Memo

Date: January 17, 2013
To: Marie Zimmerman
From: Mike Schoeberl

Subject: Payment Model Overview

The following document has been developed by Forma Actuarial Consulting Services, LLC (Forma ACS) in support of the DHS Health Care Delivery System (HCDS) Demonstration Project and the development of the January 31, 2013 Request for Proposals (RFP).

Overview

The payment model for the HCDS Demonstration involves the calculation of risk-adjusted total cost of care (TCOC) target for the HCDS’ attributed population, which is compared to the similarly calculated result for each measurement period. Calculation of the TCOC target and performance results involves several analytic processes, which are outlined in the paragraph below and described in additional detail throughout this document.

At the highest level, determining Risk-Adjusted TCOC metrics involves the development and application of member attribution algorithms, determining the relative risk for the attributed member populations and calculating the TCOC claim cost for these members, net of services excluded from the TCOC calculation. In determining the Target TCOC, a claim cost trend factor is also applied.

At the end of the performance period, the attributed population is reassessed to adjust the base period population for departing and newly attributed members, along with the change in relative risk for the population and the TCOC for the performance period. In summary, the performance measurement process consists of multiple applications of the attribution, risk adjustment and TCOC calculation processes. Below, please find additional detail around each of these key components and a more detailed description of the payment model components and anticipated timing.

Attribution

Developing a credible and defensible attribution methodology was critical to the success of the Demonstration. The ultimate methodology needed to assure providers that the majority of their
attributed patients have been assigned appropriately, and that they are not absorbing risk for a large number of patients where they have little opportunity for control within the system. The process must balance these needs, with the overall program-wide incentive of encouraging responsibility for all patients, regardless of attribution, and assuring responsibility across the HCDSs spectrum of care (primary care, hospital, specialist network). In short, the process must balance the need for equitable attribution, with the goals of encouraging and rewarding responsibility and system-wide care integration.

Prior to the launch of the actuarial contract, DHS worked with the University of Minnesota on the development of the attribution methodology. For reference purposes, a graphic describing the core steps of the attribution process is shown below:

DHS refined the attribution process during the contract negotiations with the initial set of HCDS procurement responders in 2012, through reviews of potential attribution options and discussions with the HCDS’. Below, please find a description of the attribution process, along with general estimates of the percentage of members impacted at each step of the process. For purposes of understanding the percentages, the base number represents the number of unique members who incurred any claim at one of the physicians associated with the HCDS’s.

**Member Pool Identification** – To be eligible for attribution to a HCDS, a member needs to have an Evaluation and Management (E&M) or Health Care Home claim at some point during the performance period. Typically, about 95-97% of members who incurred a claim at the physicians associated with the HCDS incurred a HCH claim or E&M visit at some point in the year (not necessarily at the HCDS). In addition to the specific codes related to Health Care Home services, the procedure codes used to define attribution in the Medicare Shared Savings Model are used to determine HCDS attribution, along with procedure codes representing preventive and well child services. A large portion of the members are

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1 The base number used to calculate the percentages represents the number of members who incurred any professional claim at the physicians on the HCDS’ provider rosters. The percentages should allow prospective HCDS’ to develop a reasonable estimate of the number of potential attributed members based on the estimated number of Medicaid members treated by their physicians, although significant differences from the above percentages could potentially occur for an individual prospective HCDS.

removed from attribution consideration due to enrollment characteristics such as Medicare eligibility or enrollment in partial benefit programs such as the Family Planning Program or Emergency Medical Assistance (around 12-18% of the potential members, depending on the HCDS). An additional 7-10% of members are removed from attribution consideration due to limited enrollment duration, including fewer than six months of continuous enrollment or fewer than nine months of non-continuous enrollment.

**Attribution Decisions** – At each stage of the attribution process, the number of each member’s attribution eligible procedures are calculated to determine whether or not the member can be attributed to an HCDS. In general, if a member has all their attribution eligible procedures occurring at one HCDS, the member is attributed to that HCDS. If a member has attribution eligible procedures at multiple HCDS’ or if there are attribution eligible procedures at providers who are not part of any HCDS, the member may be attributed based on the relative number and timing of visits occurring at the participating HCDS’ (i.e. attribution is based on highest number of visits or “plurality” at a provider system versus the majority of visits). The general details around these determinations are outlined below:

- All attribution eligible visits occurring at a HCDS’ providers are combined for purposes of determining the number of visits at the HCDS. For example, if a member has a single visit at two different PCPs within the same HCDS, the member had two visits counted for that HCDS.
- The providers associated with each HCDS are based on provider rosters submitted by each HCDS to DHS. The providers’ PCP or specialist designations are based on the taxonomy codes submitted to DHS with the provider rosters, but can be modified by the HCDS where requested. HCDS’ are also required to submit lists of tax identifiers for purposes of assuring that attribution eligible claims actually represent claims that resulted in payment to the HCDS (as opposed to payments outside the system due to the movement or part-time employment status of a provider).
- In determining number of HCH visits, the visits are not differentiated by provider type (PCP vs. specialist). For Steps 2 and 3, the number of E&M visits occurring at the HCDS’ PCPs and specialists are calculated separately. Services at providers that are not associated with any HCDS are grouped by provider and are not differentiated between PCP and specialist.
- **Step 1: Health Care Home Attribution** – Members who have one or more HCH claims are either attributed to a participating HCDS at this step or are removed from the attribution process if they cannot be attributed. Members with HCH claims at only one HCDS are attributed to that HCDS. Members who have HCH claims at more than one HCDS or HCH claims at providers outside all the participating HCDS’ are attributed to the HCDS with the largest number of HCH claims or removed from the attribution process if the largest number of HCH claims occurred at a provider outside the HCDS’. If there are equal numbers of HCH claims at multiple entities, the member is assigned to the HCDS with the most recent claim date or removed from the attribution process if the claim with the most recent date occurred at a “tying” provider outside the HCDS’. Based on a review of the 2011 claims data, very few members were attributed to a HCDS at this step (0-1%), due to the limited number of HCH claims currently being submitted by providers.
- **Step 2: PCP E&M Attribution** – As before, members with PCP E&M claims at only one HCDS are attributed to that HCDS. Members who have PCP E&M claims at more than one HCDS or E&M claims at providers outside the participating HCDS’ are attributed to the HCDS with the largest number of PCP E&M claims or removed from the attribution process if the largest number of E&M claims occurred at any provider outside the HCDS’, regardless of practice specialty. Attribution decisions for the majority of members incurring professional claims at the HCDS’ occur at this...
step, with about 30-40% of the HCDS’ base membership ultimately being attributed to the HCDS. Unlike members with HCH claims, members with E&M claims at HCDS PCPs who cannot be attributed at Step 2 may be attributed to a HCDS in subsequent steps.

- **Step 3: Specialist Attribution** – If an attribution determination cannot be made during the first two steps of the attribution process and the member has claims at HCDS specialists, the member may be attributed to a HCDS based on the number of specialist visits. Members who were not attributed or removed from the attribution can be attributed to a HCDS if there are a greater number of E&M visits at the HCDS specialists than at any other HCDS or provider outside all the HCDS’. Based on a review of the 2011 claims data, very few members are attributed to a HCDS at this step (0-2%), primarily due to the small numbers of specialists included in the rosters of the participating HCDS’.

- **Allocation of “Ties”** – Subsequent to Step 3, the only remaining members who could potentially be attributable to a HCDS are those who have the same number of E&M visits at the PCP level with multiple HCDS’ (or the same number of visits at a HCDS and a provider outside the HCDS’). These remaining members are allocated to an HCDS where their most recent E&M claim occurred, or remain unattributed if the most recent visit occurred outside all HCDS’. An additional 2-5% of the base membership is attributed the HCDS’ at this step.

**Total Cost of Care**

The core set of services included in the Total Cost of Care (TCOC) are similar to the at-risk services for the participating managed care organizations. In general, the categories of included and excluded claims are based on DHS’ service category definitions, with all services falling into the detailed service categories (e.g. anesthesia) included or excluded from the TCOC calculation. An HCDS can propose to include additional services to their TCOC calculation that are excluded from the core set. The programmatic goal for services selected for the TCOC core set is to ensure the broadest provider participation. The general service categories included in the TCOC are shown below:

- a. Physician services
- b. Nurse midwife services
- c. Nurse practitioner services
- d. Child & Teen Check-up services
- e. Public health nurse services
- f. Rural Health Clinic services
- g. FQHC services
- h. Laboratory
- i. Radiology
- j. Chiropractic services
- k. Pharmacy
- l. Vision services
- m. Podiatry
- n. Physical therapy
- o. Speech therapy
- p. Occupational therapy
- q. Audiology
- r. Mental health services
- s. Chemical dependency services
- t. Outpatient hospital services
- u. Ambulatory surgical center services
- v. Inpatient hospital services
- w. Anesthesia
- x. Hospice
- y. Private Duty Nursing
- z. Home health (non-Personal Care Assistance)

Long-term care and waiver services represent the largest portion of services excluded from the TCOC. In addition, the TCOC excludes the majority of services for dental, DME, transportation, foster care and child welfare case management. Mental health and chemical dependency services that are primarily intensive and residential are excluded from the TCOC core set, as well. In total, an estimated 35-45% of the incurred claims for attributed members were excluded from the TCOC for the initial participating HCDS’.
Risk Adjustment

DHS developed the risk-adjustment methodology based on the Johns Hopkins ACG risk-adjustment tool. The use of ACGs allows for alignment with the current risk-adjustment processes currently employed by DHS and provides the necessary analytic flexibility to develop reasonable risk scores for the Medicaid population.

While some risk-adjustment methodologies develop customized scores for each member in the population based on the cumulative impact of each piece of diagnostic information, ACGs assign each member to a finite set of risk classifications based on their expected resource needs. During the ACG risk-adjustment process, members are assigned to one of 94 risk-adjustment categories based on their diagnostic information, age and gender. For each category, an average expected cost is calculated based on the total claims incurred by members assigned to the category. These expected costs can be normalized to relative risk scores (expected cost vs. average cost across the entire population) to reflect the expected relative resource use of a member relative to a factor of 1.00. In determining the aggregate risk for a population, the expected costs (or normalized scores) for all members in the population are combined. For purposes of this discussion, the term “risk score” or “weight” refers to the expected cost or normalized score for the individual or aggregate population, while the members’ risk category refers to the ACG category assignment used to develop the risk score. Although the grouping methodology results in fewer potential risk scores for members, the explanatory power for ACGs is reasonably similar to that of other models, and the ability to recalibrate risk weights for different populations and analytic options (e.g. developing weights by capping catastrophic claims at different thresholds) provides many advantages to the development and execution of the HCDS payment model.

Based on the results of the analyses developed in support of the Demonstration, the risk-adjustment process used for the Demonstration will likely be based on separate risk weights (scores) for the Managed Care and FFS members, due to the inherent risk differences in these populations. In addition to developing weights based exclusively on the services included in the TCOC, separate sets of weights will be developed using the pre-determined claim caps to adjust the weights and reduce the impact of catastrophic cases ($200,000 or $500,000), with the weight level determined based on the size of the HCDS population as specified in the RFP. The experience for members who are excluded from the attribution process due to enrollment type or duration (e.g. Dual-eligible members or members with less than six months of enrollment) will be excluded from the weight development process.
Trend

At the highest level, medical trend expectations for a population are typically developed based on the combined impact of multiple trend components, including:

- **Unit cost trend** – The average expected increases or decreases in provider reimbursement. In practice, this trend often reflects changes in both the cost per service and the service mix (relative changes in the intensity of the average service).
- **Service utilization** – The anticipated increase or decrease in the number of services consumed by a risk-neutral population. In practice, anticipated changes in demographics are sometimes incorporated into this trend component to reflect the anticipated utilization differences due to changes in membership.
- **Demographic changes** – The anticipated impact of population-based factors that could impact the observed cost for the “average member.” These can include anticipated shifts in the average age or illness burden of a population or the change in the distribution of plan enrollment in a multiple plan environment.
- **Benefit changes** – The expected impact on paid medical cost of any scheduled benefit changes. These trend adjustments may be used to reflect the impact of changes in member cost share provisions or the expected elimination or addition of certain types of covered services. In practice, the expected impact of benefit changes is often integrated into the unit cost or service utilization trends.
- **Other** – Numerous other components can be incorporated into trend projections, including estimates for the impact of network changes, environmental factors, anticipated savings or other factors that reflect changes in the population health or the dynamics of accessing services. It is important to note that many of these factors impact one of the basic trend components outlined above (e.g. narrowing the network can drive changes in both the utilization and cost of services), so it is important not to “double count” the impact of changes and effectively isolate the impact of the each trend component.

In developing the trends for the payment model TCOC targets, it is appropriate to base the unit cost and service utilization trend components on the expected component increases for the Medical Assistance (MA) and MinnesotaCare programs. It is also reasonable to integrate the expected value of benefit changes, along with any anticipated global adjustments to provider reimbursement, provided they are not already included in the unit cost trend expectations.

The trends used to develop the targets are not expected to contain any specific adjustments to reflect the cost impact of enhanced medical management by the HCDS’. Because DHS has not established a minimum savings target (beyond the gain/loss share thresholds established for purposes of reflecting expected performance variability), the savings resulting from enhanced medical management by the HCDS should be eligible for the shared savings distribution. However, it is reasonable to assume that where specific reductions are integrated into the overall program trends to reflect assumed care enhancement savings (or costs) across the population, these trend estimates could potentially be integrated into the target calculation.
In addition, it is important to exclude the trend components that will be reflected in the payment model performance calculation process. For example, the potential trend impact of certain demographic changes (age and illness burden) would be reflected through the risk-adjustment process. On the other hand, the process should recognize the impact of macro population changes that may not be included in the risk-adjustment process. For example, if there exist differential cost, utilization and benefit change expectations between the MinnesotaCare and MA participants, the relative percentage of these members in a HCDS’ population will be reflected in the aggregate trend expectations for the participating HCDS’.

In setting the MA and MinnesotaCare trends for the HCDS payment model, Forma ACS and DHS are currently using the cost and utilization trend expectations developed by DHS’ actuarial consultant (Milliman). Milliman integrates demographically adjusted experience data, benchmark information, smoothing techniques and the judgment of the certifying actuary into the development of the utilization and unit cost trends. Additional factors are included in the trend calculation process (benefit adjustments, provider rate changes) as needed, which may or may not be relevant to the trend projection for the Demonstration, per the above discussion. As methodological changes are integrated into the MCO trend development and rate setting process over time, these will be reviewed to assure that the resulting cost and utilization trends continue to align with the goals of the Demonstration.

**Target and Settlement Components and Schedule**

To help clarify how trend will be integrated into the target setting and settlement, the proposed schedule for the initial payment model is shown below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Runout</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Yr 1 Base Performance Year</td>
<td>2 to 4 mo. runout</td>
</tr>
<tr>
<td></td>
<td>Yr 1 Measurement Year</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Interim Yr 1 Target</td>
<td>2 to 4 mo. runout</td>
</tr>
<tr>
<td></td>
<td>Final Yr 1 Target</td>
<td>14 to 16 mo. runout</td>
</tr>
<tr>
<td>2015</td>
<td>Interim Yr 1 Settlement Year</td>
<td>2 to 4 mo. runout</td>
</tr>
<tr>
<td></td>
<td>Final Yr 1 Settlement Year</td>
<td>14 to 16 mo. runout</td>
</tr>
<tr>
<td>2016</td>
<td>Yr 1 Final Settlement Year</td>
<td></td>
</tr>
</tbody>
</table>

As the payment model demonstrates, the Interim Year 1 Targets would be developed in 2014, using the calendar year 2013 attributed population and claims experience as the base performance TCOC calculation. Because of the proposed timing, the payment model trends will be developed in early 2014. Below, please find a general overview of the performance calculation process.

- **Base Period Assigned Population**: DHS will attribute patients to an HCDS using retrospective fee-for-service claim and MCO encounter data available to DHS (i.e. 2013 claim and encounter data will be used for the initial year of the contract) and the attribution process as described in this RFP.

- **Base Period Total Cost of Care (Base TCOC)**: DHS will calculate the retrospective per member per month (PMPM) total cost of care for the base period assigned population. The Base TCOC will be based on the services as outlined in the RFP, reflecting any jointly pre-negotiated exceptions or
inclusions. Claims for an individual member that fall outside of pre-determined thresholds will be capped to adjust the PMPM results for “catastrophic cases.”

c. Base Period Risk Score: Based on the services included in the Base TCOC, a risk-score will be developed for the assigned members to reflect the relative risk of the population. In addition to developing weights based exclusively on the services included in the Base TCOC, the weights will be developed using the pre-determined claim caps to adjust the weights and reduce the impact of catastrophic cases.

d. Expected Trend: DHS will develop an expected trend rate for the total cost of care based on the same trend rates used to develop the annual expected cost increases for the aggregate MHCP population, with appropriate adjustments for services excluded from the Base TCOC or other factors that are applicable to the total cost of care and goals of the program.

e. Target Total Cost of Care (Target TCOC): Based on the Base TCOC and the expected trend, the Target TCOC PMPM for the upcoming year (Performance Period) will be developed.

f. Performance Period Assigned Population: At the end of the performance period, DHS will assign additional patients to (or remove members from) the HCDS’ assigned population using retrospective claims data and the attribution process as described in the RFP.

g. Performance Period Total Cost of Care (Performance TCOC): At the end of the performance period, the total cost of care PMPM for the performance period assigned population will be calculated by DHS. Claims for an individual member that fall outside of pre-determined thresholds will be capped to adjust the PMPM results for catastrophic cases.

h. Performance Period Risk Score: Based on the services included in the total cost of care, a risk score will be developed for the performance period’s assigned population to reflect their relative risk.

i. Adjusted Target Total Cost of Care (Adj. Target TCOC): The Target TCOC will be adjusted based on the increase or decrease in the risk of the attributed populations (i.e. the change in the population risk from the base period to the performance period).

j. The Adj. Target TCOC will be compared to the Performance TCOC for purposes of determining the performance results and the basis for any financial settlement.

To balance the needs of providing timely performance information and payment settlements to the HCDS, with the need to integrate sufficient claims run-out into the calculation process, the payment model has been developed using “interim” and “final” targets and settlement amounts. Further detail around the anticipated timing of these payment amounts is included in the sample contract accompanying the RFP.