><i>Edith Stowe, Melinda Walter, Brian Keane</i></b>

# Reminder: LAN Action Collaboratives

A LAN Action Collaborative (AC) provides a **results-oriented forum** for sharing, integrating, and applying new knowledge and tailoring solutions.

This will support **committed** participants with a **shared aim** to take more effective **action** in their organizations to **increase adoption of APMs** and to make a **collective impact** on the U.S. health care system.

## ACTION COLLABORATIVE



## PAC

The Primary Care Payer Action Collaborative (PAC) serves as a “national table” for payers committed to improving the implementation of CPC+, a multi-payer primary care APM, to more effectively support practice-level transformation by:

- Identifying and committing to collective goals
- Sharing learning to accelerate action
- Tackling operational barriers to successful APM implementation

# PAC Portal

- For more information and resources please visit the [Primary Care Payer Action Collaborative \(PAC\) Portal](#).
- Slides, session highlights and polling results are posted from PAC fall webinars

## PAC Learning Labs on Alternatives to FFS Payment in CPC+ Track 2

### Learning Labs on Alternatives to FFS Payment in CPC+ Track 2

This section includes an overview of the PAC and materials from each virtual meeting beginning in August 2017, when the PAC tailored learning lab content and discussions to support payers as they operationalize alternatives to fee-for-service payment specifically in "CPC+ Track 2."

#### PAC Overview

##### [Overview](#)

#### PAC Session 1: Introduction to Designing and Implementing Alternatives to FFS in CPC+ Track 2

This kick-off webinar outlines PAC objectives and serves as a preview of four upcoming "learning labs" on key payment design and implementation topics. As part of this interactive session, members of the CMS CPC+ team outline key principles and features of the CPC+ model and address participant questions.

August 29,  
2017

[Live Poll Results](#) | [Highlights](#) | [Slides](#)

#### PAC Session 2: Design Work Flow

This learning lab discusses initial design decisions in developing any alternative to FFS payment for primary care practices, ranging from which lines of business to include in the model, to handling patient attribution.

September  
14, 2017



# Interactive Polling

# Polling Question #1a:

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Which CPC+ Region are you from?

- a) *Arkansas*
- b) *Buffalo (2018 Start)*
- c) *Colorado*
- d) *Hawaii*
- e) *Kansas City*
- f) *Louisiana (2018 Start)*
- g) *Michigan*
- h) *Montana*
- i) *Nebraska (2018 Start)*
- j) *New Jersey*



# Polling Question #1b:

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## Which CPC+ Region are you from?

- a) *North Dakota (2018 Start)*
- b) *Hudson/N Capital NY*
- c) *Ohio/N Kentucky*
- d) *Oklahoma*
- e) *Oregon*
- f) *Philadelphia*
- g) *Rhode Island*
- h) *Tennessee*
- i) *Payer in multiple regions*

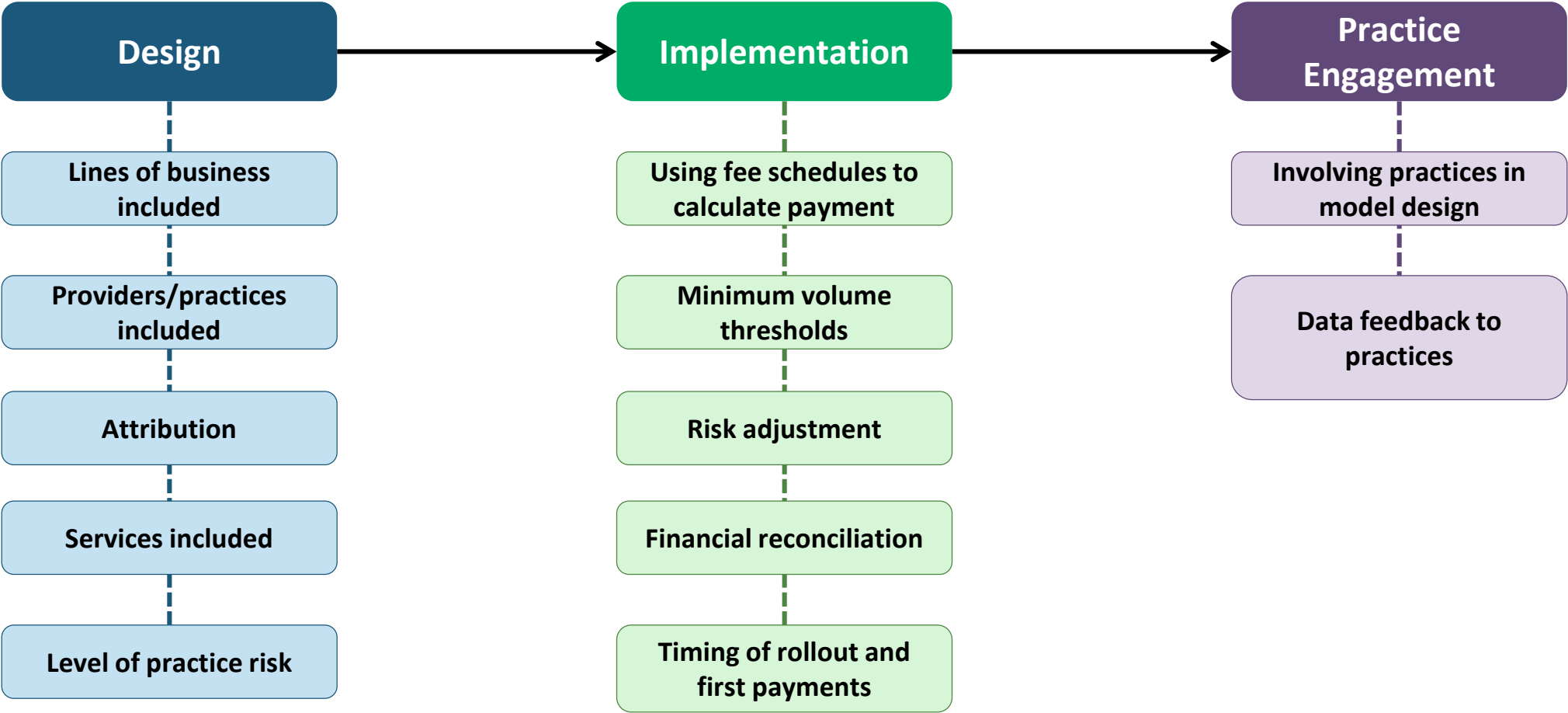


# Today's Objective

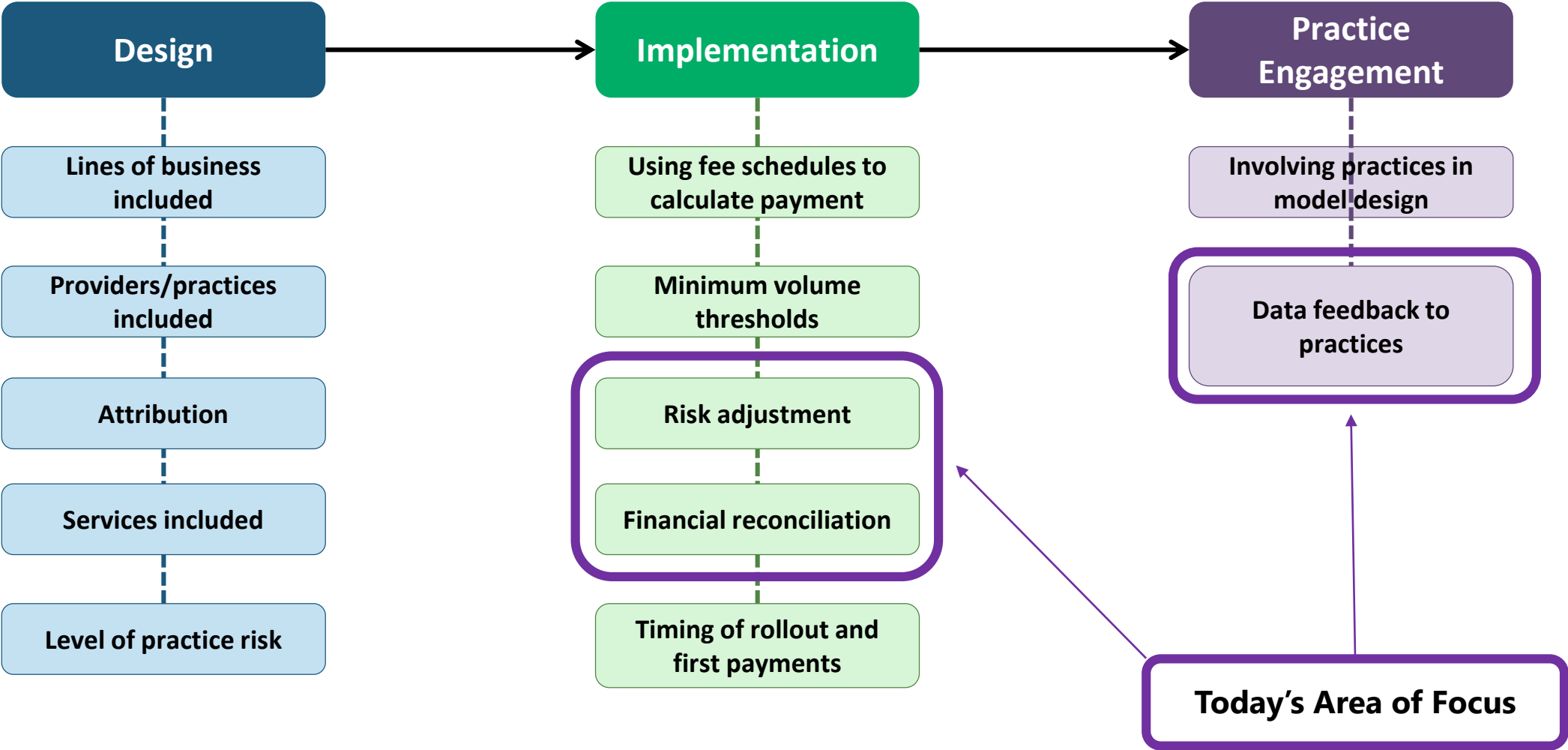
# Today's Objectives

- 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**

# Track 2 Alternative to FFS Payment: Work Flow



# Track 2 Alternative to FFS Payment: Work Flow



# Antitrust Statement

PAC Participants agree that all activities are in compliance with federal and state antitrust laws. In the course of discussion, **no financial information from payer participants will be shared with other payers or the general public.**

During meetings and other activities, including all formal and informal discussions, each payer participant will refrain from discussing or exchanging information regarding any competitively sensitive topics. Such information includes, but is not limited to:

- ✓ PMPM
- ✓ Shared savings or incentive payments
- ✓ Information about market share, profits, margins, costs, reimbursement levels or methodologies for reimbursing providers, or terms of coverage



# Speaker Introduction

# Today's Speakers

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**Melinda Walter, MHA, CPC**  
**Manager, Provider Network Analytics**  
**Independent Health,**  
**Buffalo NY**



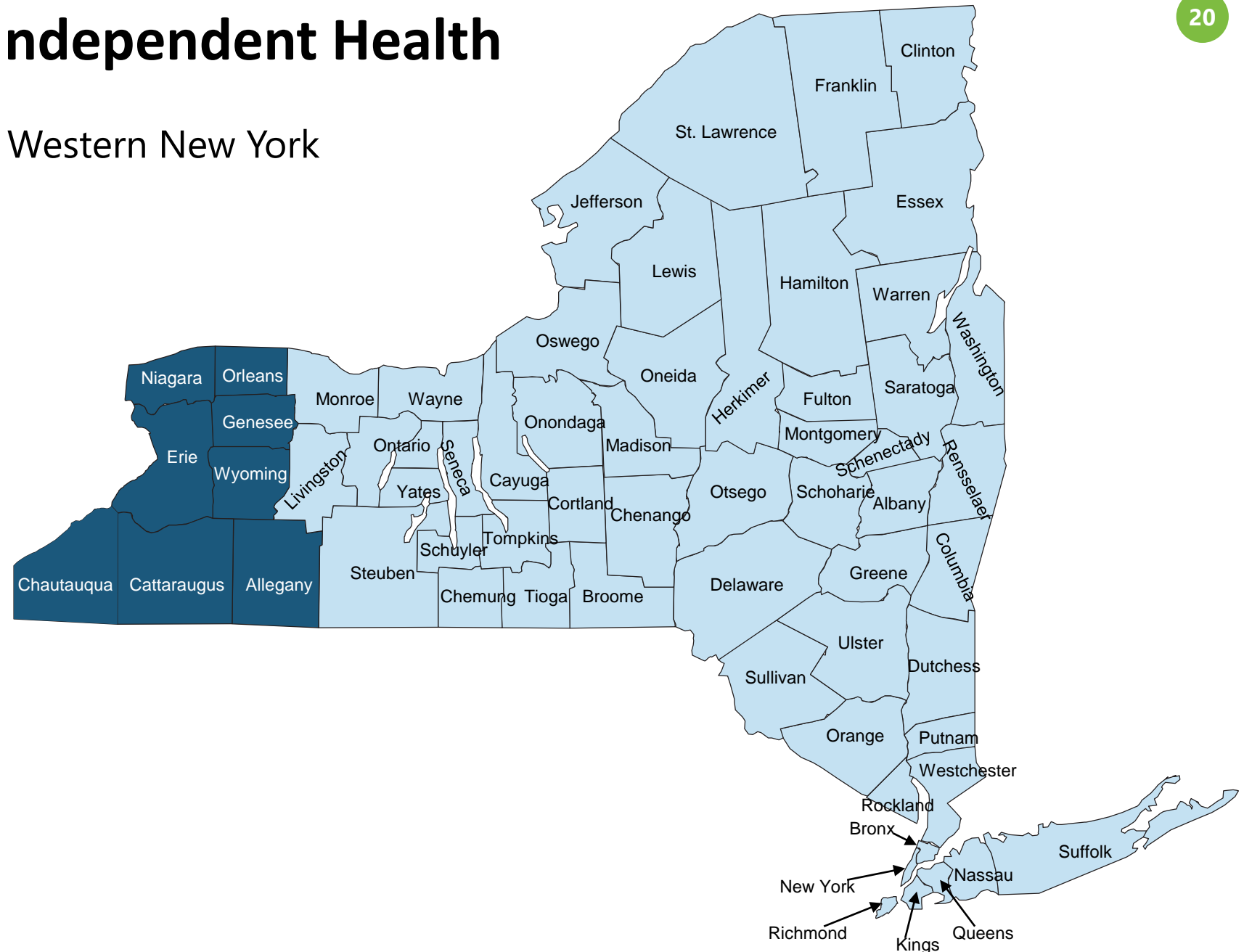
**Brian Keane**  
**Actuarial Analysis Manager**  
**Independent Health,**  
**Buffalo NY**

# Introduction to Independent Health

- Headquartered in Buffalo, New York, we are a not-for-profit health plan that continually aims to provide our community with innovative health-related products and services, which enable affordable access to quality health care
- Our award-winning customer service, dedication to quality health care and unmatched relationships with physicians and providers has allowed us to be consistently recognized as one of the highest-ranked health insurance plans in the nation
- Began operations in 1980
- Nearly 400,000 members
- 1,080 associates (staff)
- Offer Commercial, Medicare Advantage, State\* and Self-funded products

# Introduction to Independent Health

- Serving 8 counties of Western New York



# Introduction to Primary Value

- Primary Value is a program intended to transition eligible practices from fee-for-service to a value based reimbursement model.
- Primary Value was launched in 2018 with approximately 130 practices qualifying for the Alternative Payment Model (Global Payment)
  - Built off the base of a prior model that had been in place since 2012
- Wide variety of Global eligible practices, including family medicine, internal medicine and pediatrics, from large groups to solo practitioners
  - Eligible groups manage care for approximately 90% of members in participating LOB's
  - Over 99% of the eligible providers returned the contract and are fully participating in the Global Payment model.
- Since 1/1/18, 37% of Primary Value Global Payment Eligible practices are participating in CPC+ in the CPC+ Buffalo region

# Primary Value Goals



## ***Move from Fee-for-Service to Value-Based Reimbursement***

- **Reward PCPs for Providing Value**
- **Make PCPs successful in the new healthcare environment**



## ***Help Alleviate the Stressors on Primary Care Providers***

- **Provide Steady Cash Flow**
- **Care Delivery Flexibility**
- **Improve Member Access in PCP offices**
- **Provide Care Management Component**
- **Allow Providers to Practice to the Top of License**
- **Share Timely, Actionable Data on Performance and Opportunities**

# Transition from Fee-for-Service to Global

- A Global Payment had been in place for several years for a sub-set of Primary Care Practices
  - Smaller set of codes
- Over time, we have been able to refine the process as we learned and made modifications based on provider feedback
  - Managing member cost share
  - Simplified Rate Structure
- In 2018, the roll-out of the expanded program (Primary Value) included a video presentation featuring providers who were in the prior model

# Primary Value Global Payment

- Products Included:
  - Commercial
  - Medicare, excludes Institutional Products
  - State products, excludes Institutional Products
- Self-Funded products are excluded
- Membership Minimums (in the applicable lines-of-business)
  - As of March 2017, practices eligible for the 2018 global payment include those with:



OR





# Primary Value Global Payment Code Set

- The Primary Value global per-member per-month payment encompasses the majority of services typically rendered in a primary care office
- The code set was selected based on input from a PCP focus group
- Certain preventive services, medical drugs and immunizations are excluded
  - Drugs and Immunizations can have fluctuating prices that are not in providers' control
  - Want to encourage immunizations and preventive care
- Weighed the value of keeping certain services fee-for-service
  - E.g. New Patient visits are excluded to encourage providers to take on new Independent Health members

# Primary Value Rate Calculation

- Base for Calculation
  - Calculated at the LOB level
  - Overall PCP Historical Utilization of Services in Code Set (Allowed Dollars)
  - Trended out for Cost and Utilization
  - Some services earn a tiered “add-on” to the PMPM for those practices who perform them above a minimum utilization threshold to account for capital differences
    - There are two levels of add-ons for extended hours
    - There is an add-on for practices with an EKG machine

# Primary Value Rate Calculation Continued

- Adjustment Score
  - Chronic Conditions- Based on Milliman CCHG's
  - Credibility to address variation in practice size and stability
  - Member Visit Patterns
  - Benefit Adjuster - Commercial Only
- Enhancement- Commercial and Medicare Products

# Quality Incentive Opportunity

- The global payment is not adjusted in the first year of participation – allows time for changes
- After that, the global payment will be adjusted for Quality and Efficiency. Plan will consider performance in metrics such as those that are listed below to possibly include in that adjustment.
  - Patient Experience of Care
  - Transformation Opportunities
  - Gaps in care compliance
  - Access
  - Select clinical measures (HEDIS based)
  - Total cost of care

# Attribution Methodology

Member selection trumps attribution

Attribution is at the TIN/ NPI level

Attribution is run monthly

Attribution is Based on PCP with most visits in 24 month period

# Impact to Practices' Payment

- Global Payment is **Retrospective**
- Payment occurs on or about the first of the following month for the prior month
- Payment aggregates all lines of business
- Paid by the by the same method as is typical for the practice (check, EFT etc.)
- All Member liability (ex. Copayment, co-insurance, deductible) should continue to be collected from the member

# Risk Adjuster

- Independent Health has created its own risk adjustment methodology.
- Since we were considering such a narrow code set, there were no existing risk scores that fit our need. The finest breakdown for most commercially available scores was at the professional level which included specialist encounters. Our program excludes specialist claims which caused those scores to over-weight certain disease states primarily managed by a specialist, and under weight disease states primarily managed by primary care providers.
- Each line of business has its own version.

# Components

We wanted to capture four main components:

- **Product driven utilization** variance
  - We use a benefit adjuster
- **Chronic Illness & Demographics** variance
  - We use the CCHG as a base and apply our enhancements
- **Acute Member Utilization** variance
  - We use actual claim experience paired with CMS RVUs



# Benefit Adjuster

- It is a multiplicative factor to adjust for the relative difference in service use between products
- **We found that the largest benefit factor is for high deductibles**
- There are also significant differences between products for our state population, but that was largely correlated to chronic conditions (CCHG). Selection of a particular Medicaid product is largely based on condition and inelastic
- The need for this is twofold:
  - We want to be able to continue to understand a member even after a product change
  - We want to be able to account for the significant difference in utilization even for members that are rated with a demographic score


## 2

# Milliman CCHG

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- CCHG stands for Chronic Conditions Hierarchical Groups
- They assign all members to one of 43 unique categories using a clinically relevant hierarchy that is based on the way physicians make treatment decisions
- We decided to use the CCHG for the basis of our chronic conditions because it is a vetted standard that we were institutionally familiar with
- Much of the development time was spent refining the categories

**CCHG Categories, Rank and Description**



1	Major Psychoses
2	Severe Dementia
3	Active Cancer
4	Renal failure/Post Transplant
5	Liver Disease (Hepatitis, Cirrhosis) Post Transplant
6	HIV
7	Severe Rheumatic & Other Connective Tissue Disease
8	Severe Heart Failure/ Transplant/ Rheumatic Heart Disease/Non
9	Hemophilia & Sickle Cell & Chronic Blood Disorders
10	Both CAD and Diabetes
11	CAD (No Diabetes, Cerebrovascular or Peripheral Vascular Disease)
12	Diabetes (no CAD)
13	Hypertension (Includes Stroke & Peripheral Vascular Disease)
14	COPD
15	Asthma
16	Neurologic Disorders
17	Mental Retardation/Disability/Congenital Anomaly
18	Chronic Musculoskeletal/ Osteo Arthritis/ Osteoporosis
19	Other Mental Health/Substance Abuse
20	Gastrointestinal Disorders
21	Tuberculosis
22	Thyroid Disorders
23	Chronic Skin Disorders
24	Unhealthy Newborns and Premies
25	Other Chronic Diseases
26 - 35	Healthy Individuals, by age and gender

## 2 Example: CCHG variation

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- As part of our iterative process we broke some CCHGs into smaller groupings. For example we noticed that our adjuster appeared to be under-scoring pediatric practices, especially pediatric practices with high asthma incidence.
- Digging into this CCHG we realized that there is a significant difference in primary care expense and variation for pediatric asthma. By splitting this CCHG we were able to push significantly more dollars into the pediatric asthma bucket, while also improving our coefficient of variation, a measure of relative volatility within a population, for both groups.

CCHG	Age	Average PMPM	PMPM Std Dev	Coefficient of Variation
Asthma	All	\$18.45	\$17.67	96%
Asthma	0-10	\$28.02	\$23.12	83%
Asthma	>10	\$16.18	\$15.25	94%

## 3

## Utilization Adjuster

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- The utilization adjuster accounts for activity that occurs due to something other than a chronic condition and helps to vary intensity within our groupings.
- We leveraged the Medicare RVUs
- We used the “Work” portion to capture the effort of the providers for a particular service
- This is meant to capture increased incidence of acute conditions
- The inclusion of the RVUs tripled the efficacy of the overall adjuster

# Reports to Support Payments

## Monthly Reports:

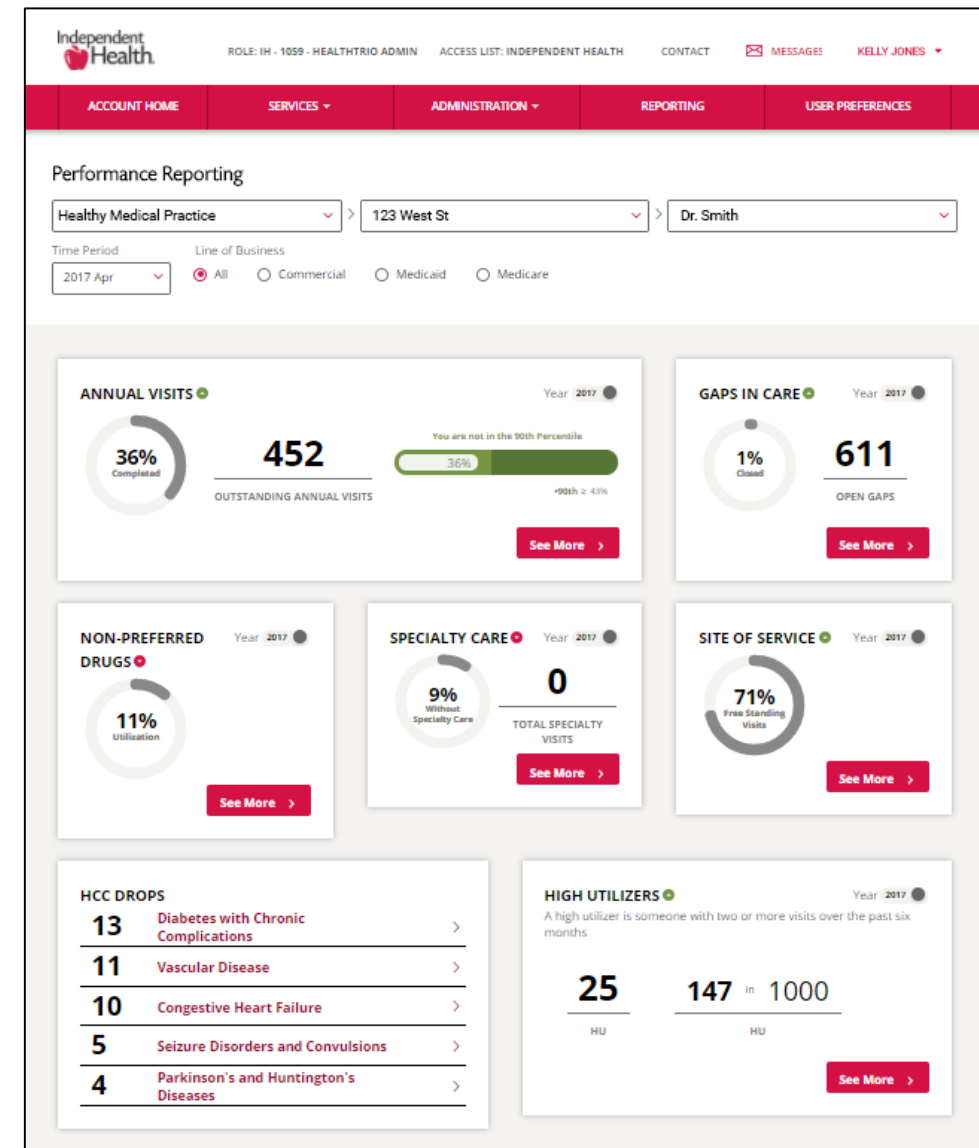
- Member Roster Report
- Payment Summary Report (including totals by provider)
- Member Liability Report
- Out-of-Practice Claims Report - starting in April of 2018

## Quarterly Reports:

- Adjustment Score Update Report

# New Performance Reporting Tool

- Interactive reporting tool covering the key metrics that Quality and Total Cost of Care will be based on for 2019:
  - Annual Visits, Gaps in Care, Non-Preferred Drugs, Specialty Care, Site of Service, HCC Drops, High Utilizers
- Dashboard Provides an Overview
- Drill Down to Patient Details (Gaps in care)
- Track and Compare with Simple Visuals
  - Charts and Graphs with Benchmarks and Trends
- Print and Export Patient Lists



# Additional Transition Support

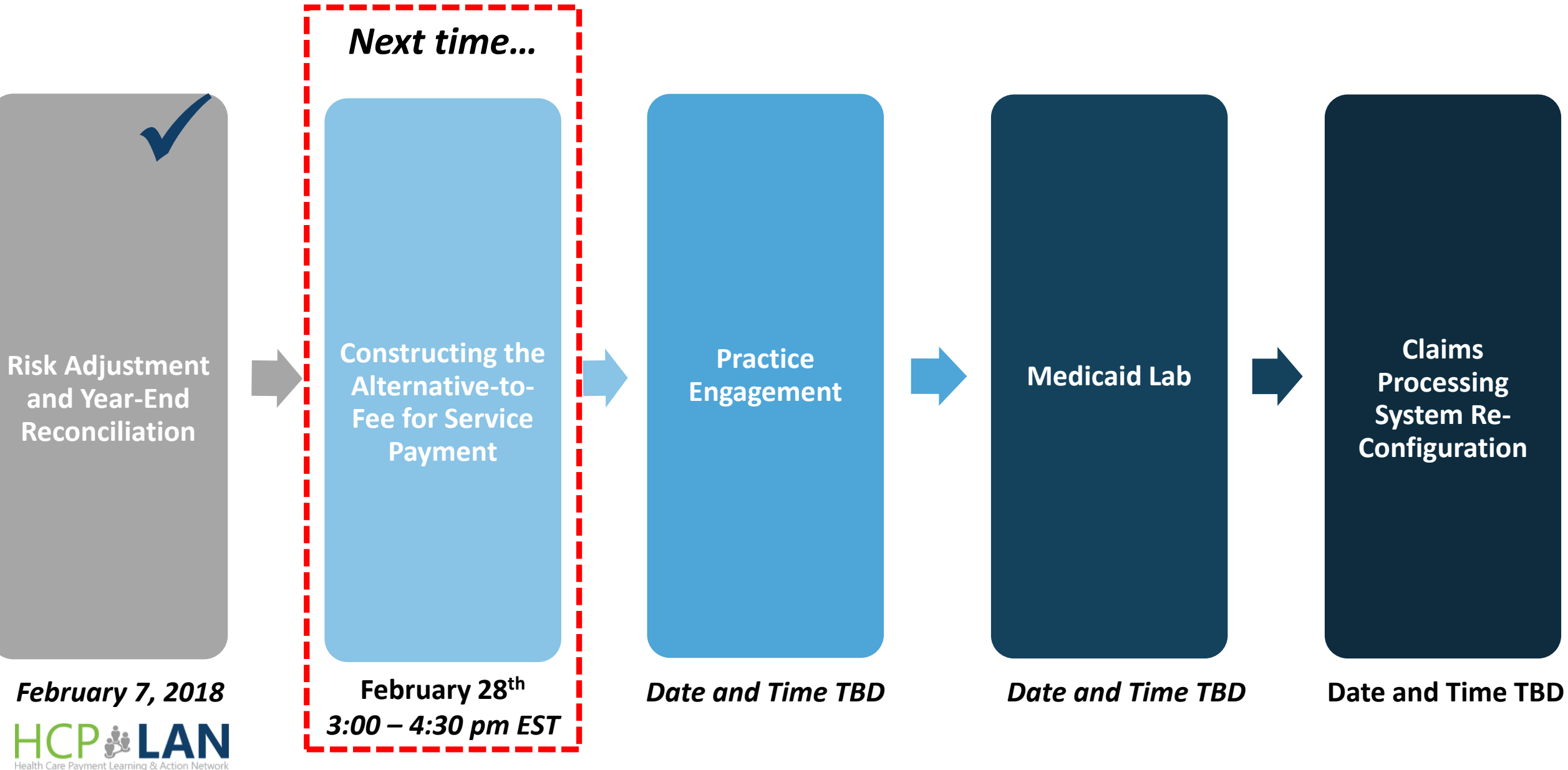
- Reports were prepared for each practice estimating the impact of transitioning to the global payment
- Created a dedicated web page
  - FAQ's
  - Reference Material
  - Background on Value Based Reimbursement in general
- Dedicated email inbox
- Formal presentations

# Wrap-Up



# Next Time

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# Interactive Polling

## Polling Question #2:

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Please rate your overall satisfaction with this event.

- a. *Very satisfied*
- b. *Somewhat satisfied*
- c. *Somewhat dissatisfied*
- d. *Very dissatisfied*

*Please type additional thoughts in the chat,  
especially any suggestions for improvement*



# Polling Question #3:

44

Today's Lab enhanced my knowledge of the subject area.

- a. *Strongly Agree*
- b. *Agree*
- c. *Disagree*
- d. *Strongly Disagree*

*Please type additional thoughts in the chat,  
especially any suggestions for improvement*



## Polling Question #4:

45

**I will take action or work with others in my organization to take action based on today's lab.**

- a. *Strongly Agree*
- b. *Agree*
- c. *Disagree*
- d. *Strongly Disagree*

*Please use the chat to tell us what you will act on,  
or why the information was not actionable*



## Polling Question #5:

46

The PAC is helping my organization make progress towards its goals in CPC+.

- a. *Strongly Agree*
- b. *Agree*
- c. *Disagree*
- d. *Strongly Disagree*

*Please type any additional thoughts in the chat,  
especially any suggestions for improvement.*



**Thank You!**

# Optional Q&A Time