

CONNECTICUT'S DUAL ELIGIBLE INITIATIVE SHARED SAVINGS

APRIL 4, 2012

Maria Dominiak, FSA, MAAA
Partner

Phoenix - 2325 East Camelback

CMS Shared Savings Model

- CMS will share 50% of Medicare savings with the State
- CMS assumes upfront State investment in care coordination
- State is eligible for a retrospective payment if there are certified Medicare savings
- CMS calculates available savings as Medicare savings net of increased Federal Medicaid costs

Two Models for Connecticut Duals

- Existing Administrative Services Organization (ASO)
 - Improved management for many duals
 - Data analytics and intensive care management
 - Additional funding related to greater complexity
 - Not eligible for shared savings; value-based incentives
- New Health Neighborhoods (HN)
 - Share savings to reward cost reductions
 - Contingent on meeting quality standards

Key Policy Question: Should Savings be Shared with Health Neighborhoods?

Context

- Emerging consensus: must address quality and cost to ensure value
- Specific interventions to reduce waste are one approach (e.g., duplicative and non-evidence based services, preventable care)
- Goal of creating a provider mindfulness regarding cost and quality
- Changes must be systemic, not marginal, to truly affect cost
- PCCM and pay for performance focus on quality – adding shared savings incentives completes equation

Key Policy Question: Should Savings be Shared with Health Neighborhoods? (cont'd)

Cautions

- Stakeholder concern about incentives to reduce care
- Possible to reward random fluctuations in costs
 - CMS addresses by establishing “minimum required savings”
 - Having more enrollees mitigates this risk
 - Bigger issue at individual provider level
- Administrative complexity of distributing savings
 - Requires distribution mechanism – state, HN, fiduciary
 - Requires CMS approval – possible complex waiver application?

Key Policy Question: Should Savings be Shared with Health Neighborhoods? (cont'd)

Supporting reasons

- Possibly insufficient providers without shared savings – providers must choose only one competing shared savings initiative (ACOs, CPCI)
- Incentives for efficiency may lead to some increased services (e.g., reduce hospitalization)
- If there are disincentives to service, they are present in rest of environment

Other Policy Questions

Dimensions of Shared Savings – Pooling

Should savings be pooled? Distribute global savings based on quality metrics regardless of HN savings?

- Doesn't take into account local variation
- Skewed incentives – doesn't push toward higher value
 - HN with improved quality but increased cost could get incentive payments
 - HN with improved quality and reduced cost could receive no reward if no statewide savings
- Providers don't seem to favor such arrangements

Other Policy Questions

Dimensions of Shared Savings – Services

Which services to include?

- Some programs exclude limited services
- Excluding certain services may lead to cost shifting
- Excluding services may lead to incentive payments when total costs have not decreased – increasing total costs
- PGP evaluation found that there may not have been adequate incentives to reduce costs when not included in calculation

Other Policy Questions

Dimensions of Shared Savings – Provider Allocation

Which providers receive shared savings? How should savings be allocated?

- Patient's health neighborhood is determined by patient's selection of PCP
- Other providers may decide about expensive services
- Other providers may lose revenue
- Distribution could affect provider choice of initiatives
- Analysis has shown this distribution may be complex and require some infrastructure

Other Policy Questions

Dimensions of Shared Savings – Beneficiaries

Beneficiary Participation

- Include all “full” duals, including nursing home residents and waiver participants

Assignment of Beneficiaries to HNs

- Can be complex and controversial
- Unlike managed care, typically no formal enrollment
- Typically passively “attributed” retrospectively based on practitioner visits
- Total freedom of choice of providers – may change at will – no “lock-in”
- Participation by attribution is generally invisible to beneficiary

Other Policy Questions

Dimensions of Shared Savings – Beneficiaries (cont'd)

Data Sharing

- Some privacy concerns
- Potential benefits by ensuring comprehensive medical record
- Allow beneficiary to choose not to share data (ACO approach)

Beneficiary Choice

- Some stakeholders advocate active choice of HN, not passive attribution with opt-out
- Concerns about adequate beneficiary participation
 - Active choice produces lower participation, regardless of beneficiary concerns
 - Insufficient numbers for evaluation?
 - Insufficient care management fees to achieve goals?
 - Goal of 5,000 – 7,000 per HN implies minimum 30–40% active choice
 - Experience shows much lower active choice in other programs
- Can result in providers trying to “cherry pick” beneficiaries

Shared Savings Evidence

Limited evidence of effectiveness of shared savings approaches

- PGP Model – only example with a formal evaluation
 - Performance bonus of up to 80% of savings if costs were less than 98% of trended target expenditures
 - No downside risk
 - 4 groups out of ten were found eligible for bonus – 2 standalone groups and 2 academic groups, no integrated systems
 - Organizational structure and previous expenditure trends were best predictors of eligibility for bonuses
 - All ten groups showed excellent quality measures and quality improvement

Shared Savings Evidence (cont'd)

- North Carolina – 646 waiver
 - Medicare shared savings program with organized provider networks (8 of 14 networks participating)
 - No savings found in first year
 - Did achieve improvements in 17 of 18 quality measures

Other Shared Savings Programs – Federal

- Comprehensive Primary Care Initiative (CPCI)
- Medicare Shared Savings Program – Accountable Care Organizations (ACOs)
- Pioneer ACOs
- Independence at Home
- Physician Group Practice Transition Demonstration

Other Shared Savings Programs – States

- Louisiana – Medicaid Coordinated Care Network (pending CMS approval)
- Maryland – Health Home Practices
- Massachusetts – Medical Home Initiative
- North Carolina – “646” waiver
- Ohio – Duals Proposal
- Pennsylvania – Medical Home Initiative
- West Virginia – Medical Home Performance Incentive Pilot
- Washington – Patient Centered Medical Home Multi-payer Reimbursement Pilot

Quality Incentives

Some stakeholders suggest encouraging cost savings through quality measures only (e.g., reduced ED use)

Are these sufficient?

- Other costs could rise (e.g., primary & specialist visits, home and community-based services, etc.)
- Potential for cost shifting – e.g., NF residents use ED less
- Evidence mixed at best – e.g., patient satisfaction correlates with higher costs

Continued Work: Modeling & Risk

Savings estimates

- Minimum panel requirement
- Minimum savings requirement

Timing

- Upfront costs
 - Establishing programs
 - Preventive care investments
- Savings
 - Data availability
 - Timing of potential savings
 - Phased payments?

Continued Work: Modeling & Risk (cont'd)

Other

- Interaction with other initiatives – e.g., enrollment
- Connecticut-specific factors
- Statistical validity of quality measures (subpopulation issues)
- Risk adjustment

Recommendations: General Principles

- Adequate participation of providers and beneficiaries
- Providers who achieve savings should share savings, but only if they meet quality benchmarks
- Promote accountability for overall value
- Base incentives on local rather than global performance
- Do not track savings to individual HN providers – too few beneficiaries
- Aim for administrative simplicity
- Aim for transparency and predictability in savings distribution
- Broadly include providers and services to prevent cost shifting and ensure accountability
- Retain flexibility during this new venture

Recommendations: Connecticut

- Provide upfront funding for HNs to support infrastructure development
- Share savings to encourage provider organization and participation
- Share savings based on HN-specific cost performance above a minimum threshold
- Only share savings with organizations that have met quality standards
- Each HN decides how to share savings with member providers based on quality, subject to DSS approvals
- Consider no shared savings first year dependent on availability of data and findings related to net savings
- Track complaints, grievances and quality measures – follow-up with providers as indicated

Recommendations: Connecticut (cont'd)

- Provide data on a consumer-focused website
- Consider periodic provider quality audits
- Attribute beneficiaries to HNs, but allow data sharing opt-out
- Require each HN have minimum threshold of participating beneficiaries
- Revisit decisions as appropriate and as allowed by CMS

