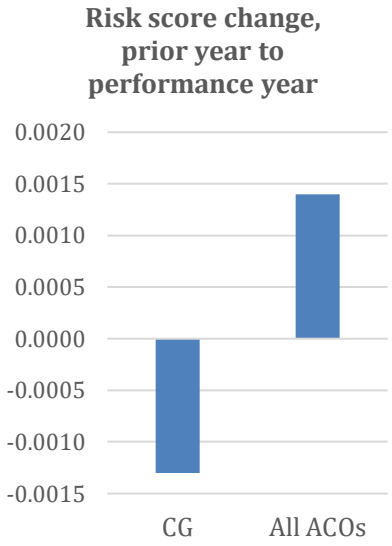
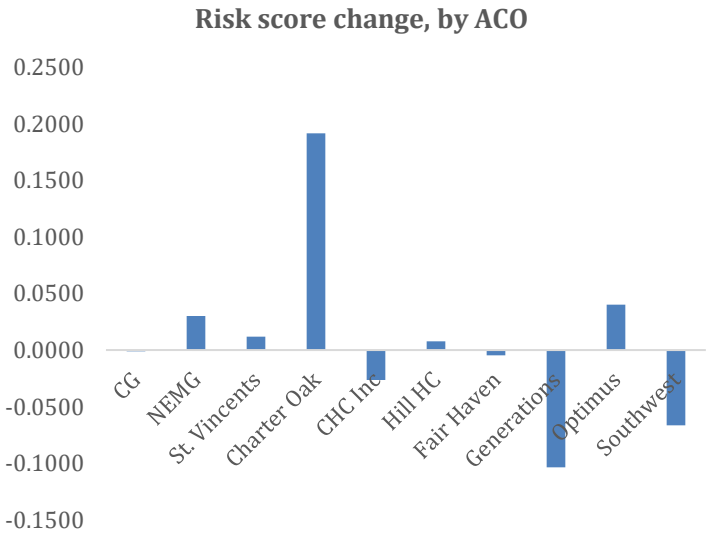
August 1, 2019

To: Kate McEvoy, Director, Health Services, CT Department of Social Services
From: Ellen Andrews, CT Health Policy Project
Re: Problems with risk adjustments in PCMH Plus

I am writing to bring to your attention, and get feedback on, a troubling analysis of PCMH Plus Year 1 performance results. I've also included some possible explanations and **some recommendations** to address the problem. I would appreciate an opportunity to discuss these concerns further.

As noted in our previous analysis (12/20/18), risk scores for HUSKY members in PCMH Plus Accountable Care Organizations (ACOs) rose between the year prior to the program's start and the end of the program's first year while risk scores for the matched Comparison Group (CG) improved over that same timeframe. As risk scoring in the program is longitudinal, it is troubling that the program appears to be linked with a reduction in health status for PCMH Plus members, while the health of other HUSKY members improved. There is great variability in risk score change between ACOs and that variability tracks with financial rewards to the ACOs.

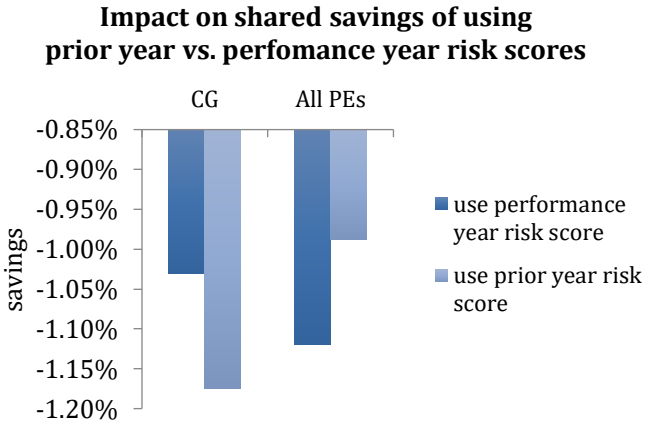


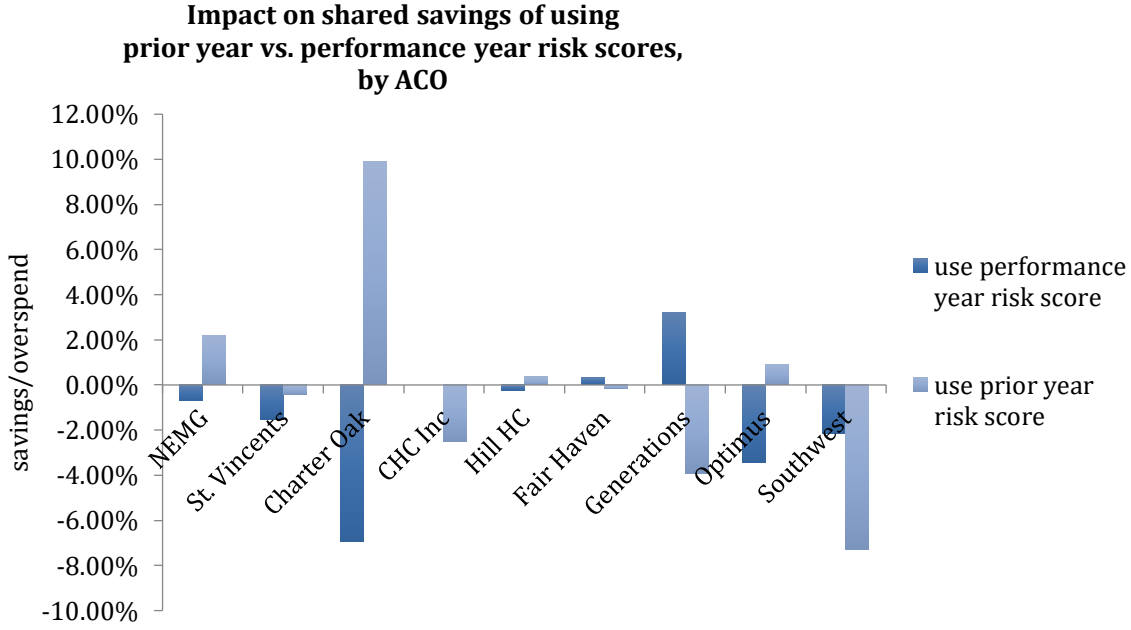


The independent advocates' Medicaid Study Group recommendations for the future of PCMH Plus (5/10/19) urge that **risk scores for purposes of payment calculations should be set at the prior year level**, rather than changing every year. There are several reasons to support using members' initial pre-program risk scores. It would promote consistency and stability in the payment model. It would

reward improving member health status and would remove any disincentive to accept members with needs that may not improve or improve quickly, especially people with disabilities. Recognizing that improvements in health status usually require maintenance, especially for members with complex needs, using prior year risk scores compensates for that effort. **Ongoing monitoring of risk scores should continue for quality purposes. Reasonable payment adjustments can be made for deteriorations in health status that could not be prevented.**

We calculated how using prior year rather than performance year risk scores would have impacted ACO payments. The results were significant and prompted this letter asking for feedback. In both scenarios, per member per month (PMPM) costs fell. However, using prior year risk scores to adjust PMPM calculations, the costs of care for the Comparison Group fell 1.17% while costs of care for ACO members fell only 0.99% from the prior year to PCMH Plus's first year. This erases any savings from the program and indicates that the program cost taxpayers more than estimated. We again found great variability between ACOs in the impact on costs, creating winners and losers based on the methodology.





Several possibilities could account for the deterioration of risk scores among ACO members in aggregate and for the variability between ACOs. It is possible that the results are due to random variation and the small numbers of members attributed to some ACOs. To address this problem, we previously recommended that **the minimum number of members in future ACOs should be increased significantly from 2,500.** Medicare's shared savings program requires at least 5,000 members for each ACO. Thankfully, in developing PCMH Plus, CMS insisted on a minimum savings benchmark for shared savings payments. However, the one ACO that exceeded that benchmark would not have if the prior year risk score was used. **Quality performance payments should also include a minimum threshold to ensure taxpayers are rewarding meaningful improvement.**

It is also possible that one or more ACOs are gaming the system, for instance by upcoding to inflate risk scores. **Fixing risk scores for payment purposes at prior year levels** would remove this problem. It would also remove unintended financial disincentives to improve members' health status and would ensure continued resources to ACOs necessary to maintain health improvements.

The most troubling possibility is that the PCMH Plus program has failed. It is possible that one or more features of the program lowered the health status of ACO members, increasing their risk scores. Underservice incentives in shared savings to inappropriately deny members' necessary care is a likely suspect. Despite the PCMH Plus policy that ACOs do not receive any savings generated by systemic underservice, advocates have documented serious deficiencies in monitoring for underservice. As we noted, there were hints of underservice in durable medical equipment and dental care during the first year, but there has been no follow up on those concerns, to our knowledge. I renew **advocates' strong recommendations for robust, transparent underservice prevention, monitoring and enforcement**.

Given the large difference in risk scores and total cost of care between the comparison group and PCMH Plus group, your **proposal for a post-hoc change to the comparison group is particularly troubling**. It bears repeating that until all the concerns are addressed, including risk score adjustments, **it is imprudent to either release applications for a third wave of PCMH Plus contracting or to consider moving fragile Medicare and Medicaid dually eligible members into this payment model.**

I look forward to your feedback on this analysis and plans to protect both PCMH Plus members and state taxpayers from these and other concerns with the program.

Cc: Rep. Cathy Abercrombie, MAPOC
Sen. Abrams, MAPOC
Commissioner Gifford, DSS
Charles Lassiter, Mercer
Anne Foley, OPM