Alabama Coordinated Health Network (ACHN)

Thursday, September 19, 2019 -- The webinar will begin at 12:00 p.m. CST

Cost Effectiveness in
the ACHN Program

Attention!

Please MUTE your <u>phone</u> and <u>computer microphone</u>!

- You will not hear any sound until the webinar begins.

- Use the <u>Chat Box</u> function to type in questions.

- Questions will be answered at the end of the webinar.

Alabama Coordinated Health Network:

Cost Effectiveness in the ACHN Program

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Alabama Medicaid Agency

Attribution Overview

- Attribution is the process that will be used to associate a Medicaid recipient to the PCP Group that provides primary care to that recipient.

  o PCP Groups must sign the two agreements (one with Medicaid, one with an ACHN entity) to participate.

- Under the ACHN Program, Medicaid recipients will be attributed to PCP Groups based on historical claims data utilization.

- PCPs are encouraged to continue seeing patients, as medically necessary, on a consistent basis to increase the likelihood of attribution.

- Attribution is a critical factor in determining distribution of bonus payments among eligible providers.

- Attribution will replace panel assignments. Under ACHN, the Patient 1st program ceases to exist and capitation payments will no longer be paid.

  o A smaller number of attributed members compared to members in the previous panel does not necessarily equate to a reduced payment.

Attribution Rule: Alabama Medicaid Administrative Code Rule 560-X-37-.09

Key Steps in Attribution

- Medicaid recipients that have met criteria for the ACHN Program for three out of the previous 24 months will be attributed. This does not have to be a continuous period.

- The previous two-year history of face-to-face provider visits:
  - Both preventive visits and regular office visits are scored.
  - Preventive visits receive a higher point value.
  - Recent visits are scored higher than older visits.
  - PCP visits receive a higher point value than specialist visits.

- The previous 12-month history of filled prescriptions for chronic care conditions are scored.

Attribution Process

On a quarterly basis, the Medicaid Agency will determine attribution for each Medicaid recipient under the ACHN Program in accordance to the following process:

- Point values for face-to-face visits will be assigned to the individual provider that performed the service.

- The individual PCP scores will be combined to form the PCP Group's total point score for each patient.

- The PCP Group with the highest number of points will have the Medicaid recipient attributed to that PCP Group.

  o If a specialist group has the highest number of points, then the specialist group will be attributed the Medicaid recipient; however, a specialist group shall not be eligible to receive the bonus payments.

Guiding Principles for Cost Effectiveness

- Consistency with ACHN's principles of paying for activity with a focus on preventative care and health outcomes.

- Acknowledgement that risk levels vary across practices.

- Adherence to commonly-accepted, validated risk-adjustment methodologies.

- Evaluation of activities at the group level.

Cost Effectiveness Overview

- All participating PCP groups will be eligible for a performance payment if the PCP group meets or exceeds the cost effectiveness criteria established by Medicaid.
- Medicaid will utilize Milliman Advanced Risk Adjusters (MARA) software to assess the cost risks of the ACHN population and apply a customized algorithm to calculate a Cost Effectiveness score for each participating PCP group.
- To qualify for the Cost Effectiveness bonus, PCP groups must have a score less than or equal to the statewide median Cost Effectiveness score.
- Cost Effectiveness scores incorporate the following:
  1. Overall risk of a PCP group's attributed recipients;
  2. Overall per member per month (PMPM) cost of a PCP group's attributed recipients; and
  3. Overall PMPM cost of the statewide attributed ACHN population.
- Actual PMPM costs are compared to risk-adjusted, expected PMPM costs to determine a PCP group score.

MARA Risk Scoring

- Risk scores are standardized metrics used to evaluate a member's previous health experience and/or to predict health outcomes.
- Medicaid utilizes software developed by MARA for these calculations. Several statistical models are employed for these processes.
- Some ACHN processes will incorporate Concurrent risk scoring methodology.
- Concurrent risk scores are used in cost effectiveness calculations.

- Concurrent risk scores assess members' health risks based on a previous year's claims information (including costs and diagnoses codes) and predict member costs for that same period.
- Concurrent risk scores are based on the claims information (i.e., 12 months), adjusted for the risk based on the actual experience of the attributed members over the measurement period.
- Claims information will include costs generated by inpatient, outpatient, ER, physician and other categories that will be taken into risk scoring determination.
- The average concurrent risk scores are calculated for a PCP group's attributed members and are considered the PCP group's risk score.

$$PCP\ Group's\ Concurrent\ Risk\ Score = \frac{Sum\ of\ the\ Concurrent\ Risk\ Scores}{Sum\ of\ members}$$

Paying for Cost Effectiveness

PCP Payment Structure

Quality Metric Performance

Cost Effectiveness

Patient-Centered Medical Home Activities

Impacted by attribution

Regional ACHN Participation Payment
Enhanced FFS Rate

Above payments are achievable if physician participates with regional ACHN entity

Base Fee-For-Service – Current FFS schedule for all physicians*
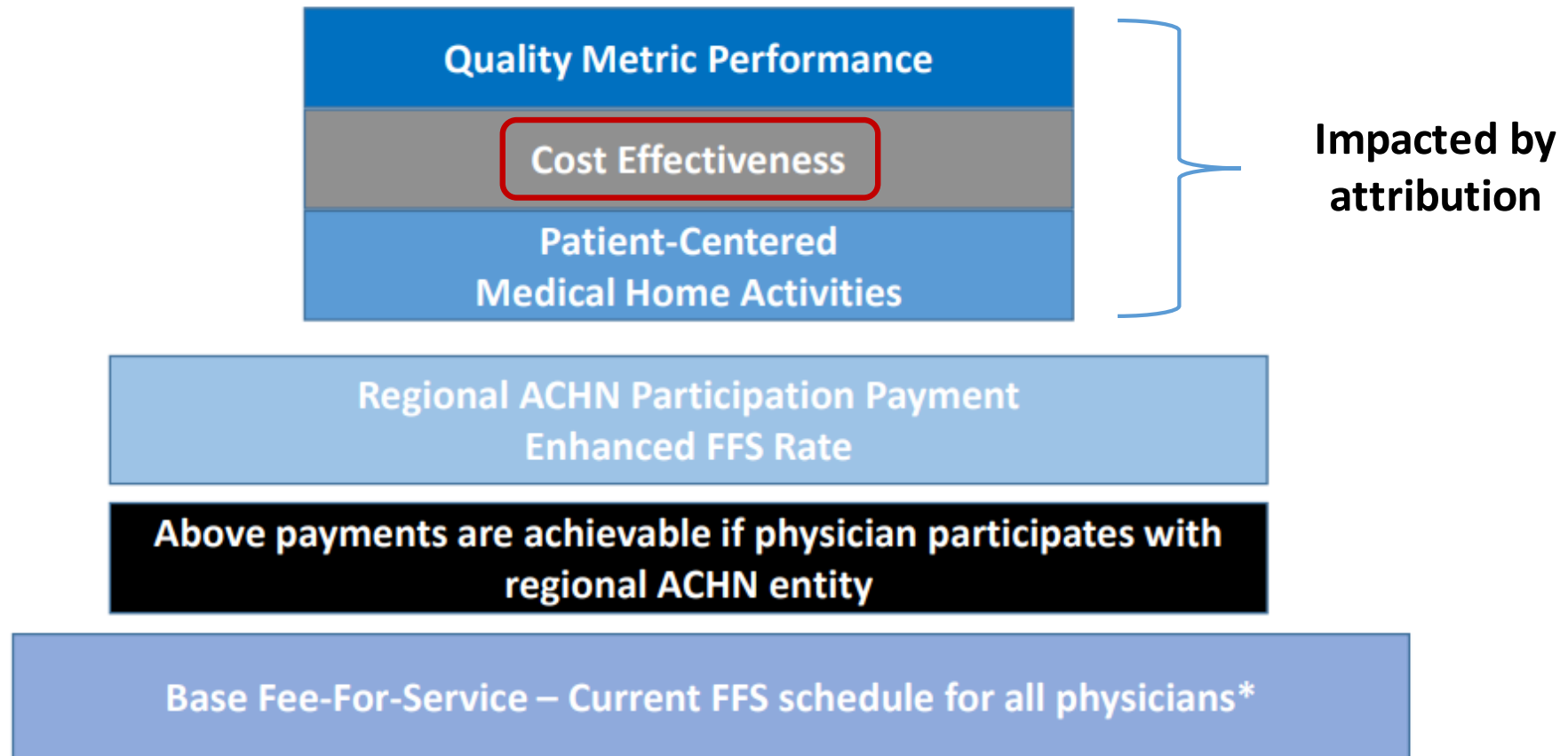
* Providers currently eligible for BUMP Payments will still be able to receive BUMP rates if they choose to not participate with the ACHN but will *NOT* be eligible for Participation Rates or Bonus Payments.

Bonus Payments

BONUS PAYMENTS

This is a Bonus pool in the amount of $15 million annually to fund three Bonus payments for Participating PCP groups.

The Bonus Payment pool is allotted as follows:
- 50% for Quality
- 45% for Cost Effectiveness
- 5% for PCMH Recognition

The first quarterly payment will be made on the first checkwrite in November 2019. Subsequent payments will be made on a quarterly basis beginning in January 2020.

PCP Bonus Payment Timeline

Base Timeline Model For Initial Calculated Payment	July-19	August-19	September-19	October-19	November-19	December-19	January-20	February-20	March-20	April-20	May-20	June-20	July-20	August-20	September-20	October-20	November-20	December-20	January-21	February-21	March-21	April-21	May-21	June-21	July-21	August-21	September-21
				Fall 2019			**Winter 2020**			**Spring 2020**			**Summer 2020**			**Fall 2020**			**Winter 2021**			**Spring 2021**			**Summer 2021**		
Patient Attribution			*Rolling 24 Month Lookback*																								
Quality							*Calendar Year w 6 Months Roll Out*																				
Cost Effectiveness				*12 Months Data w 3 Months Roll Out*																							
PCMH																											
				Data Source Month									*First Calculated Payment Date*														

Cost Effectiveness Bonus Distribution Process

- For the first 5 quarters, ACHN participating PCP groups will receive a Cost Effectiveness bonus payment based on the number of Medicaid recipients attributed to the PCP group for the prior quarterly period.
- PCPs are encouraged to see their patients to increase likelihood of attribution.
- After the first 5 quarters, PCP Groups will be eligible for a bonus payment if the PCP group meets or exceeds the Cost Effectiveness criteria established by the Agency. Payments will be distributed to each PCP group that has met criteria. The Cost Effectiveness Bonus calculation that will begin with the January 2021 payment is described below:
  - Based on actual Cost Effectiveness calculated for the period between October 1, 2019, and September 30, 2020, providing for a 3 month of claims payment run-out period.
  - Likewise, the quarterly payments made in April 2021 will be based on the actual cost effectiveness calculated for the period between January 1, 2020 and December 31, 2020.

Cost Effectiveness Bonus Determination Process

- Compares a 12-month per member per month (PMPM) to a <u>risk-adjusted</u> expected PMPM.
- Groups ranked by a Cost Effectiveness score that is derived from actual PMPM versus the expected PMPM.
- Bonus payment is paid for PCP groups at or below the median Cost Effectiveness score.
- Cost Effectiveness calculation includes a PMPM calculation for the state-wide attributed ACHN population.
    - o Cost Effectiveness calculation excludes certain costs (e.g., Network entity case management costs, other bonus payments, waiver costs, drug rebates, etc.).

ACHN PROVIDER GROUP COST EFFECTIVENESS BONUS PAYMENT EXAMPLE: GALLAGHER FAMILY PRACTICE

In this example, Total number of Attributed ACHN Members: 500,000

Quarterly Cost Effectiveness Bonus Payment Pool: $1,687,500

ACHN Provider Group: Gallagher Family Practice

→ **(a)** Members Attributed to the Gallagher Family Practice: **6,300**

→ **(b)** Distribution Rate of Attributed Members = Members attributed for group (6,300) / Total ACHN attributed members (500,000): **1.26%**

→ **(c)** PCP Group PMPM (Per Member Per Month): **$462**

→ **(e)** PCP Group Risk Score: **1.89**

(d) Statewide PMPM used to calculate the Expected PMPM: **$297**

(f) Expected PMPM = PCP Group Risk Score X Statewide PMPM: **$561**

(g) Cost Effectiveness Score= PCP Group PMPM / Expected PMPM: **0.82**

(h) At or below Median Cost Effectiveness Score (Median Threshold): **0.86**

(i) Yes, Eligible for Cost Effectiveness Bonus: **0.82**

No

This elimates attributed members in groups above median Cost Effectiveness score

(j) and (k) Distribution Rate of Attributed Members = Group's attributed members (6,300) / Attributed Members in Groups at or below Median Threshold (307,341): **2.05%**

→ **(l)** Bonus Distribution Rate = Member Distribution for PCP Group at or below Median Threshold: **2.05%**

→ **(m)** Bonus Distribution Amount = Bonus Distribution Rate (2.05%) X Quarterly Pool Amount ($1,687.5 M): **$34,591**

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EXAMPLE: GALLAGHER FAMILY PRACTICE

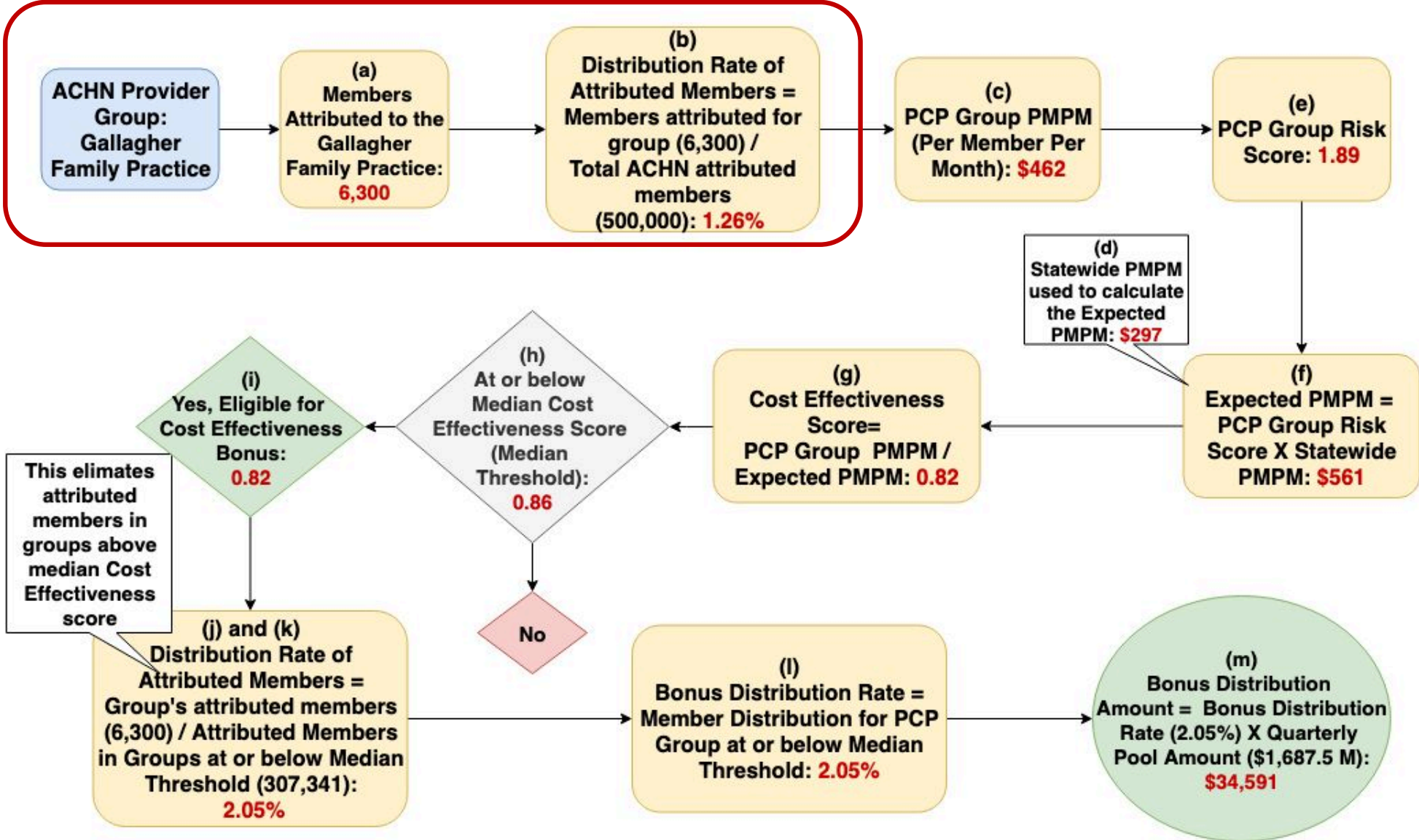In this example, Total number of Attributed ACHN Members: 500,000

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ACHN Provider Group Cost Effectiveness Bonus Payment Example, Continued

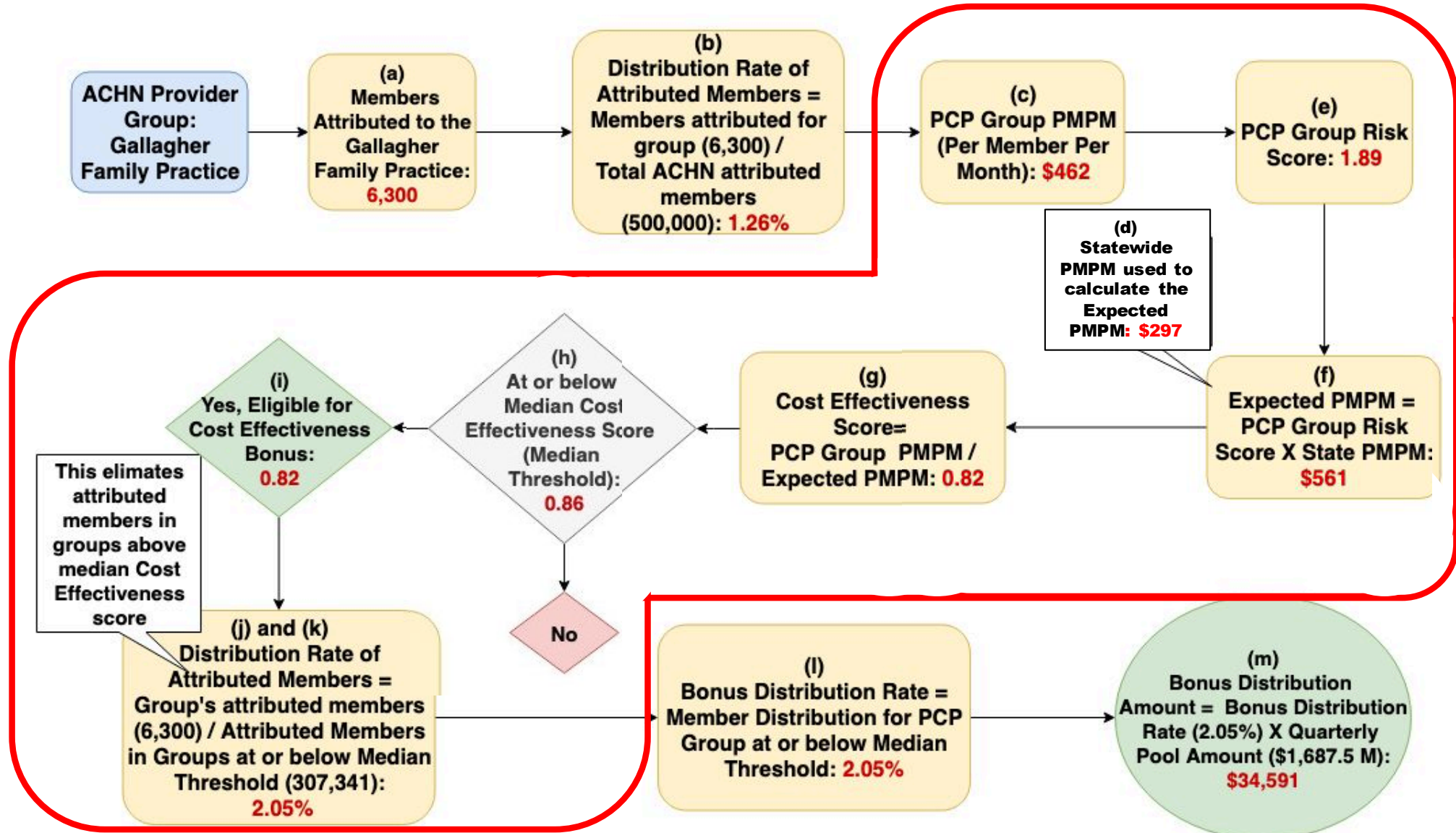| PCP Group	Member Attribution		Cost Effectiveness Score								Cost Effectiveness Bonus		
	Member Attribution	Distribution of Members	Group PMPM	Statewide PMPM	Group Risk Score	Expected PMPM = Group Risk Score* State PMPM	Cost Effectiveness Score = Group PMPM/Expected PMPM	Median Threshold (Median Cost Effectiveness Score)	At or Below Median Threshold?	Member Attribution for Groups at or below Median Threshold	Member Distribution for PCP Groups at or below Median Threshold	Bonus Distribution Rate	Bonus Distribution Amount
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3	68,480	13.70%	$300	$297	2.10	$624	0.48	0.86	Yes	68,480	22.28%	22.28%	$376,001
4	64,493	12.90%	$490	$297	1.18	$350	1.40	0.86	No		0.00%	0.00%	$0
5	14,071	2.81%	$475	$297	1.22	$362	1.31	0.86	No		0.00%	0.00%	$0
6	73,672	14.73%	$390	$297	1.52	$451	0.86	0.86	Yes	73,672	23.97%	23.97%	$404,507
7	38,110	7.62%	$410	$297	1.61	$478	0.86	0.86	Yes	38,110	12.40%	12.40%	$209,247
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9	72,467	14.49%	$400	$297	1.84	$546	0.73	0.86	Yes	72,467	23.58%	23.58%	$397,892
10	45,614	9.12%	$600	$297	1.11	$330	1.82	0.86	No		0.00%	0.00%	$0
Total	500,000	100.0%					0.86			307,341	100.0%	100.0%	$1,687,500

Methodology:

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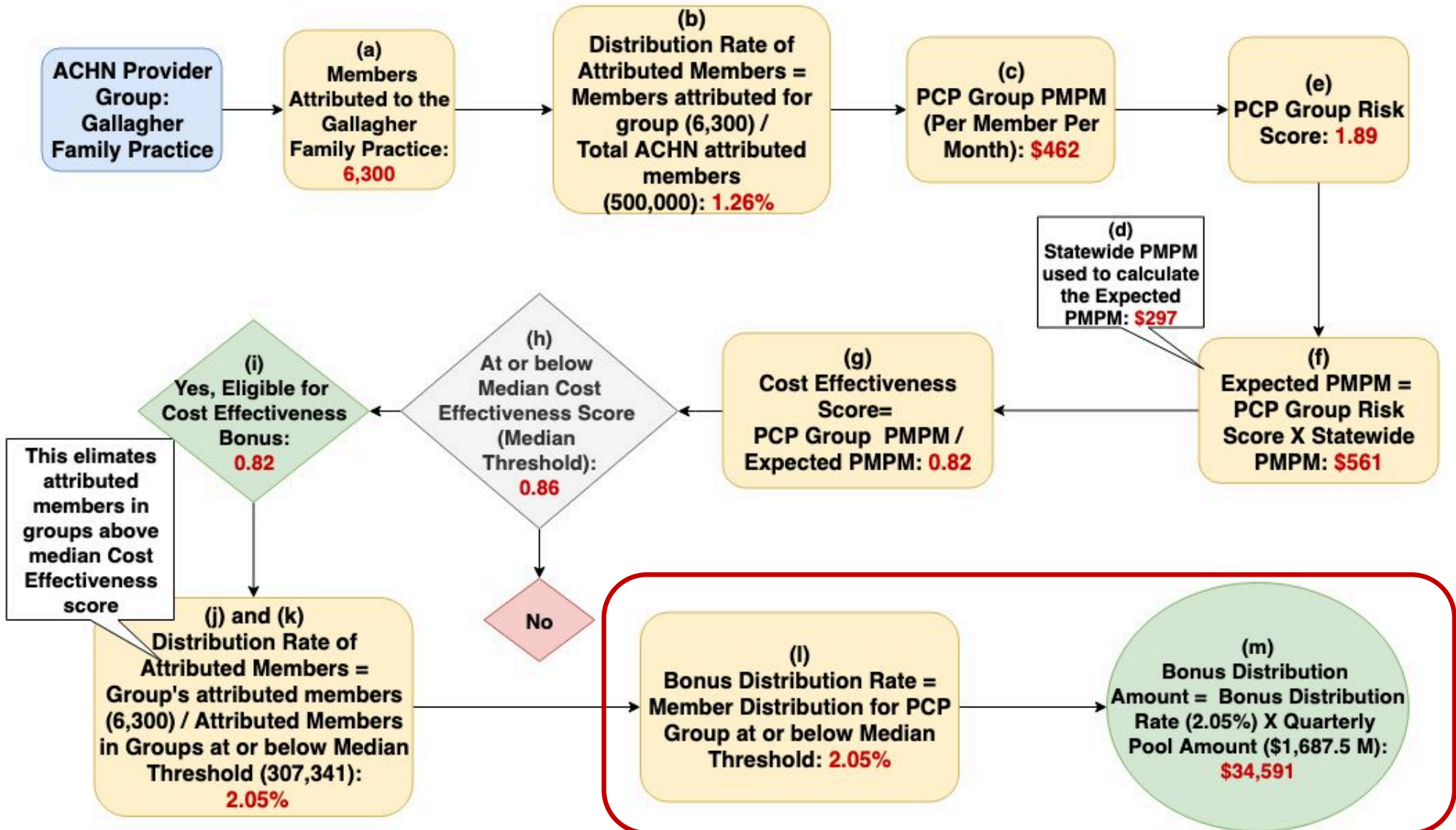| PCP Group	Member Attribution		Cost Effectiveness Score									Cost Effectiveness Bonus	
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Questions

- **Website: www.Medicaid.alabama.gov**
  https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx

- **Direct Link to Frequently Asked Questions:**
  https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.1_ACHN_FAQs.aspx

- **Submit questions for official response to:**
  ACHN@medicaid.alabama.gov