

SHARED SAVINGS AND THE DUAL ELIGIBLES INITIATIVE

FEBRUARY 7, 2012

Maria Dominiak, FSA, MAAA
Ernest Jaramillo, ASA, MAAA
Phoenix - 2325 East Camelback

Agenda

- What does shared savings look like and why is it important?
 - Definition
 - Goal/purpose of shared savings models
 - Illustrative per member per month (PMPM) example
 - Other shared savings initiatives recently approved by CMS
- What are the key decision points in shared savings?
- Questions

Shared savings model – Description and purpose

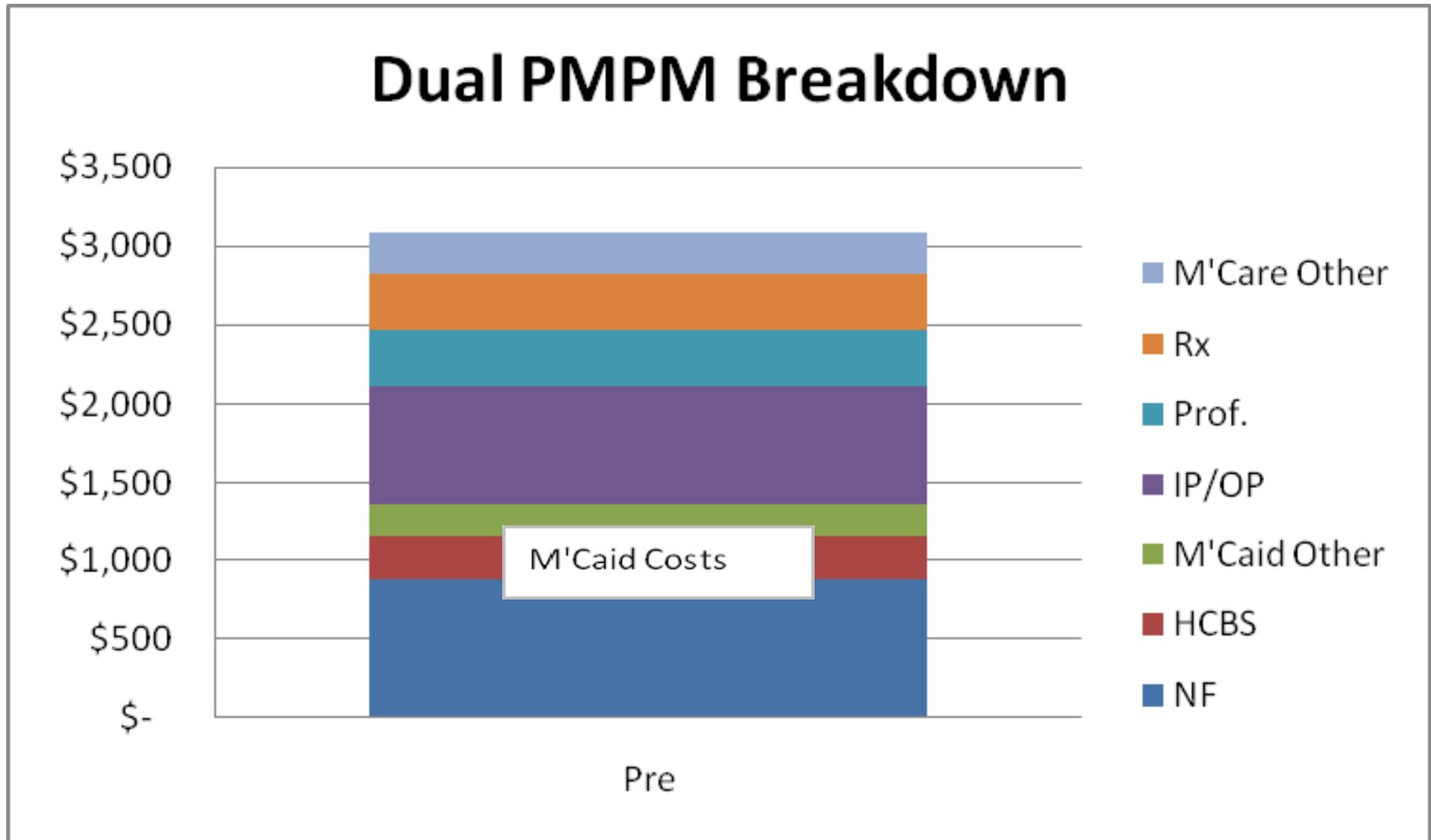
- Shared savings is a payment strategy that gives financial incentives to providers to motivate them to provide more appropriate and efficient care
- Providers receive additional payments for savings provided they can simultaneously meet performance and quality targets
- Emphasis on efficiency and cost effectiveness helps curb incentives to order unnecessary care
- Shared savings are monitored based on requirements around quality and performance measures
 - Performance on access, patient experience, quality and/or service utilization used
 - Metrics tend to encompass preventive and chronic care services and, for Accountable Care Organization (ACO) like entities, acute care services

Shared savings model goals

- Provider community must be engaged and supportive
- Methodology needs to be transparent
 - Needs to be able to consistently define quality and measure outcomes
 - Providers have to understand how it all works – can't be a “black box”
 - Needs to reward providers that are already doing well as opposed to just those providers that improve performance
- Balance competing goals of various stakeholders
 - CMS/State will want savings reflected in reduced costs and improved outcomes
 - Some providers (e.g., hospitals, nursing homes) may end up with less volume and want savings/higher rates to offset losses
 - Providers that are ultimately responsible for coordination or outcomes will want to be rewarded for efforts
 - Dual eligibles and families will want savings reinvested in additional services

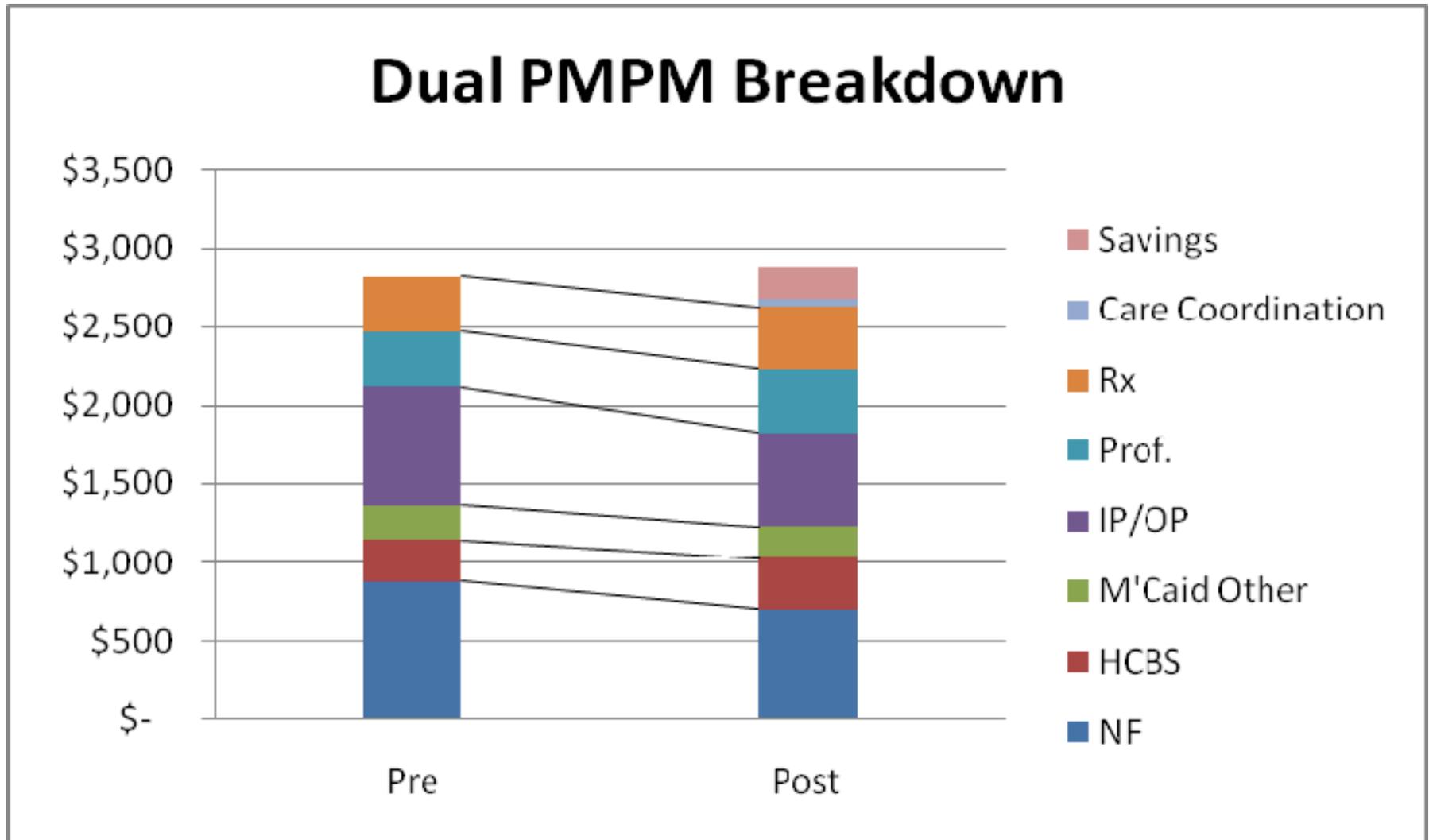
How do shared savings models work?

PMPM example



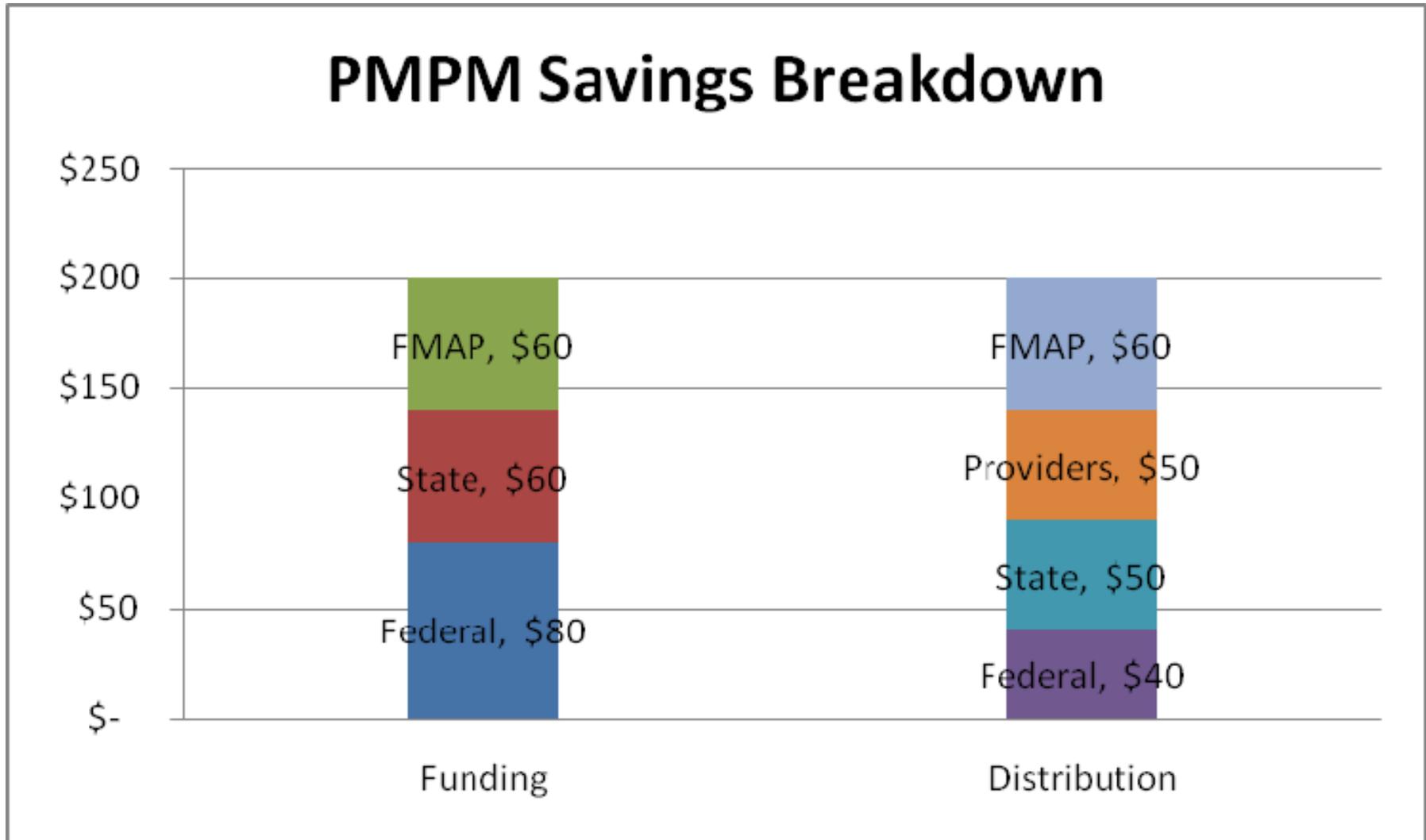
How do shared savings models work? (cont'd)

PMPM example



How do shared savings models work? (cont'd)

PMPM example



How do shared savings models work? (cont'd)

Global versus targeted savings

- Global savings
 - Most shared savings programs include all covered services
 - Some programs exclude certain services from consideration such as organ transplants, high cost claims, sub-capitated arrangements and out of area/network services
 - The advantage to global savings is the incentive to cost-shift is decreased; providers would not have adverse incentives to shift costs but would be accountable for all costs

How do shared savings models work? (cont'd)

Global versus targeted savings

- Targeted savings
 - Share only on savings attributed to specific services (ER, IP, etc.)
 - This arrangement tends to be more advantageous to specific provider types
 - Incentives can be created and the system gamed by shifting costs to other services that may or may not be in the patient's best interest and may be more expensive overall
 - Targeting services may not bring overall savings, which are what will drive efficiency and cost effectiveness; so targeting certain services for measurement can cause other services to increase in cost
 - CMS has only limited approval of targeted shared savings plans so far

Examples of shared savings initiatives

- Comprehensive Primary Care Initiative (CPCI)
- North Carolina 646 Demonstration
- Medicare Shared Savings Program with ACOs
- Independence at Home Medical Practice Demonstration
- Medicare Health Care Quality Demonstration for the Indiana Health Information
- Physician Group Practice (PGP) Transition Demonstration
- Care Management for High-Cost Beneficiaries Demonstration
- The Pioneer ACO Model
- Louisiana Medicaid Coordinated Care Network (pending CMS approval)

Example of shared savings initiatives recently approved by CMS Comprehensive Primary Care Initiative (CPCI)

- Multi-payer initiative that provides monthly care management fee and opportunity for shared savings with PCPs
- Providers have substantial flexibility about how to use the money, as long as it advances primary care
- Special considerations for Medicaid:
 - Leveraged as an add-on to existing primary care case management (PCCM) infrastructure
 - CMS will pay PMPM for Medicaid FFS
 - Must share cost and utilization data
 - Must report specific PMPM beneficiaries
 - No administrative cost reimbursement or ability to retain any funds

Example of shared savings initiatives recently approved by CMS (cont'd)

Comprehensive Primary Care Initiative (CPCI)

- Can only participate in one Medicare shared savings initiative; if participating in CPCI, cannot participate in an ACO, FQHC Advanced Primary Care Practice Demonstration, Independence at Home, Medicare High Cost Demonstration, Multi-payer Advanced Primary Care Practice Demonstration or Physician Group Practice Demonstration
- Savings shared within the Medicare program between CMS and PCPs in years two to four of the initiative based on 25 quality measures
 - Connecticut proposed calculating savings based on a global Medicare risk-based PMPM target
- Shared savings not available for Medicaid FFS
 - Connecticut proposed an incentive pool to reward Medicaid efficiencies subject to CMS approval

Example of shared savings initiatives recently approved by CMS (cont'd)

North Carolina 646 waiver

- North Carolina took part in a five-year demonstration to integrate care for duals on January 1, 2010
- It began as a Medicaid-only PCCM program –Community Care of North Carolina (CCNC) – but expanded to include duals (Years 1 and 2) and Medicare-only individuals (beginning in Year 3)
- Initial challenges:
 - Limited data from Medicare
 - Pharmacy data incomplete
 - How to measure savings
- Program too new for evaluation results
- Savings shared on Medicare costs (excluding Part D) between CCNC and CMS

Example of shared savings initiatives recently approved by CMS (cont'd)

North Carolina 646 waiver

- Features of program:
 - Beneficiaries attributed retrospectively to participating PCPs
 - Community-based care coordination services provided to participating practices and beneficiaries
 - Current case management information system expanded to include duals and Medicare-only populations
 - Performance measurement, reporting and incentive program developed and implemented
 - NC-CCN linked with CMS claims data to produce patient-level and provider-level quality reports, alerts and reminders for participating providers

Example of shared savings initiatives recently approved by CMS (cont'd)

North Carolina 646 waiver

- Shared savings component
 - Savings shared 50/50 between CMS and NC-CCN
 - In first year, half of shared savings payment made to NC-CCN contingent on meeting performance metrics (e.g., measures for management of diabetes, heart failure and transitional care)
 - 18 metrics evaluated in first year and will increase each year
 - A minimum savings threshold must be identified before sharing can occur
 - External evaluators determine cost savings based on comparison states
 - Savings determined by comparing actual versus target expenditures
 - Performance metrics calculated using administrative claims data and chart reviews

Example of shared savings initiatives recently approved by CMS (cont'd)

Medicare Shared Savings Program with ACOs

- An ACO is a legal entity that is composed of certified Medicare providers or suppliers who work together to manage and coordinate care for a defined population of Medicare fee-for-service (FFS) beneficiaries
- Shared governance (75% providers) that provides appropriate control over the ACO's decision-making process.
- Eligible to receive payments for shared savings if the ACO can reduce spending growth below target amounts while also meeting quality performance standards

Example of shared savings initiatives recently approved by CMS (cont'd)

Medicare Shared Savings Program with ACOs

- Eligible providers:
 - Professionals (e.g., physicians and other clinicians) in group practice arrangements
 - Networks of individual practices
 - Joint venture arrangements between hospitals and professionals
 - Hospitals employing professionals
 - A subset of critical access hospitals, rural health clinics and federally qualified health clinics (FQHCs).

Example of shared savings initiatives recently approved by CMS (cont'd)

Medicare Shared Savings Program with ACOs

- Have a membership of at least 5,000 Medicare beneficiaries
- Will receive data on Medicare Part A, B, and D costs and utilization monthly from CMS
- Medicare beneficiaries are assigned to the ACO retrospectively if they receive a majority of their primary care from that provider for the most recent 12 months based on allowed charges (not volume of services)
- Providers must be exclusive to the ACO
- Shared savings 50/50 for the no-risk model; 60/40 for model that employs risk
- Must meet quality and performance standards
 - 33 performance measures to report on in the first year

Example of shared savings initiatives recently approved by CMS (cont'd)

Medicare Shared Savings Program with ACOs

- Shared savings methodology
 - Report on each measure in first year
 - Meet 25 of the measures in second year and 32 in third year
 - Shared savings based on points assigned to performance measures with the electronic health record double-weighted to emphasize its importance for ACO success

Example of shared savings initiatives recently approved by CMS (cont'd)

Medicare Shared Savings Program with ACOs

- CMS mandated a minimum savings rate (MSR) to compensate for possible random fluctuations in improved performance
- Cap on amount of savings that can be shared with ACOs, with a cap of 10% for ACOs using one-sided (no risk) models and 15% for ACOs with two-sided (risk based) models to help offset the greater risk
- Additionally, a cap on shared losses that will steadily increase from 5% in the first performance period to 7.5% in the second and 10% in the third
- Benchmark rate is established using per capita historical expenditures and risk adjusted

Key decision points

Which providers are eligible for the shared savings program?

- Core versus optional providers
 - Assignment is generally based on services provided by PCPs (e.g., internal medicine, geriatric medicine, family practice or general practice) only
 - Many Medicare beneficiaries have conditions that are best managed by specialists, so they often receive the majority of their care from a specialist
 - Shortages of PCPs exist in certain regions of the country
 - Other essential providers may participate in Health Neighborhoods (e.g., nursing homes, home health agencies, hospitals)
 - Providers eligible to participate in shared savings models will need to choose which program to participate in (ACO, CPCI, etc.)

Key decision points (cont'd)

How do members get into the program?

- Attribution versus enrollment
 - Attribution: Members assigned a core provider based on retrospective analysis of enrollment and claims data
 - Enrollment: Members choose to take part in the program
- Attribution is the primary method in most shared savings models
 - May allow patients to opt-out in special circumstances (participation in demonstrations or for data sharing reasons)
- How to attribute:
 - Determine which practice a patient had the most primary (or primary and specialty, or specialty) care visits for certain evaluation and management codes in a certain timeframe, such as the past one to three years
 - Might also only include patients who were continuously enrolled for 11 or 12 months of the year
 - Might also only look at most recent visits

Key decision points (cont'd)

How are savings measured?

- Benchmark PMPMs
 - Calculate a statewide PMPM using historical expenditures for all duals in the demonstration
 - Apply trend factor to project historical expenditures to the baseline year(s)
 - Apply risk adjustment to reflect risk profile of members attributed to the Health Neighborhood
- Savings is calculated as the difference between actual and projected cost, adjusting for changes in risk
- Control Group

Key decision points (cont'd)

What are the sources of savings?

- Medicare savings
 - Decreases in potentially preventable hospital admissions and readmissions
 - Decreases in unnecessary and low acuity non-emergent ED visits
 - Elimination of duplicative services
 - Increases in PCP and OP visits
- Medicaid savings
 - Decreases in institutionalizations
 - Increases to home- and community-based waiver services

Key decision points (cont'd)

How much savings should be shared?

- Medicare savings are split evenly between CMS and the State 50%/50%
- Savings between the State and the Health Neighborhoods is TBD
- Medicaid savings will be shared with CMS and the State at the current FMAP rate
- Most common arrangement is 50% to the provider and 50% to the payer
- Could allow provider to earn more, dependent upon provider meeting quality and care targets
 - Distribution of savings could be scaled or providers could earn a flat percentage with a capped total amount

Key decision points (cont'd)

How much savings should be shared?

- State shares with providers
 - Health Neighborhoods (clusters of providers in close geographic proximity who have a substantial number of Dual Eligibles in common) would be created with the purpose of coordinating care delivery across the continuum and determining shared savings with providers
 - Health Neighborhoods expand on the PCMH concept. Where PCMHs are Medicaid-only, Health Neighborhoods would serve both Medicare and Medicaid consumers
 - Health Neighborhood would be responsible for establishing process for sharing savings with member providers
 - Fiduciary issues
 - To whom does the State write a check?
 - How are providers contractually linked? Are they contractually linked?

Key decision points (cont'd)

How much savings should be shared?

- State shares with consumers and taxpayers
 - The State shares with consumers through reinvestment
 - In addition to dispersing savings to providers, a portion of savings could be used for reinvestment. The State could use reinvested savings dollars to:
 - Expand its ASO infrastructure to include Medicare/Medicaid data integration, data analytics and intensive care management
 - Invest in local system development
 - Provide additional benefits to members
 - Enhance health information technology
 - The State shares with taxpayers through reductions to the General Fund

Key decision points (cont'd)

How do you enhance the quality of care?

- Performance measures: Benchmarks versus improvement
 - Benchmark: Using HEDIS or other percentiles as targets to meet or exceed
 - Improvement: Assessing whether provider performance has improved compared with the previous year
 - Both benchmarks and improvement: Requiring improvement each year until a certain benchmark has been achieved, and then maintain performance after that
 - Ways to apply performance targets:
 - The percentage of savings that is subject to selected performance measures increases over a five-year phase-in period
 - In first year provider either reports measures or maintains performance, while in subsequent year performance improvement is required

