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To: EOHHS
From: G. Alan Kurose, MD, CEO, Coastal Medical
Christopher Ferraro, CFO, Coastal Medical
Re: Comments on the Accountable Entity Total Cost of Care Model
Date: August 14, 2017

1. Goals of the Payment Model

The underlying design of a total cost of care model should offer an opportunity for success to both the Managed Care Organization (MCO) and the Accountable Entity (AE) and result in no unintended circumstances. The AE should have a chance for success that is proportionate to its actual performance in delivering on the Triple Aim goals for the member population that is being served.

2. Transparency

To accomplish these goals, each piece of data used to calculate financial performance needs to be clearly identified, defined and transparent to all stakeholders. This is most evident when calculating cost performance and risk scores. Every aspect of these calculations must be evaluated to ensure that the methodology does not unknowingly favor one entity over the other. Full transparency is crucial here.

Historically, aspects of payment models derived from software applications have often been fully understood by payers while existing within a "black box" from the provider perspective. Determination of risk scores is an important example where this dynamic has been challenging for providers. Different payers choose different risk scoring algorithms and make specific choices about constraints that are applied as data files are built to serve as inputs to the software. If this process is less than fully transparent then AE's are left to confront an incomplete understanding of how the model works and an inability to reconcile financial performance results. In order to eliminate any "black box" aspect of these calculations, MCO's need to be fully transparent with regard to the algorithms utilized by their software, how data files are built to serve as inputs to the software, and how specific data elements influence risk scores. Each element should be evaluated so that both parties understand its impact.

3. Performance Relative to Others

MCO's should also share with each AE the blinded cost performance of the other AE's as well as the rest of the providers in their network. Doing this will provide AE's with a frame of reference for their own quality and cost performance as compared to their peers. This level of transparency currently exists in the Medicare Shared Savings Program in which expenditure and utilization comparisons are provided quarterly. In addition, *unblinded* aggregated cost and quality scores of all participating ACO's are published annually by CMS.

4. Historical Base and Initial Total Cost of Care Target

Under the proposed Total Cost of Care model, EOHHS is calling for a three-year aggregate PMPM that will be weighted 10%/30%/60% when determining the AE's historical cost base. This methodology disadvantages AE's that have been improving their performance during the three-year baseline period. Therefore, EOHHS should consider a historical base methodology that weights performance equally over the three historical base years (33%/33%/33%). The historical base methodology currently proposed by EOHHS is the same that was originally used under the Medicare Shared Savings Program (MSSP) model. Because of concerns raised from ACO's around the country, Medicare revised that benchmark methodology to equally weight the three years as we suggest here.

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5. Mitigating the "Race to the Bottom" Dynamic

Because the proposed methodology compares the AE's cost performance to its own historical performance, over time the AE's ability to continue to drive down cost will become nonexistent. Having an AE compete against itself becomes increasingly problematic as rebasing causes a "race to the bottom" dynamic. (This was also called out in our January 27, 2017 memo to EOHHS.) Consideration should be given to including regional cost performance in the AE's historical base calculation. This solution to the "race to the bottom" problem is being implemented now in the Medicare Shared Savings Program, and will allow cost efficient ACO's to continue to capture a portion of the value that is created by their improved cost efficiency.

6. Maximum Allowable Shared Loss Pool

Under the proposed guidance, the calculation of the AE's maximum allowable shared loss pool is based on 5% of target expenditures. For primary care AE's this level of financial risk is daunting. We propose that calculation of the AE's maximum allowable shared loss pool be consistent with the minimum downside risk requirement stipulated in OHIC's "2017-2018 Alternative Payment Methodology Plan". Under that plan the percentage of risk a physician-based ACO assumes is defined as a percentage of *their contract revenue* with the MCO. Using this methodology properly aligns the risk level of the AE with their fee for service revenue.

CMS in their Track 1+ model has created two distinct paths for maximum risk that will qualify as an advanced APM under MACRA. CMS has chosen –as OHIC did – to define maximum downside risk for physician based ACO's as a percentage of their fee for service revenue.

7. Investment Risk

It is the expectation that AE's will be entering into shared savings agreements that will have progression to meaningful downside risk. As AE's move towards becoming financially responsible for losses, the MCO's also need to consider the specific level of investment risk that is being taken by each AE.

In speaking of "investment risk" for AE's we are referring to the fact that AE's incur specific incremental costs in purchasing new technology, building new human infrastructure, and employing and training a new workforce to deliver population health management services to its patients. Investments are needed to design and implement expanded clinical and centralized programs that deliver a differentiated level of service and value to patients. The amount and the pace of that investment will differ greatly from one AE to the next, but these are real investments that entail significant financial risk for AE's.

The new workforce for population health management will include nurse care managers, clinical pharmacists, pharmacy technicians, diabetes management team, transitions of care team, quality assistants and much more. Most if not all of the members of this new workforce cannot bill for their services. Therefore, infrastructure support, quality payments and shared savings are necessary to assist the AE in covering these costs.

As downside risk is mandated in the future of these MCO/AE contracts, the specific investment risk of each individual AE should be brought into the discussion and included as part of their downside risk calculation. Coastal was a participant in the Advanced Payment Model offered by CMS as part of the Medicare Shared Savings Program. The Advanced Payment Model required Coastal to specifically document each incremental expense of population health management to which the CMS Advanced Payment Model revenues were applied.

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This task was easily accomplished by Coastal in a manner deemed to be satisfactory by the independent accounting firm engaged by CMS to provide oversight of our use of the funds. With only 6 or so AE's in the state, assessment of investment risk for each AE should be very manageable from an operational standpoint.

8. **Splitting of Adult and pediatric populations when calculating risk score and financial performance**
   Due to significant differences in cost and risk scores of adult and pediatric populations, EOHHS should strongly consider assessing each population separately under the total cost of care model. Aggregating adult and pediatric risk score and cost performance data could potentially cause both confusion and distortion in the assessment of performance. We can walk through examples of this in our own historical performance data if that would be of interest to EOHHS.

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