

# Health Enhancement Community Initiative

## Population Health Council: Finance Design Team

July 20, 2018  
9:00 – 10:30 a.m.  
WEBINAR

# Today's Objectives

- I. **Background:** Provide a brief overview of the Health Enhancement Community (HEC) Initiative to orient the Design Team
- II. **Feedback:** Obtain feedback on initial principles and parameters for:
  1. Geography
  2. Attribution
  3. Payment Model
  4. Funds Flow

## ROUND TABLE FEEDBACK

Will be using a **round table process** to obtain feedback. Please stay actively engaged throughout the webinar. Discussion items are noted in the upper right hand corner of relevant slides. Each participant is encouraged to comment.

*Example:*

Discussion  
Item

## Part I

# Background

Provide a brief overview of the Health Enhancement Community (HEC) Initiative to orient the Design Team

# Health Enhancement Community: Provisional Definition

**A Health Enhancement Community (HEC) is a cross-sector collaborative entity that:**

- Is accountable for reducing the prevalence and costs of select health conditions and increasing health equity in a defined geographic area
- Continually engages and involves community members and stakeholders to identify and implement multiple, interrelated, and cross-sector strategies that address the root causes of poor health, health inequity, and preventable costs
- Operates in an economic environment that is sustainable and rewards communities for health improvement by capturing the economic value of prevention

# HEC Functions

**HECs will need to have capabilities to perform functions that most community collaboratives have not had to do previously or as precisely before.**

## **HECs will need to:**

1. Implement interventions that can achieve and demonstrate reduced prevalence and costs and improved outcomes
2. Coordinate, manage, and monitor multi-pronged strategies and interrelated programmatic, systems, policy, and cultural norm activities among multiple cross-sector partners
3. Use data to manage and report on defined performance measures
4. Manage risks
5. Govern and distribute implementation funds and financing

# Potential Variation in HECs' Geographic Configurations

## EXAMPLE 1

Existing Community Collaborative



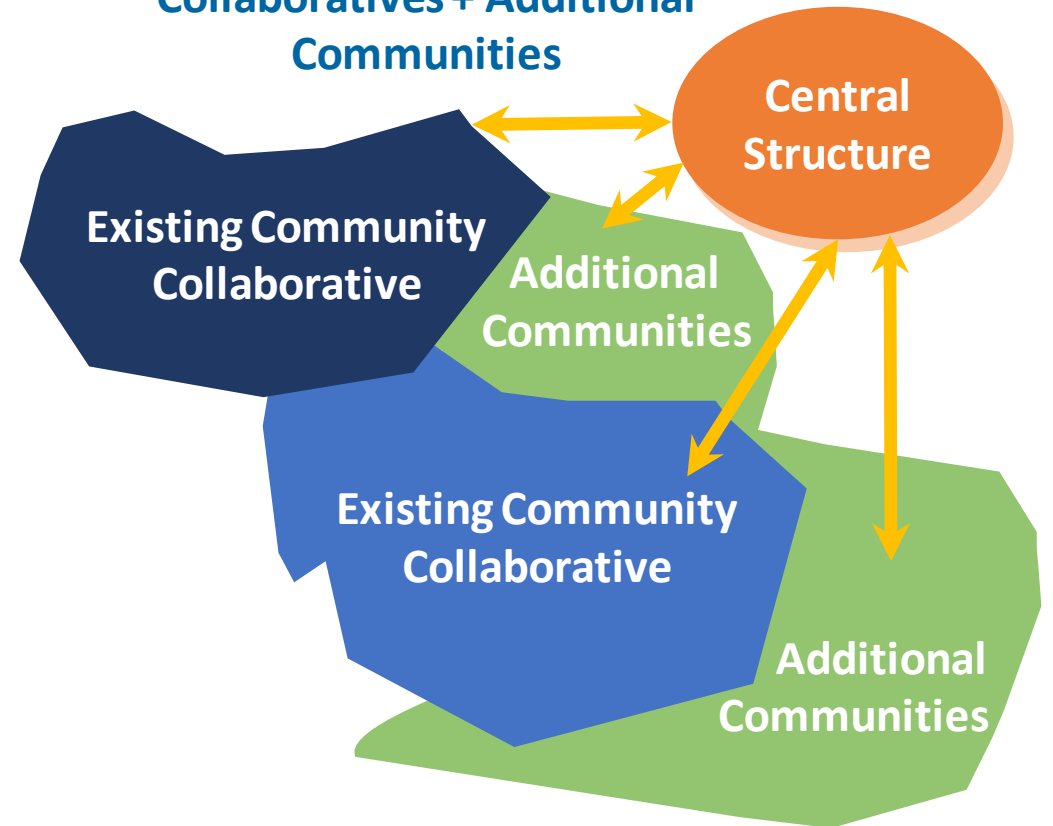
## EXAMPLE 2

Existing Community Collaborative + Additional Communities

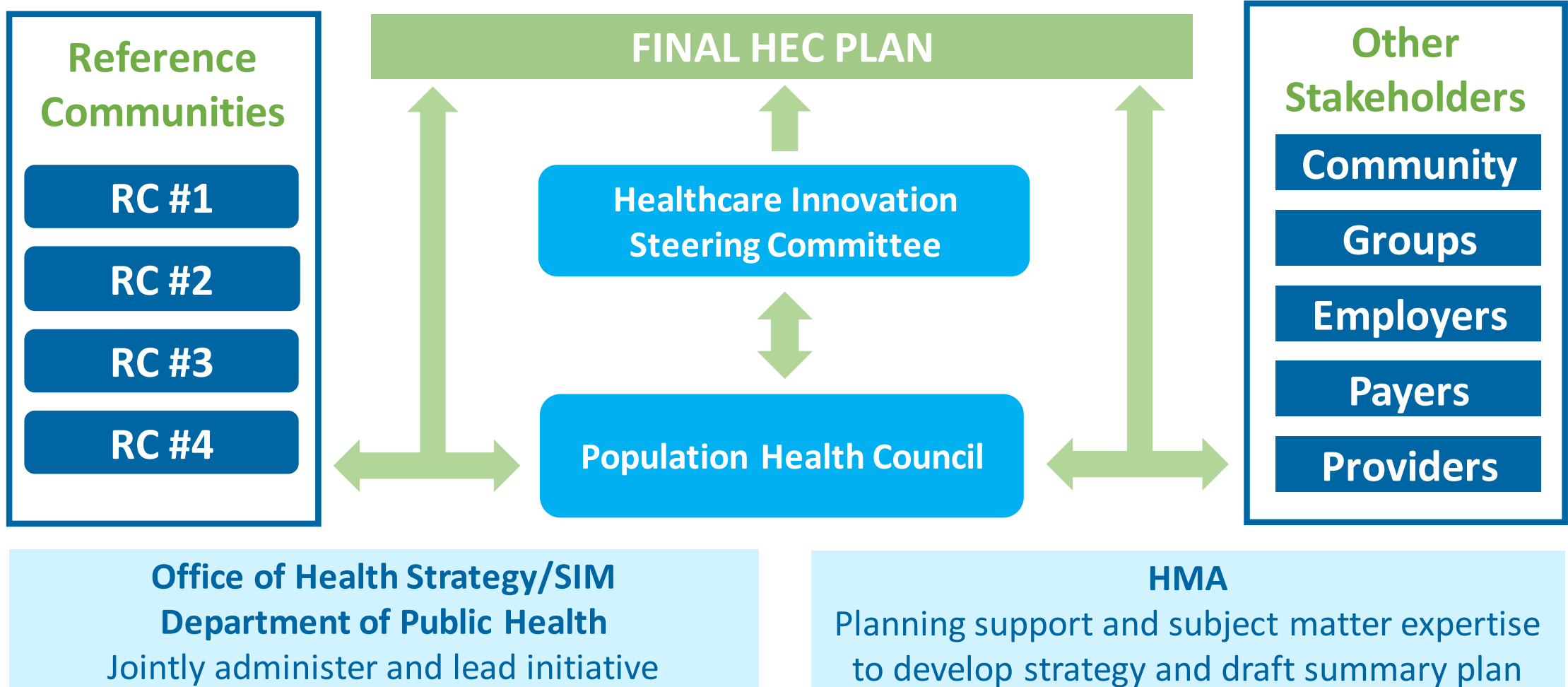


## EXAMPLE 3

Multiple Existing Community Collaboratives + Additional Communities



# Multidirectional Flow of Information and Input to Support Decision Making



# Key Design Questions

DOMAIN	DESIGN ELEMENTS
Boundaries	Define the best criteria to set <b>geographic limits</b> .
Focus and Activities	Define <b>what HECs will do to improve health and health equity</b> and appropriate flexibility/variation.
Health Equity	Define <b>approaches to address inequities and disparities</b> across communities
Structure	Define <b>how HECs will be structured and governed</b> and appropriate flexibility/variation.
Accountability	Define the appropriate <b>expectations</b> for HECs.
Indicators	Define <b>appropriate measures</b> of health improvement and health equity.
Infrastructure	Define the <b>infrastructure needed</b> to advance HECs (HIT, data, measurement, workforce).
Engagement	Define how to ensure <b>meaningful engagement from residents and other stakeholders</b> .
Sustainability	Define <b>financial solution</b> for long-term impact.
Regulations	Define <b>regulatory levers</b> to advance HECs.
State Role	Define <b>State's role</b> .



## Design Questions

Obtain feedback on initial principles and parameters for:

1. Geography
2. Attribution
3. Payment Model
4. Funds Flow

# HEC Geography

Establishing geographic boundaries for each HEC is necessary to determine a service area for:

1. Implementing interventions
2. Measuring population health
3. Establishing clear accountability
4. Rewarding and sustaining success (payment model)

*Note: Geography also discussed as part of Governance Design Team*

# HEC Geographies

## Design Principles

1. Statewide coverage (all areas would be part of an HEC)
2. No overlapping boundaries (an area may be in only one HEC)
3. Minimum population (Threshold TBD): Necessary to be able to measure changes and minimize risk
4. “Rational” boundaries to avoid “cherry picking;” boundaries need to be functional

## Proposed Process

- Iterative formation process between the State and prospective HECs

# HEC Attribution

- Attribution is a key element of HEC accountability.  
Attribution determines:
  - Population whose health the HEC is accountable; and for whom the HEC may be eligible for shared savings
  - Denominator for performance measurement
- Options:
  - Retrospective
  - Prospective
  - Snap-shot in time (beginning/end)

# HEC Attribution: Options

	Retrospective	Prospective	Snapshot
Description	<ul style="list-style-type: none"> <li>Retrospective (also referred to as “concurrent” or “performance year”) attribution assigns patients to providers based on historical claims at the <b>end of the performance period measured</b></li> </ul>	<ul style="list-style-type: none"> <li>Uses historical claims to identify the persons included in a providers’ patient <b>roster prior to the start of a defined performance period</b></li> </ul>	<ul style="list-style-type: none"> <li>Uses a methodology to capture a <b>defined population group at a point in time</b>, which can be repeated at a subsequent point in time</li> </ul>
Considerations	<ul style="list-style-type: none"> <li>Ensures the patient actually received care from the attributed provider during the performance year</li> <li>Proponents of retrospective attribution argue that providers should treat all patients in the most effective and efficient manner; therefore, advance notification is unnecessary</li> </ul>	<ul style="list-style-type: none"> <li>Roster of patients is known before the performance year begins. (Patients can “fall out” of the attribution methodology during the performance year, but new people cannot be added.)</li> <li>Quality and cost data can be shared with provider on a timely basis during performance year</li> </ul>	<ul style="list-style-type: none"> <li>May be more consistent with a population health approach</li> <li>“Open group” approach does not account for in- or out-migration</li> <li>Could adjust methodology to account for significant changes in makeup of a community over time</li> </ul>

# ACO Attribution: Rolling Retrospective Example

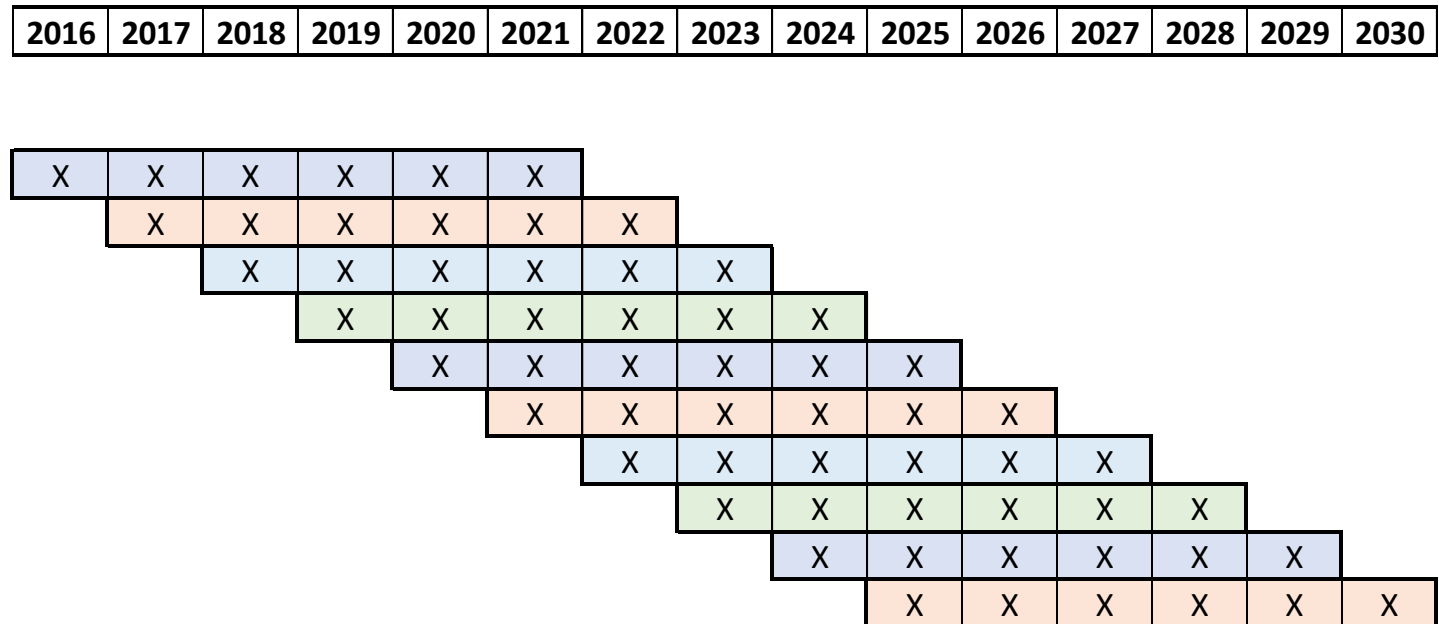
## Rolling Retrospective attribution - Example

In any given performance year, include all persons who reside within a HEC geographic boundary, except the following:

- Persons who did not live in the HEC geography for 12 or more of the previous 60 months (5 years)
- Persons who did not live in the HEC geography during any part of the of the most recent 12 months
- Newborns of mothers who fall into the previous exclusions (#1 and #2)

### Example: 10-Year Medicare Demo Waiver

Demonstration Year	Attribution
1	Attributed Population 2021
2	Attributed Population 2022
3	Attributed Population 2023
4	Attributed Population 2024
5	Attributed Population 2025
6	Attributed Population 2026
7	Attributed Population 2027
8	Attributed Population 2028
9	Attributed Population 2029
10	Attributed Population 2030



# ACO Attribution: Fixed Prospective Example

## Fixed Prospective Attribution - Example

In any given performance year, include all persons who resided within a HEC geographic boundary during the 60 months (5 years) prior to the beginning of the Demonstration Period except persons who moved out of the HEC geographic boundary. Include any newborns of mothers who fall into the first category.

### Example: 10-Year Medicare Demo Waiver

Demonstration Year	Attribution
1	Attributed Population 2021
2	Attributed Population 2022
3	Attributed Population 2023
4	Attributed Population 2024
5	Attributed Population 2025
6	Attributed Population 2026
7	Attributed Population 2027
8	Attributed Population 2028
9	Attributed Population 2029
10	Attributed Population 2030

2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
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X	X	X	X	X										
X	X	X	X	X										
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- Subtract individuals who move in/out of HEC geography

- Add newborns of mothers who resided in the HEC geography from 2016 - 2020

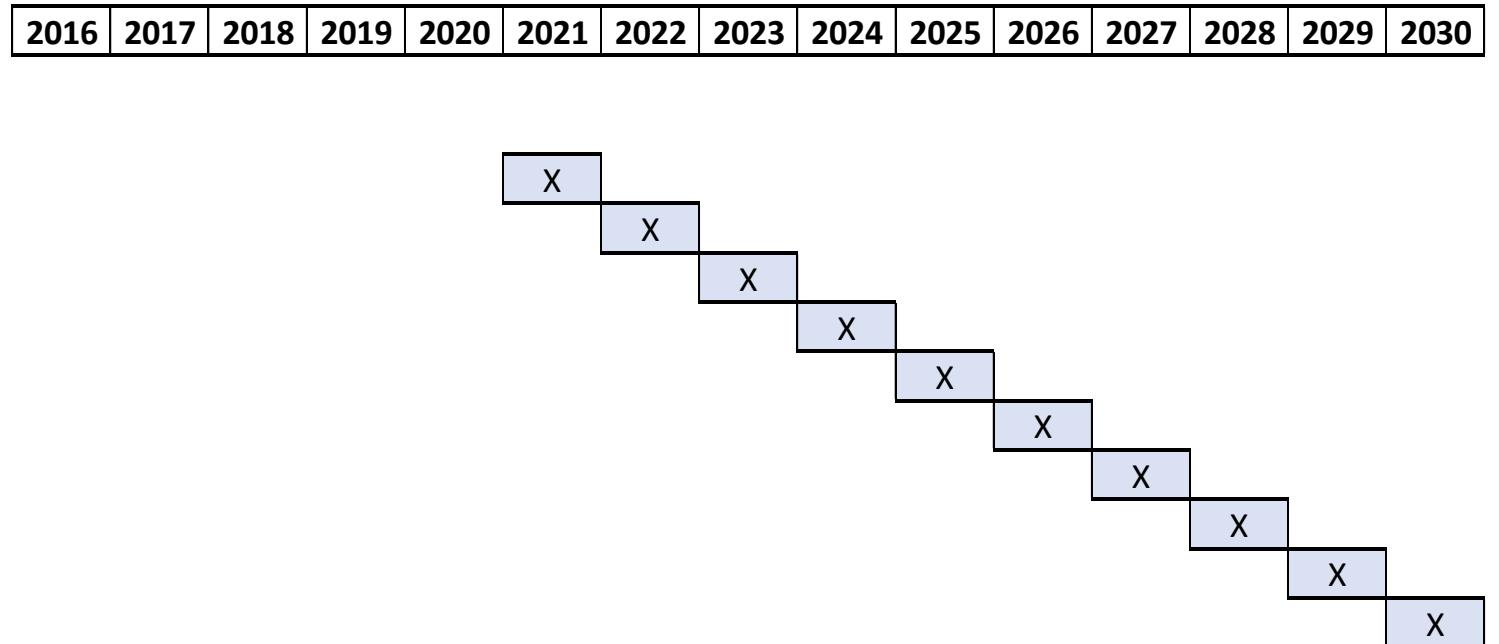
# ACO Attribution: Snapshot Example

## Snapshot Attribution - Example

In any given performance year, include all persons who resided within a HEC geographic boundary.

### Example: 10-Year Medicare Demo Waiver

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1	Attributed Population 2021
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# HEC Attribution: Considerations

- Within an HEC's geographical boundaries, who should be attributed to an HEC (for purposes of calculating shared savings and performance improvement) for any given performance period?
  - Everyone in the geographic boundaries? Or a subset?
  - **Churn** is an issue: births, deaths, in- and out- migration
- By design, HECs are intended to impact medium- and long- term trajectory of health care cost and health status; therefore, churn can confound precision of HEC performance measurement
- Community-based organizations and health and social service programs (by law) do not condition services based on length of community tenure/residency.
- Snapshot approach creates challenges with accounting for changes but may consistent with a pure population health approach

# HEC Attribution: Questions/Challenges

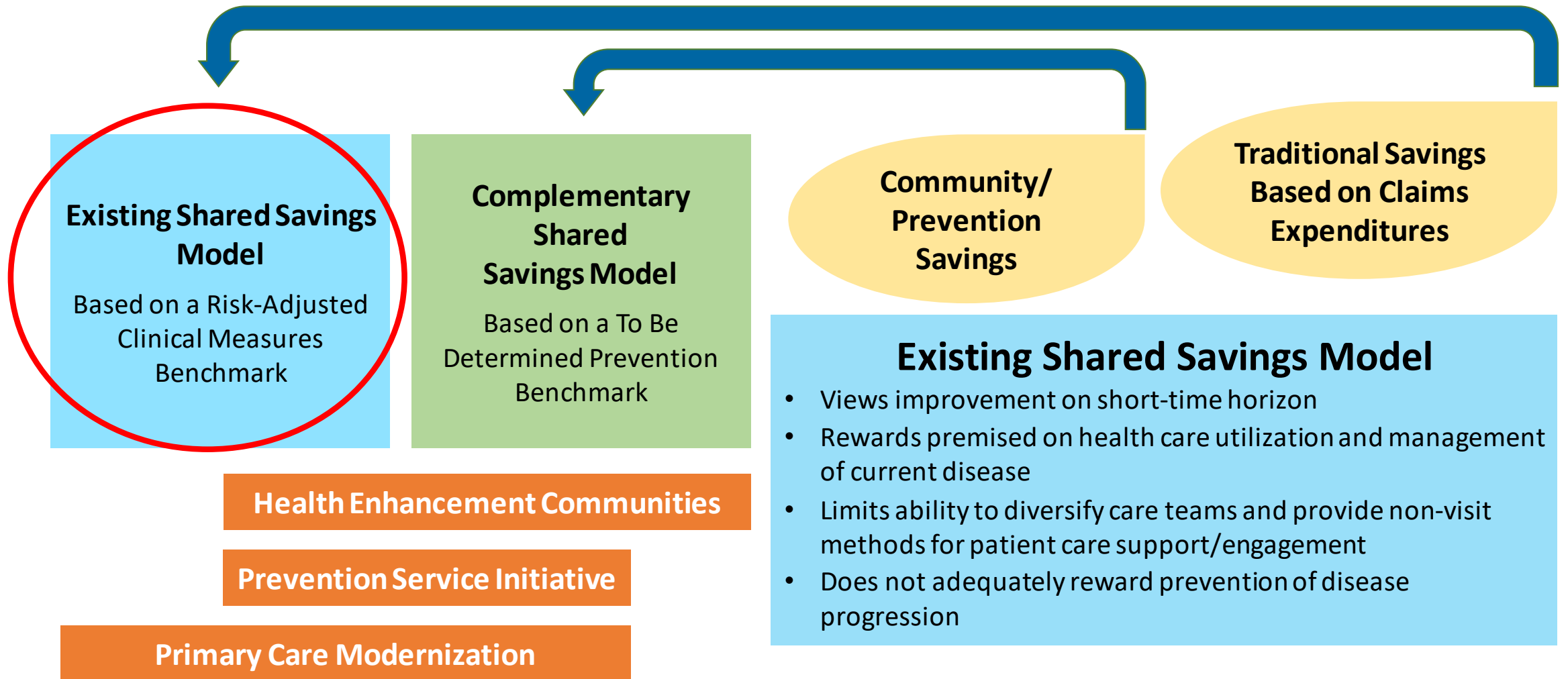
- 1. HEC Residency:** Residency, as a key element of performance measurement, requires accurate person-level data. What could be the source of data to establish residency within a HEC geography? How do we establish residency for persons without a stable address?
- 2. Payer Preferences:** While each attribution approach presents varying advantages and disadvantages, payers and other HEC funders may have specific preferences due to the availability of data and/or their own goals and interests. It may be that the HEC model retain this as a point of flexibility pending negotiations with payers and funders.

# Payment Model: Sustainability

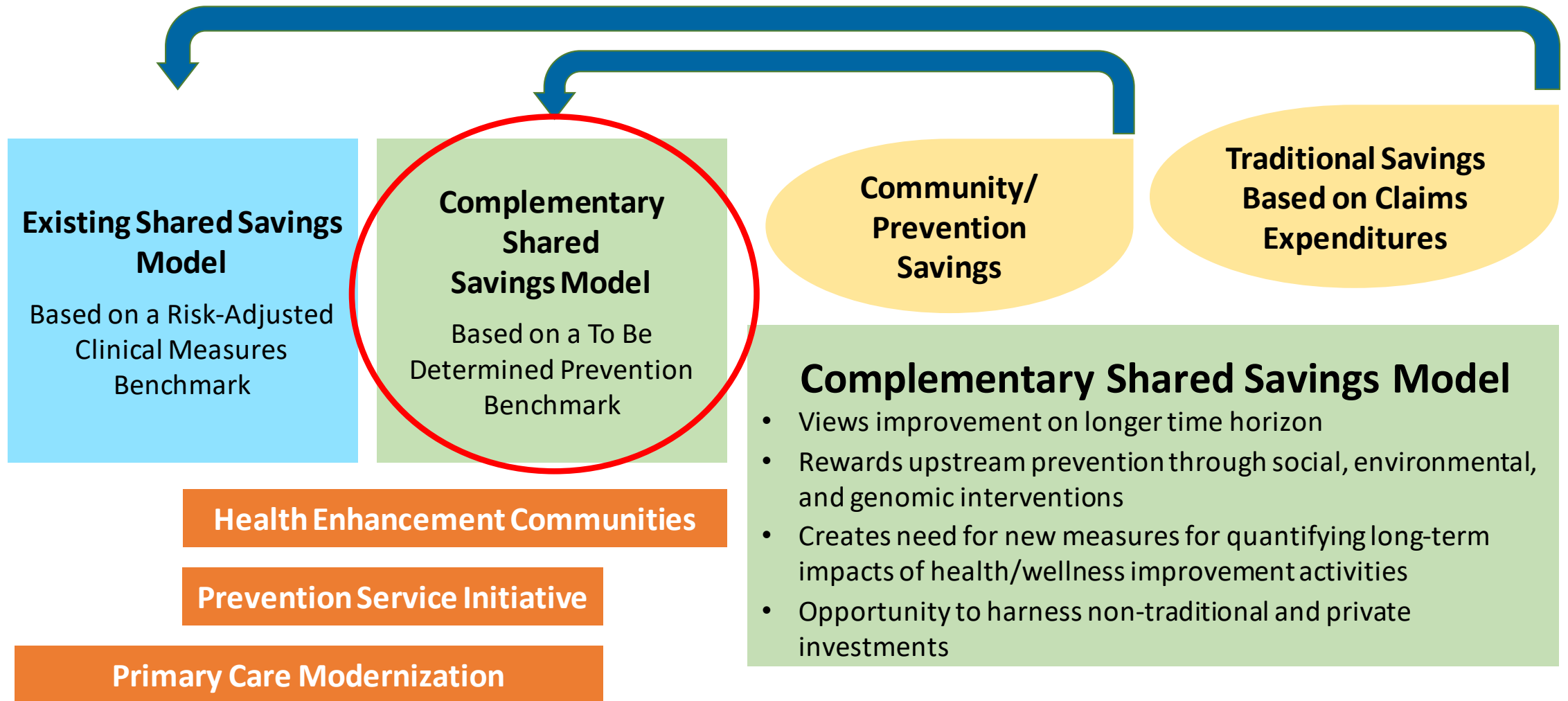
A critical component of securing long-term financing for HECs is developing **prevention-oriented shared savings arrangements with Medicare and other payers**

- Prevention-oriented shared savings arrangement would complement the existing Medicare Shared Savings Program (MSSP) with Accountable Care Organizations (ACOs)
- HECs will also work on pursuing additional sustainability strategies including with other payers and state agencies

# Existing Shared Savings Models Do Not Adequately Reward Prevention



# Existing Shared Savings Models Do Not Adequately Reward Prevention



# Distribution of Shared Savings

- Monetizing and delivering prevention savings is at the core of the HEC Model
  - Savings to Medicare and other payers
  - Savings to provider entities
  - Savings to sustain HEC activities

# Developing Prevention Benchmarks

- **How should HECs be measured on success with upstream prevention efforts?**
  - Population-level risk scores
  - Condition-specific prevalence trends
- Tentative focus areas for HECs:
  - Child Well-being: Adverse Childhood Experience data
  - Healthy Weight & Fitness: Obesity prevalence measures
- Time horizon of demonstrating impacts of interventions is a central challenge
  - This will affect whether payers and funders participate in the HEC model
  - This will affect the performance period

# Medicare Hierarchical Condition Category (HCC) Score

- Risk adjustment uses a patient's demographics and diagnoses to determine a **risk score**, which is a relative measure of how costly that patient is anticipated to be.
- CMS uses **HCC risk scores** to pay Medicare Advantage plans and set cost benchmarks/budgets for ACOs
- HCCs are **useful information in comparing the risk and predicted cost of different populations** (e.g., by geography, health condition)
- **Nationwide risk score = 1.0**, recalibrated each year



# Medicare HCC Risk Score: Illustrative Example

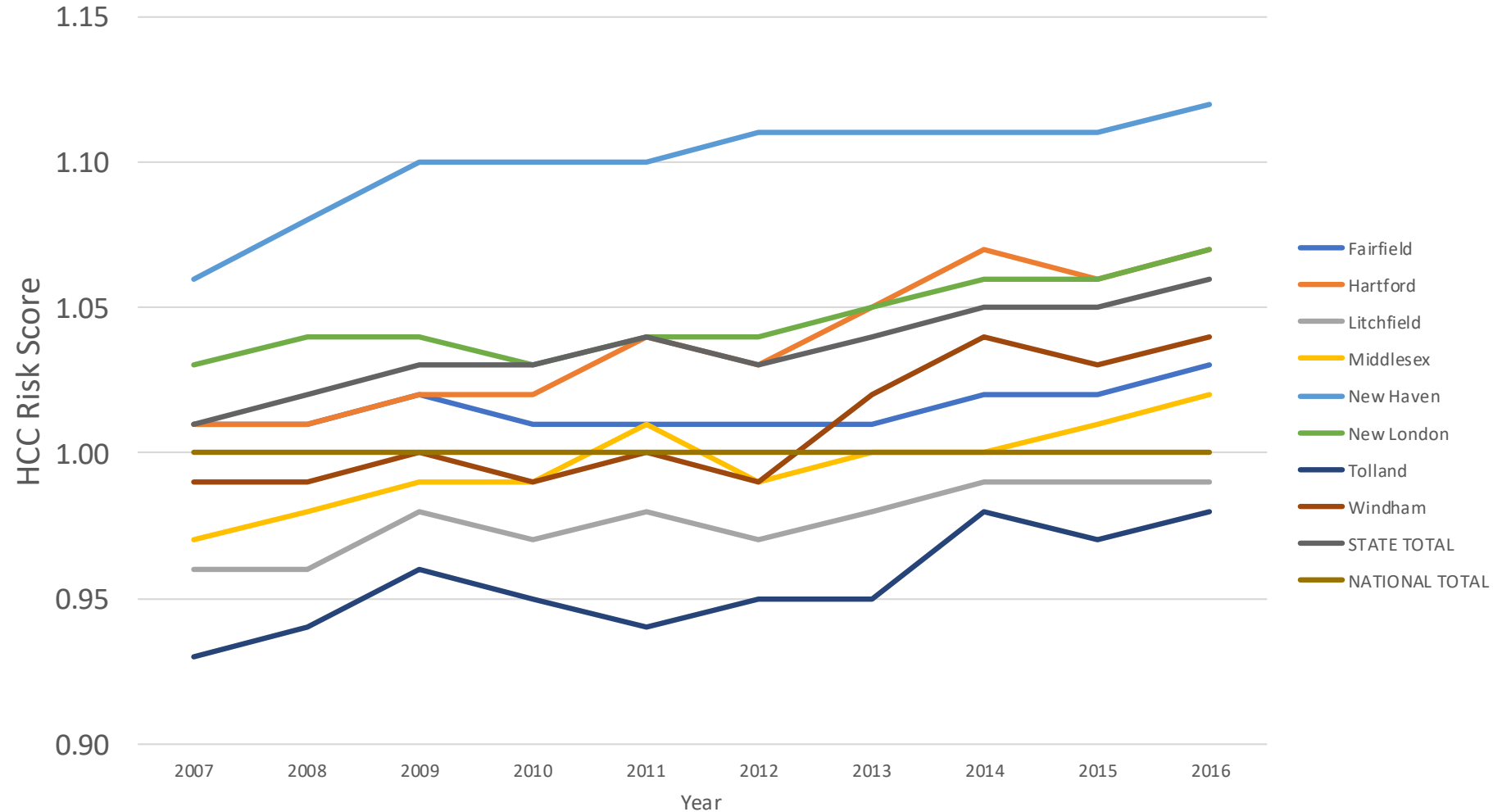
	Person A CHF, diabetes, and morbid obesity	Person B CHF, no diabetes, normal weight
76 year old female living in the community, no Medicaid	.452	.452
Congestive Heart Failure (CHF)	.310	.310
Diabetes with complications	.307	--
Morbid obesity	.262	--
Interaction (Diabetes + CHF)	.152	--
Total HCC Risk Score	1.483	.762
Average Annual Per Capita Medicare FFS Costs	<u>x \$15,000</u>	<u>x \$15,000</u>
<b>Total Annual Medicare Cost Per Capita</b>	<b>\$22,245</b>	<b>\$11,430</b>

Source: CMS-HCC Relative Factors from CY 2019 Medicare Advantage Final Call Letter, April 2, 2018, Table VI-1.

# Connecticut Medicare HCC Risk Score by County

2007 - 2016

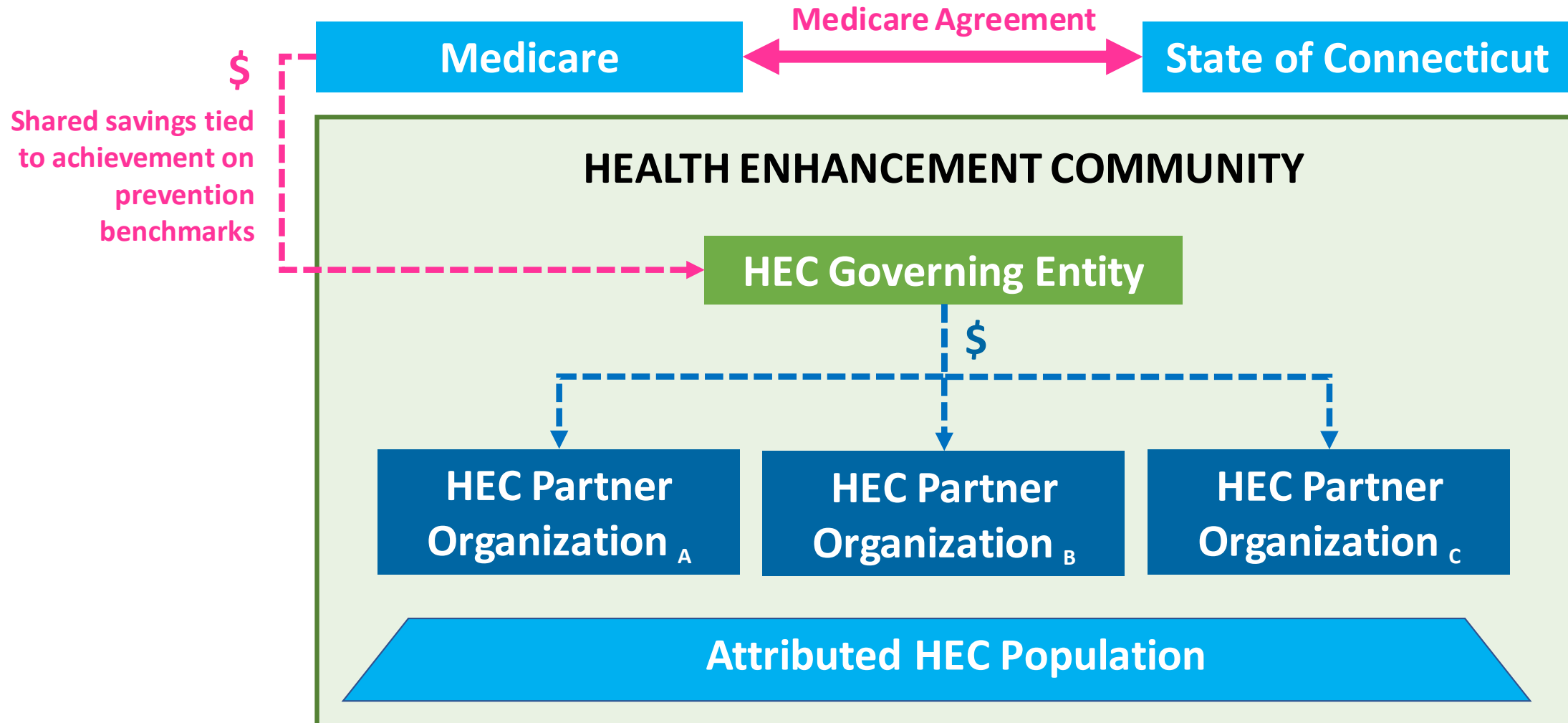
## HCC Risk Scores – Medicare Fee for Service Population



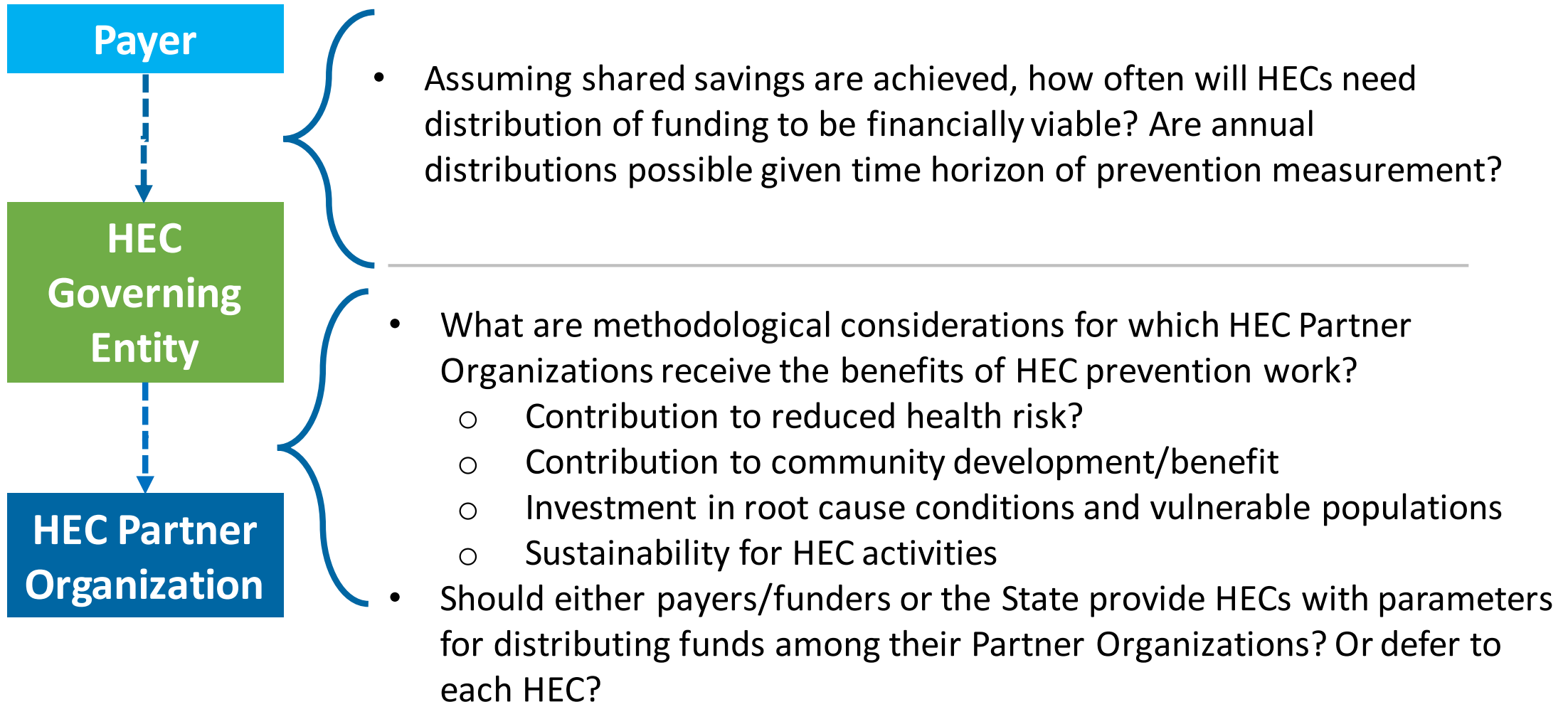
## Key Observations

- HCC risk scores in CT have steadily increased from 1.01 to 1.06 over the last 10 years
- In 2016, 6 of the 8 counties in CT had HCC risk scores higher than the national average
- New Haven has the highest HCC risk score of all counties in CT
- Tolland and Litchfield have the lowest HCC risk scores in CT

# Example: Medicare Funds Flow



# Funds Flow Considerations



End