

Washington State Health Care Authority

Paying for Value Webinar Series: ACP Financial Approach & Risk Sharing

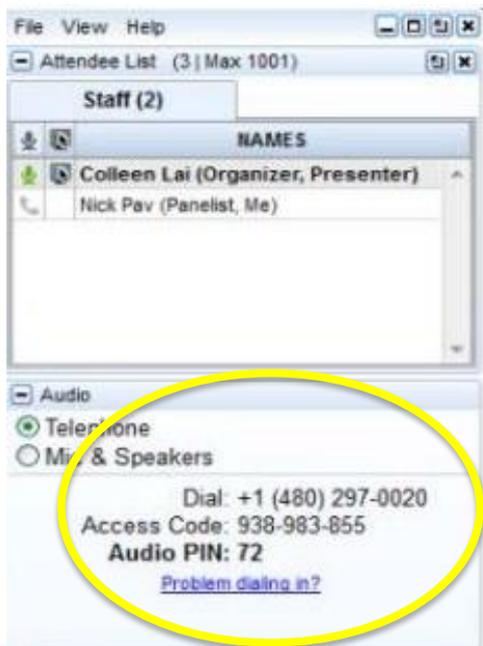
Cade Walker
Health Care Authority

Ben Diederich
Milliman

Before we get started, let's make sure we are all connected

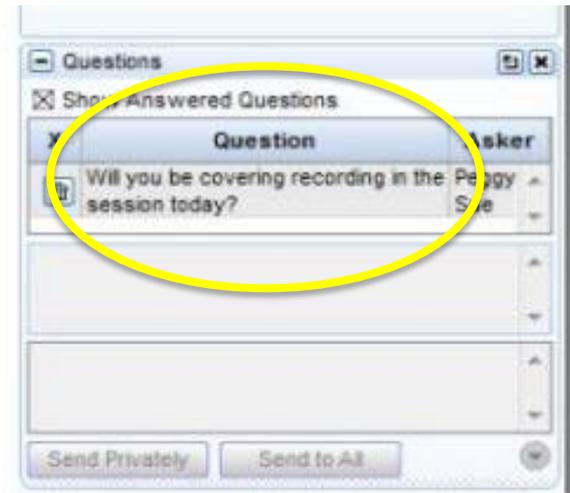
Audio options

- Mic & Speakers
- Telephone: Use your phone to dial the number in the "Audio" section of the webinar panel. When prompted, enter your access code and audio pin.



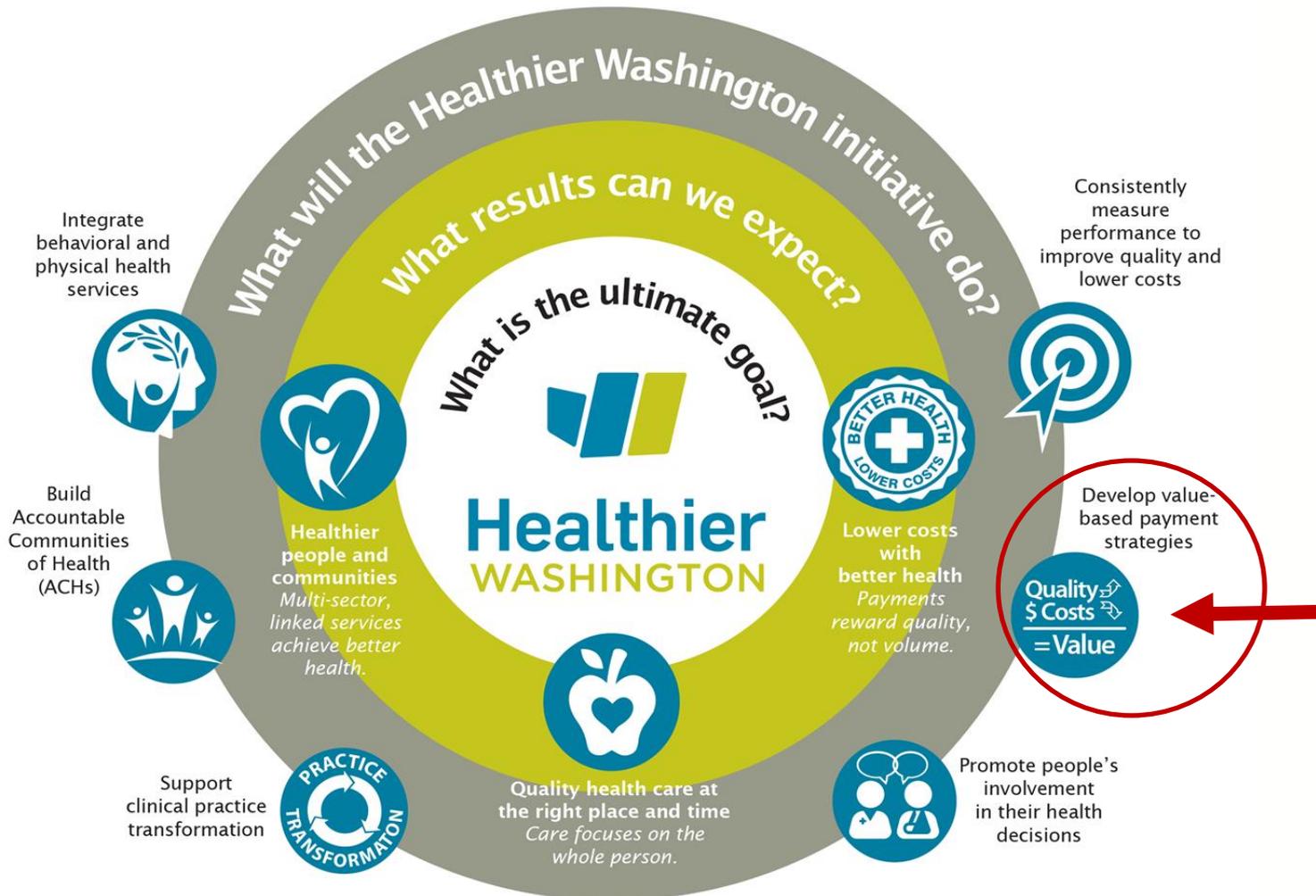
Have questions?

Please use the "Questions" section in the webinar panel to submit any questions or concerns you may have. Our panelists will answer questions at the end of the presentation.



Purpose

- Discuss HCA's financial approach to its ACP contract, and how risk is shared between HCA and the Accountable Care Networks
- Understand where this model fits in on the national scene of payment redesign
- Provide insights into how employers can approach risk sharing contracts for their health benefits

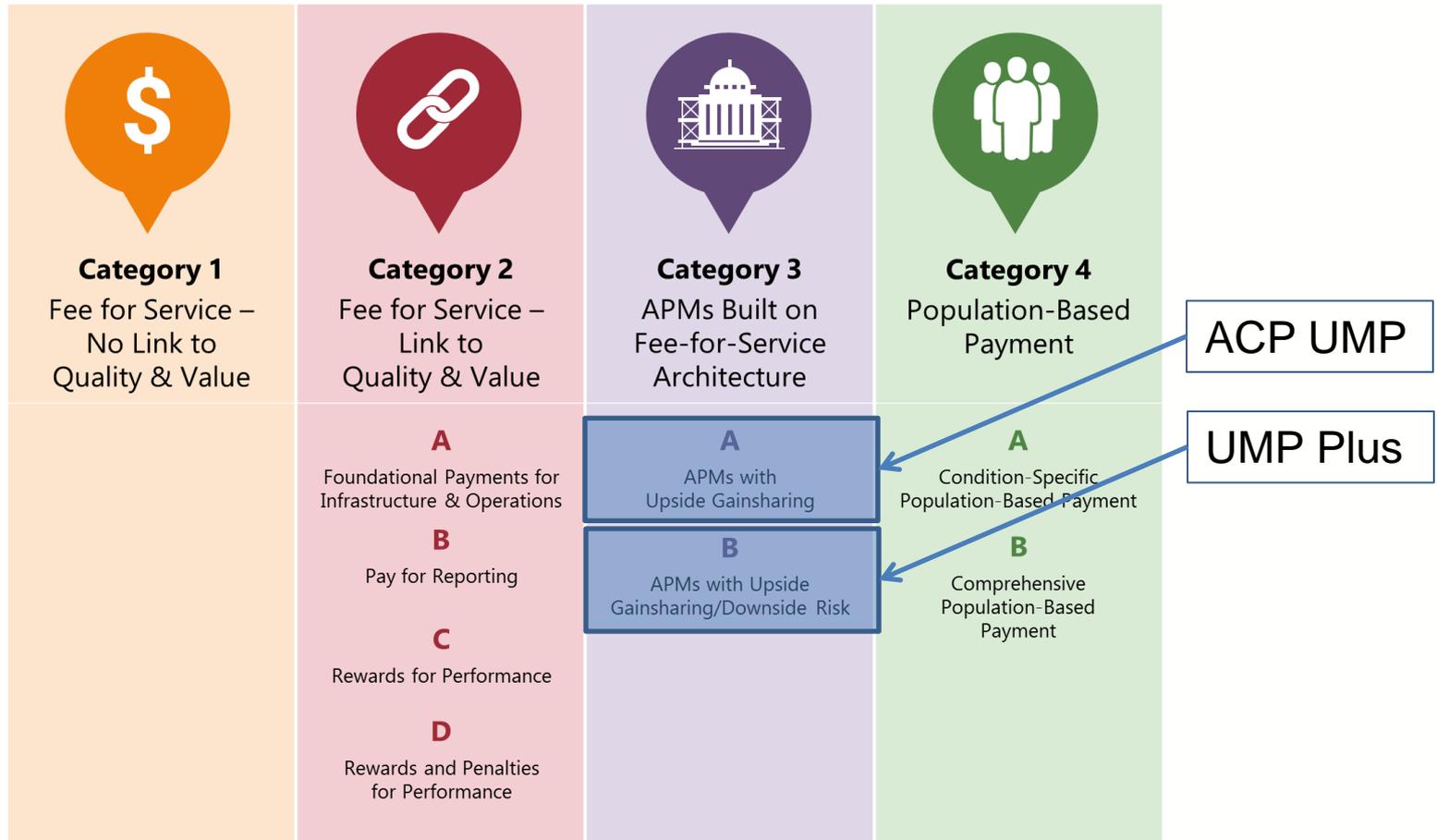


HCA Purchasing Goals

By 2019:

- 80% of state-financed health care & 50% of commercial health care will be in value-based payment arrangements (measured at the provider level)
- Washington's annual health care cost growth will be 2% less than the national health expenditure trend

CMS Alternative Payment Model Framework



Public Employee Benefits Overview

- 1 Uniform Medical Plan (UMP) Classic
- 2 Managed Care Organizations
 - Group Health and Kaiser Permanente
- 3 Benefit Design or Plan Types before ACP
 - Classic, Value, and Consumer Directed Health Plan (CDHP) with a Health Savings Account
- For 2016 HCA added the UMP Plus benefit plan design for ACP and Group Health added SoundChoice.

ACP Overview

- UMP Plus Differences from UMP Classic
 - Narrow(er) networks (PSHVN, UWMedACN)
 - Work directly with provider systems
 - Designated population (upside/downside risk)
 - Lower Cost Sharing
- Impacts on UMP Classic and UMP CDHP
 - Attributed population (upside risk)
 - Nested within our Self-Insured administrator

UMP Plus - Overview

Goals

- Improved patient experience
- Integrated “head and body” care
- Financial and clinical accountability

2016 Partners

- UW Medicine Accountable Care Network
- Puget Sound High Value Network LLC

2017

- Expand statewide
- Recruit more employers and purchasers to join and implement approach

Currently available to public employees in Puget Sound region

Financial Model Overview

- Built on shared-risked foundation of bending the cost curve (reducing trend) while increasing quality of care.
- Rewards high-quality care provided by the networks, and provides incentive payments based on the achievement of savings in excess of the targeted cost reduction.
- Networks have financial risk should quality of care diminish or if financial targets are not achieved.
- Sections in ACP Contract:
 - Section 2.7 – Financial Approach and Guarantees
 - Section 2.8 – Compensation and Payment
 - Exhibit 3 Series - Finance
 - Exhibit 5 – Quality Achievement Measurement Program

How it Works

- Performance incentives and penalties tied to measureable improvements (or lack thereof) for costs, quality, member experience, and clinical outcomes.
- Attributed vs. Designated (Section 2.7):
 - Passive (ACP) vs. Active enrollment (UMP Plus)
 - Separate financial reconciliation for each cohort.
 - Upside for attributed population
 - Upside/downside for designated population

Trend (Savings) Guarantee

- Annual Trend (Savings) Guarantee (Exhibit 3.3(2)):
 - Negotiated with Networks (proprietary)
 - Cumulative year over year
 - A component of Target Cost PMPM
 - Relative to the Benchmark Trend

<i>Example Contractor Annual Trend Guarantee Rates</i>		
	Designated Cohort	Attributed Cohort
2015	Adj. Base Cost PMPM	Adj. Base Cost PMPM
2016	-2%	-2%
2017	-3%	-3%
2018	-4%	-4%
2019	-5%	-5%

Target Cost Development

- Annual Trend Guarantee Rate is only one component of Target Cost
- Other components included:
 - Base Year 2015 Considered Costs
 - Concurrent Risk Scores
 - Base Year and Performance Year
 - Attributed, Designated and Benchmark Cohorts
 - Benchmark Trend from Base Year to Performance Year

Deficit Reduction Factors

- Performance Criteria (Section 2.8(a)), such as:
 - After-hours access
 - Contact center performance
 - EHR adoption and use
- Net deficit reduction for late delivery of data/reports (Exhibit 3.1)
- Quality Model (Exhibit 5)

Quality Model

- Rewards achievement and improvement through greater savings and lower deficits.
- Quality Achievement Measurement Program (Exhibit 5)
 - Quality Improvement Score (QIS) is calculated based on 19 quality measures
 - Subset of the [Statewide Common Measure Set](#)
 - QIS may reduce either the savings share or the deficit share

Quality Model

- 19 quality measures that impact the net savings/overages.
 - Clinical/claims (15), CG-CAHPS scores (4)
 - Most measure targets are at the 90th percentile

1-Diabetes patients with A1C>9.0%	Diabetes patients with BP>140/90	Diabetes patients with eye exam
HTN patients with BP>140/90	CAD Statin prescribed	CAD Statin adherence
Depression Medication Management (12 Weeks)	Depression Medication Management (6 Months)	Member satisfaction with Timely Care (always)
Member satisfaction with Provider Communication (always)	Member satisfaction with Office Staff (always)	Member satisfaction with Overall Provider Rating (9/10)
Adult BMI Measurement	Immunization (child - Combo 10)	Cervical Cancer Screening
Chlamydia Screening	Breast Cancer Screening	Colorectal Cancer Screening
1-NTSV C-Section		

Financial Model Hypothetical

For the second performance year of the attributed population assume:

- Benchmark 2-yr Trend Standardized for Risk: 16%
- Attributed Cohort Assumptions:
 - Base Year Risk Score: 1.650
 - Performance Year Risk Score: 1.810
 - Base Year Cost PMPM: \$500

- Target Cost:

$$\$500 \times \frac{1.810}{1.650} \times (1.161) \times ((0.98) \times (0.97))$$

- Quality Model Result: 50% Savings Share

Financial Model Hypothetical cont.

Savings: Actual Cost is less than Target Cost

Deficit: Actual Cost is more than Target Cost

- Attributed Population does not need to consider deficits
- Target Cost = \$605
- Actual Cost Scenario 1 = \$575
 - Savings = \$30
 - Savings Payment = \$15
- Actual Cost Scenario 2 = \$501
 - Savings = \$104
 - Savings Payment = \$52

Financial Model Hypothetical 2

Variable	Formula	2016 (deficit)	2017 (savings)
Unadjusted Base Cost PMPM	A	\$500.00	\$500.00
Base Year Risk Score	B	1.00	1.00
Performance Year Risk Score	C	1.05	1.10
Ratio of Performance to Base Year Risk Score	$D = C/B$	1.05	1.10
Adjusted Base Cost PMPM	$E = A \times D$	\$525.00	\$550.00
Benchmark Trend Rates (Cumulative)	F	1.075 (7.5%)	1.161 (8%)
Annual Trend Guarantee Rates (Cml.)	G	0.9800 (2%)	0.9506 (5%)
Benchmark and Trend Guarantee Rates (Cml.)	$H = F \times G$	1.0535	1.1036
Target Cost PMPM	$I = E \times H$	\$553.08	\$607.00
Considered Amounts PMPM	J	\$560.00	\$570.00
Gross Savings/(Gross Deficit) PMPM	$K = I - J$	(\$6.92)	\$37.00
Savings Share	L	25%	25%
Net Savings PMPM	$M = \text{if } K > 0 \text{ then } K \times L, \text{ otherwise } 0$	n/a	\$9.25
Deficit Share	N	40%	40%
Gross Deficit PMPM	$M = \text{if } K < 0 \text{ then } K \times N, \text{ otherwise } 0$	(\$2.77)	n/a

Milliman's Perspective

- Ben Diederich, Consulting Actuary

Actuary's Role in the Process

- Advising during the negotiations for the evolution of the financial structure
- Calculation of the technical components of the financial reconciliation
- Ensure the results are sound
- Adjust for differences between public purchasers and commercial purchasing strategies

Technical Details for Consideration

- A retrospective settlement for a savings/deficit payment is different from prospective risk
- Relies upon the third party administrator(s) for unit cost contracting with the network partners
- The future performance of the peer group or benchmark is both beneficial and unknown
- Adjustment of Allowed Costs to Considered Amounts can reflect conditions, provider types, procedure types or stop loss for claimants.

Employee Contributions

- Health Care Authority calculates the monthly state employee premium contributions on a risk standardized basis.
- Milliman assists in these calculations and is also needed to make considerations for selection of the new UMP Plus options
- Existing methodology allowed for the savings to be shared with Employees
- Initial observations are that UMP Plus attracted a healthier than average population

Enticements for Enrollment

- To encourage enrollment within UMP Plus HCA had two enticements:
 - Lower monthly employee contribution
 - Reduced Cost Sharing
- Milliman projects bid rate costs for setting the employee contributions
- HCA used the Federal Actuarial Value Calculator to estimate the reduced cost sharing

Other Observations for Risk Based Contracting

- Center for Medicare and Medicaid Services (CMS) releases Next Gen ACO Medicare arrangement
- Setting Prospective Cost Targets
- Retrospective Settlement for a Prospectively Attributed population
- Greater reliance on risk adjustment
- Alternatives to unit cost containment strategies

Employers: Shared Risk Contracting

- Ask your health plans how they measure value
- Add quality elements to contracts
- Ask your broker how the plans are implementing value-based purchasing
- Talk directly with providers and encourage them to engage in risk-bearing contracts

Available Resources

- [ACP Request for Application](#)
- Redacted HCA/ACP contracts:
 - [UWMedACN](#)
 - [PSHVN](#)
- Healthier Washington – ACP Contract Attachments and Exhibits [here](#).
- Paying for Value summary [here](#).
- Technical Assistance or 1:1 meetings with HCA staff is available upon request

Q&A

Thank You

Next Webinar is June 13th at 1PM and will focus on *Value-Based Benefit Design*

For more information, please contact:

Cade H. Walker
Health Care Authority
cade.walker@hca.wa.gov
(360)725-0855