Aligning Higher Performance Through Shared Savings Programs

A Discussion Paper

Executive Summary

March 2014

Prepared by Pacific Health Consulting Group in collaboration with Andrew Naugle and Susan Philip of Milliman, Inc. for the Center for Care Innovations (CCI)

EXECUTIVE SUMMARY

The Center for Care Innovations commissioned this background paper to stimulate discussion and educate Medi-Cal managed care plans, safety net providers, and other California stakeholders about the potential of using shared savings programs to incentivize providers and improve health plan performance. Consultants from Pacific Health Consulting Group and Milliman, Inc. prepared this discussion paper, gathering the materials and commentary based on field knowledge, direct experiences with managed care plans in California and around the country, and discussions with leaders in the field. This paper focuses on shared savings programs including where providers share in upside risk *or* where they share in both upside and downside risk as participants in Medicaid managed care programs.

This paper is organized into five sections:

- **Introduction:** Key environmental elements that are driving changes in payment methodology and performance, and key terms used throughout the paper.
- **A Brief History of Risk Sharing in California's Local Public Plans:** How local public plans in California that were formed to provide certain protections for safety net providers have used risk-sharing approaches.
- **Approaches to Risk Sharing from Around the Country:** How commercial, Medicare, and Medicaid organizations have used shared savings strategies to improve performance.
- **Strategic Steps for Shared Savings Program Design:** Key elements in designing a shared savings program.
- **Lessons Learned and Looking Ahead:** What has been learned across the country from many different experiences, looking forward to what might be useful in future efforts.

INTRODUCTION

The passage of the federal Patient Protection and Affordable Care Act (ACA) in 2010—combined with regulatory pressures, federal incentives, and market demand—has set the stage for testing and adopting payment models to drive better health outcomes, population health management, and efficiencies.

Fundamentally, payment methods can be arrayed by the level of risk that a provider takes for managing a defined patient population. Payment methods include fee for service, pay for performance, shared savings (upside risk), shared risk (downside risk), episodic/bundled payments, and capitation/global payments. There are two perspectives from which the payment methods and financial risk can be interpreted: the health plan perspective and the provider perspective. Without risk sharing, the health plan accepts full financial risk for the services provided to its members. Plans use strategies to transfer this financial risk downstream to providers. Conventional wisdom suggests that the more financial risk transferred to downstream providers, the more incentive providers will have to optimize healthcare utilization.

The transfer of financial risk from the health plan to providers can affect the operational and administrative requirements of both parties. For example, transfer of risk creates new responsibilities for

the plan to aid in management of the risk arrangement; and it also creates new responsibilities for the provider to support management of the risk and activities otherwise performed by the plan. In addition, the nature of activities that remain with the plan may change; for example, the plan may also need to invest in infrastructure to assess the initial financial and administrative capability of the provider to perform delegated responsibilities, and to monitor ongoing performance under the delegation agreement.

As financial risk delegated to the provider increases, the health plan's share of total financial risk falls. As a health plan capitates more services, its administrative complexity declines. For the health plan, this decline in administrative complexity also means a change in administrative focus. Health plans often become more focused on ensuring that their members have access to and use services, and on monitoring and oversight of delegated functions. It is not surprising that the direct administrative costs incurred by health plans that transfer risk and delegate services to other parties are typically less than the administrative costs incurred by plans that retain all financial risk and administrative responsibilities. California has been a testing ground for a variety of different payment methods, the transfer of financial risk, and delegation of risk and administrative duties to providers.

APPROACHES TO SHARED SAVINGS

Approaches to shared savings and risk sharing vary depending on the market, target population, and providers' abilities to manage risk. Typically, capitation is used in conjunction with risk-sharing arrangements that hold the provider at risk for loss of payments if specified utilization or financial targets are not met.

The commercial insurance market has a long history of experimenting with risk-sharing methods, such as shared savings, pay for performance, capitation, and global fee payment arrangements. While shared savings per se is not a new concept, shared savings arrangements within an accountable care framework are being newly tested with hope to bend the cost curve, drive improvements in patient care, and improve population health.

Shared savings as a payment strategy has gained momentum over the last several years, especially with the creation of the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs) under the ACA. The MSSP, with incentives to reduce cost and improve quality, is a marked step in moving away from pure volume-based payment to rewarding value generation.

The managed Medicaid market has traditionally used risk-sharing arrangements (including global capitation) with managed care organizations (MCOs) and providers under which a delegated entity assumes the professional and hospital services risk for most services, or a more limited professional services capitation, in which a delegated entity takes the risk associated with the total cost of care for a shorter list of covered services. This discussion paper presents a recap of the risk-sharing trends in California's local public plans serving the Medi-Cal (Medicaid) population, with the adjustments and hybrids that are employed to improve quality scores and service encounter reporting.

Medicaid experimentation with shared savings is also occurring in the context of ACO structures. States have made adjustments, given the differences among Medicaid populations, the managed care practices within market regions, and the implications of potential savings on capitated rates to the MCO in subsequent years.

STRATEGIC STEPS FOR SHARED SAVINGS PROGRAMS

Several strategic steps are essential in designing a shared savings program. To improve the chance of adoption, sustainability, and long-term success, payors, providers, and relevant stakeholders such as state Medicaid agencies need to work collaboratively to make decisions. The following steps summarize the lessons learned from shared savings efforts undertaken in the Medicaid, Medicare, and commercial insurance markets.

⇒ **STEP 1:** Assess the current environment and goals of shared savings programs.

⇒ **STEP 2:** Determine the role of provider partners.

⇒ **STEP 3:** Determine the target member population.

⇒ **STEP 4:** Determine the minimum panel size.

⇒ **STEP 5:** Develop a patient attribution methodology.

⇒ **STEP 6:** Establish the benchmark.

⇒ **STEP 7:** Determine the method for calculating and distributing savings.

⇒ **STEP 8:** Establish quality-of-care metrics and targets.

KEY LESSONS LEARNED AND LOOKING AHEAD

Based on our review of the literature, discussions with experts, and our collective experience and knowledge, we summarize below several key lessons learned:

- Shared savings arrangements (upside only) are regularly used by California local public health plans. However, shared risk arrangements where providers are exposed to downside risk are not allowed by the California Department of Managed Health Care (DMHC) unless the provider group is licensed to assume risk under California law.

- Shared savings arrangements have been combined, and in some cases have been replaced, with pay for performance and other incentive programs in Medi-Cal Managed Care programs.

- Payment methodologies and incentive programs need to be designed to fit the existing capabilities of community providers to improve the chance of adoption, sustainability, and long-term success. For payment methodologies and incentive programs affecting publicly sponsored members, state Medicaid agencies, health plans, and providers will need to work collaboratively when such programs require regulatory approvals.

- Shared savings and risk-sharing strategies need to be considered in the larger context of payment and delivery system reform, including efforts to drive clinical transformation and to create a culture of accountability. Shared savings program designs should align with other reform efforts providing incentives for quality improvement.
- A key lesson of ACO experience is the importance of patient engagement and activation, especially for those with chronic conditions. Engaged and activated patients are associated with healthcare delivery improvements including reduction in duplicative and unnecessary diagnostic testing, reduced elective surgeries, and improved medication adherence.
- Payment and delivery system transformation efforts such as shared savings programs, must be supported by health information technology (IT) infrastructure, data exchange, and data analytics. These capabilities allow those participating in shared savings programs to make sense of the data collected and translate that information into actionable performance improvement initiatives.
- Health plans must make timely evaluations of payment arrangements and methodologies to help determine whether effective programs should be adjusted, expanded, or discontinued if they are ineffective.
- In the case of federal and state demonstration projects, evaluations of the effectiveness of payment arrangements and delivery models are needed (e.g., methodologies used to calculate the benchmark, apply risk adjustment, calculate the savings amounts, etc.).
- Plans and providers must reach agreement on the evidence-based, achievable process and outcome quality measures against which they will be held accountable. The agreement must be aligned with strategies to facilitate data collection and streamline metric calculations and reporting.

The use of shared savings programs offers promise as one compelling approach to payment reform. For a more thorough explanation of the topics described in this executive summary, please refer to the full text of the discussion paper titled "Aligning Higher Performance Through Shared Savings Programs," dated March 2014.

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I. INTRODUCTION

In the United States there is widespread recognition that the current healthcare reimbursement system largely relies on a fee-for-service (FFS) volume-driven system that creates perverse incentives to provide unnecessary services and uncoordinated care. Federal, state, and private payment reform initiatives are underway to move to a more outcome-based and value-driven system that reduces these incentives and prioritizes care management and care coordination.

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010—combined with regulatory pressures, federal incentives, and market demand—set the stage for testing and adopting payment models that drive better health outcomes, population health management, and efficiencies. The ACA directly encourages innovations in payment reform by establishing bundled payments and value-based payment demonstrations under Medicare, creating accountable care organizations (ACOs) under the Pioneer ACO program and the Medicare Shared Savings Program (MSSP), and providing funding for states seeking to implement Patient-Centered Medical Home (PCMH) models under Medicaid. The ACA also establishes payment penalties for health systems to reduce avoidable readmissions.

In this new environment, there is a greater need for care management and coordination that go beyond the traditional boundaries of delivery settings, along with a greater need to share rewards, risks, and accountability. True transformation includes delivery *and* payment system transformation. This discussion paper focuses primarily on payment reform efforts, with special attention paid to shared savings programs in which providers share upside risk only *or* share in both upside and downside risk.

Fundamentally, payment methods can be arrayed by the level of risk that a provider takes for managing a defined patient population. Payment methods include fee for service, pay for performance, shared savings (upside risk), shared risk (downside risk), episodic/bundled payments, and capitation/global payments. These payment methods are defined in the glossary at the end of this paper.

In managed care arrangements, payment methods are typically used in conjunction with retained or delegated financial risk. There are two perspectives from which the payment methods and financial risk can be interpreted: the health plan perspective and the provider perspective. In this paper, we have taken a broad view in defining "provider," to include the full spectrum of individuals and organizations that provide clinical services to patients, including physicians, physician groups, independent practice associations (IPA), hospitals, and organizations such as Federally Qualified Health Centers (FQHC).

Without risk sharing, the health plan accepts full financial risk for the services provided to its members. Plans use strategies to transfer this financial risk downstream to providers. Conventional wisdom suggests that the more financial risk transferred to downstream providers, the more incentive providers will have to optimize healthcare utilization.

The transfer of financial risk from the health plan to providers can affect the operational and administrative requirements of both parties. For example, transfer of risk creates new responsibilities for the plan to aid in management of the risk arrangement; and it also creates new responsibilities for the provider to support management of the risk and activities otherwise performed by the plan. In addition, the nature of activities that remain with the plan may change as well (i.e., claim processing work may be replaced with analysis of capitation payments). The plan may also need to invest in infrastructure to

assess the initial financial and administrative capability of the provider to perform delegated responsibilities, and to monitor ongoing performance under the delegation agreement.

As financial risk delegated to the provider increases, the health plan's share of total financial risk falls. As a health plan capitates more services, its administrative complexity declines. For the health plan, this decline in administrative complexity also means a change in administrative focus. Health plans often become more focused on ensuring that their members have access to and use services, and on monitoring and oversight of delegated functions.

It is not surprising that the direct administrative costs incurred by health plans that transfer risk and delegate services to other parties are typically less than the administrative costs incurred by plans that retain all financial risk and administrative responsibilities. California has been a testing ground for a variety of different payment methods, the transfer of financial risk, and delegation of risk and administrative duties to providers.

II. A BRIEF HISTORY OF RISK SHARING IN CALIFORNIA'S LOCAL PUBLIC PLANS

California has been the national leader in providing services to vulnerable Medicaid populations through managed care. The state has approximately 6.1 million lives enrolled in Medi-Cal Managed Care (MCMC), a larger Medicaid population than any other state.

California pioneered the enrollment of Medi-Cal beneficiaries under financial risk arrangements with commercial health plans in the 1970s. However, through the 1980s, enrollments slowed as commercial HMOs found Medi-Cal business to be only marginally profitable. Changes in federal and state Medicaid policies, combined with the initiatives of county governments, gave rise to locally administered and publicly sponsored health plans. These local public plans led the resurgence of MCMC in the 1980s and 1990s, and today have a statewide enrollment in excess of 4 million Medi-Cal eligibles. For a current landscape of Medi-Cal Managed Care, see Appendix 1; for a list of local public plans, see Appendix 2.

Local public plans in California first came to life as federal and state Medicaid Section 1115 demonstration projects to change payment incentives, improve access, and make local administration more responsive to providers. MCMC grew slowly during the 1980s, with the only significant expansion being the implementation of public plans in Santa Barbara and, later, San Mateo counties. These local public plans were called "County Organized Health Systems" (COHS) and were established by county governments as independent public entities so that the financial risk would be borne by local public plans, not by the county governments. By holding a single countywide public agency responsible for all Medi-Cal eligibles in the county and creating a larger risk pool, organizers hoped to realign financial incentives, emphasize primary care case management, respond more promptly to provider and beneficiary concerns, and improve access and quality of care.

The California Department of Health Care Services (DHCS) and others harbored ongoing concerns about the conventional Medi-Cal Program: specifically, about fee-for-service healthcare costs, poor access, and uneven quality. Based on its experience with COHS plans, commercial plans, and the poor performance of the conventional Medi-Cal Program, DHCS shifted its preference toward organized systems of care to improve Medi-Cal in the state's most populous regions. The state adopted policies to accelerate the development of managed care systems. The state also promoted the development of a new model of local public plans to compete directly with commercial plans in designated counties, including some of the most populous in California. State policy called for the formation of new local public plans, termed "Local Initiatives" (LIs). Like the COHS plans, LIs were established by county governments, though they are operationally independent of county control. Today, public plans have 70% of the Medi-Cal Managed care enrollment in California. See Figure 1.

Figure 1: Medi-Cal Managed Care Enrollment

Two-Plan Local Initiatives	
Alameda Alliance for Health	192,517
CalViva Health	231,317
Contra Costa Health Plan	108,236
Health Plan of San Joaquin (San Joaquin)	147,246
Health Plan of San Joaquin (Stanislaus)	58,239
Inland Empire Health Plan	708,693
Kern Family Health	140,385
LA Care	1,340,710
San Francisco Health Plan	82,419
Santa Clara Family Health	170,116
	3,179,878
	46.1%

County Organized Health Systems	
CalOptima	529,737
CenCal	115,158
Central California Alliance for Health	228,907
Gold Coast Health Plan	133,041
Health Plan of San Mateo	88,067
Partnership Health Plan of CA	383,563
	1,478,473
	21.4%

Local Nonprofit	
Community Health Group	171,406
	171,406
	2.5%

Commercial Health Plans	
Anthem Blue Cross	498,126
CA Health & Wellness	122,783
Care 1st Health Plan	47,031
Health Net	1,033,198
Kaiser	79,414
Molina Healthcare	285,837
	2,066,389
	30.0%

February 2014 Medi-Cal Managed Care Total	**6,896,146**

Local public plans have emerged as important players in community-based efforts to solve a variety of health and healthcare problems. One of the elements of these community-based efforts was risk sharing with the provider community.

From their inception, the local public plans were at risk for financial losses if costs exceeded the per-member-per-month (PMPM) capitated payment rates provided by DHCS. Consequently, local public plans were motivated to seek arrangements that transfer risk downstream at the provider level, where care is delivered and resources can be more carefully managed. The first COHS, the Santa Barbara County Special Health Care Authority (Santa Barbara COHS), which began operating in 1983, pioneered risk sharing with primary care providers. Since that time, COHSs and LIs have been expanding and adjusting risk sharing to include more providers while utilizing multiple methods of sharing risk with providers in their communities.

EARLY EXPERIENCE OF RISK-SHARING ARRANGEMENTS WITH PRIMARY CARE PROVIDERS

Beginning in 1983, the model of reimbursement for the Santa Barbara (SB) COHS was a capitated payment for primary care case management. Figure 2 summarizes the model. Medi-Cal recipients selected a primary care provider (PCP) who was responsible for directly providing primary care and arranging and authorizing referral services. PCPs were reimbursed using a variety of methods that aimed to encourage and reward them for managing care and to accommodate existing community practice patterns. PCPs could receive reimbursement in one or more of the following three ways:

- Capitation for case management and basic primary care services
- FFS for selected services not considered primary care, but provided within the PCP's scope of practice
- Shared financial risk through accounting for the healthcare expenditure experience associated with each PCP contract.

All other participating providers were paid based on Medi-Cal fee-for-service schedules.

Figure 2: Santa Barbara COHS Reimbursement Model

	Payment Method				
Network	Professional-Primary Care	Professional-Specialty Care	Hospital	Other	Pharmacy
Primary Care Providers	Cap	FFS	FFS	FFS	FFS
SB County Health Department Clinics	Cap	Cap	FFS	FFS	FFS

Individual PCPs in the Santa Barbara COHS were mainly reimbursed by capitation rates, adjusted for age, sex, and Medi-Cal aid category. Safety net providers, like community clinics, were also paid a capitation rate, similarly adjusted, but which also included a boost to reflect the higher fee-for-service rate to which they were entitled by Medi-Cal regulations. The capitation approach made PCPs and community clinics aware that they were at risk for their services and there were limited budgets. PCPs were also linked in a risk-sharing system built around "Trust Accounts."

Figure 2 shows what services were reimbursed on a capitated basis. PCPs (and community clinics) were reimbursed by capitation for primary care services, as agreed upon in contractual protocols. Another safety net provider, the Santa Barbara County Health Department, was reimbursed by capitation for primary care and specialty care The County Health Department employed both primary care and specialist physicians. This arrangement is very similar to the independent practice association (IPA) capitation and shared-risk program for other services found today.

Providers such as specialty physicians, hospitals, pharmacies, and others were paid on a fee-for-service basis

For each PCP and for the Santa Barbara County Health Department, the Santa Barbara COHS established shared savings (i.e., Trust Accounts). Monthly, the COHS allocated a budgeted dollar amount to the account of each PCP for each enrolled Medi-Cal member, adjusted by age, sex, and aid category. Actual expenses (fee-for-service reimbursements in Figure 2) were charged against the account and any surplus was split equally between the PCP and the plan. The PCP was paid a capitation equal to 80% of the allocated amount for primary care services. The remaining 20% of the capitation for primary care services was withheld and used to fund deficits in the trust accounts across the range of covered services. This program included both upside and downside shared savings.

When the Santa Barbara COHS began, PCPs had no expectation of receiving additional compensation other than the monthly capitation. Gradually, as PCPs gained experience in working with the COHS, there was a change in their thinking. The Trust Accounts reports were essentially status reports of the debits (capitation and fee-for-service payments) and credits (the allocations for capitation and healthcare costs) for each PCP's patient panel under case management. Trust Accounts were maintained for the Santa Barbara County Health Department and for community clinics as well. After the plan distributed the first set of Trust Accounts reports, several physicians commented that, until the advent of the Santa Barbara COHS, they had never seen the full range of services and costs for any specific patient, Medi-Cal or not, once those patients left their offices. Fortunately, the first year was a significant financial success, which was mostly attributable to improved primary care access and lower inpatient utilization. Most PCPs received significant risk-sharing payments.

EARLY EXPERIENCES IN EXPANDING RISK-SHARING ARRANGEMENTS TO OTHER PROVIDER TYPES

As the PCP case management model was adopted by succeeding COHSs, a number of modifications took place. The number of providers participating in the risk program expanded as the plans tried to incentivize more of the network.

When Health Plan of San Mateo started in late 1987, it included hospitals in the risk-sharing program. Hospital "pods" were created that brought PCPs and the hospital to which they admitted patients into alignment. The hospitals shared in both upside and downside risk. Hospitals were subject to a 20%

withhold on per diem inpatient payments and eligible to a share of savings. The health plan and PCPs had to reduce their shares of the hospital savings. The risk-sharing program was consistently deemed successful.

The next COHS was established by Santa Cruz County and it added specialists to the risk-sharing group. It was difficult to add specialists because the plan wanted to reward them for participating and managing care, but did not want to reward them for providing more and possibly unnecessary services. The specialists joined the program only through upside risk.

To accommodate specialist participation in risk sharing, the local public plan, PCPs, and hospitals had to accept reduced levels of savings. Planners in Santa Cruz County wanted to integrate Federally Qualified Health Centers (FQHCs) into the risk-sharing program. However, after further consideration, they decided that if an FQHC would not assume downside risk, they should not be able to accept surplus sharing either. This was deemed an inadequate balance of compensation incentives. Other local public plans believed it was appropriate for FQHCs to participate in shared savings programs that involved only upside risk.

In Solano County, the next COHS site, a similar risk-sharing model was implemented, but with increased downstream service delegation and added capitation. Two additional provider networks were formed by subcontracting with a licensed HMO and subcontracting with an existing IPA. These changes were based on the interest and capability of local providers to manage risk.

When DHCS implemented the Medi-Cal managed care Two-Plan Model in the mid-1990s, all of the aforementioned risk-sharing and subcontracting methods were utilized. Safety net providers, like community clinics and FQHCs, were integrated into risk-sharing arrangements. In some counties, there was one other important development: the scope of services covered by capitation increased substantially with the corresponding delegation.

California's regional differences in the healthcare economy play an important role in driving financial risk-sharing models. Southern California has a large Medi-Cal population that makes network development a significant undertaking. However, parties such as HMOs, and Physician-Hospital Organizations (PHOs) in Orange County, were willing to perform delegated duties and accept the financial risk of capitation for a broader array of covered services. Los Angeles and Orange counties implemented Medi-Cal managed care programs that almost exclusively utilized capitating HMOs and PHOs as their principal provider subcontractors. Those subcontractors also often capitated IPAs, and in many cases also capitated the hospitals affiliated with IPAs. This method is often referred to as "Dual Risk" capitation in that both the IPA and the hospital are capitated. For the plans this meant they passed on almost all of their risk.

In the late 1990s and early 2000s, the local public plans started to move away from shared savings programs. This move was motivated by two issues: regulatory requirements and the drive to focus incentives on performance. The first issue dealt with regulatory matters under the Knox Keene Act/Health Care Service Plan Act, California's HMO licensing law. The California Department of Managed Health Care (DMHC), the state agency entrusted with enforcing that law, became increasingly concerned that, in commercial health insurance markets, medical groups that did not have HMO/limited liability licenses were assuming financial risk. This exposure could eventually lead to financial problems and imperil access to care. DMHC began to limit the amount of risk that medical groups could assume. Essentially, DMHC determined that provider groups could not be capitated for services they are not professionally licensed to provide directly unless the group obtains a "Limited License" approval from DMHC. The license is

limited in the sense that the group is not licensed to do all HMO functions. DMHC held that medical groups/IPAs could not have downside risk without a license.

There was another regulatory concern. DMHC and other public policy makers wanted to address the appropriateness of making direct surplus payments to physicians. Such reimbursement systems could be interpreted as paying physicians to withhold care. In the end, DMHC did not require plans to eliminate shared savings programs, but many of them voluntarily eliminated or modified them, making them less direct and more driven by healthcare utilization. In the latter case, utilization targets are set, primarily for hospital admissions and emergency room use, and payments are made to physicians/physician groups when target utilization levels are met.

The second issue during this period involved sharing financial success. Local public plans and their participating providers were regularly generating financial surpluses to share. As a result of public and regulatory pressures, the plans wanted to target funds to achieve quality and mission-driven goals as well. Among the purposes for which local public plans wanted to target a return of surplus revenues were the following:

- Improved access to primary care
- Increased percentage of inpatient admissions at safety net (i.e., county) hospitals
- Improved Healthcare Effectiveness Data and Information Set (HEDIS) and/or Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores
- Improved grievance scores
- Increased encounter reporting

These programs are all variations of pay for performance (P4P). Most plans funded these efforts by shifting the allocation of dollars from shared savings programs to achieve other health plan objectives, such as promoting the use of safety net clinics and hospitals. The safety net measures were adopted to incentivize providers to utilize safety net clinics and hospitals. (Figure 4 shows examples of these programs).

By the mid-2000s, most local public plans were "mixed" models in that they used several types of networks, reimbursement methods, and risk-sharing programs. Figure 3 shows how provider networks were paired with reimbursement methods. In both Northern and Southern California, financial risk models varied from plan to plan based on the local healthcare economy and plan decisions around regulatory reserve requirements.

In the late 2000s, local public plans started to move to fewer capitation contracts and more fee-for-service contracts. The plans were driven not only by the limitations on certain risk-bearing organizations (RBOs) set by DMHC, but also by plan experience that capitation made it more difficult to influence directly the care provided to members and to improve scores on quality measures. It proved to be very difficult to improve HEDIS scores if subcontractors were capitated. Even when plans created these same quality improvement programs for their subcontracting HMOs and IPAs they never proved as effective as when the plans dealt directly with physicians.

Figure 3: Spectrum of Reimbursement and Risk-Sharing Models

Plan Reimbursement Method / Provider Network	Payment Method: Professional-Primary Care	Professional-Specialty Care	Hospital	Other	Pharmacy
PCP (including FQHCs)	Cap	FFS	FFS	FFS	FFS
IPA/Medical Group (including FQHCs)	Cap	Cap	FFS	FFS	FFS
Dual Hosp-IPA Cap/PHO	Cap	Cap	Cap	FFS	FFS
HMO	Cap	Cap	Cap	Cap	Cap

MOVEMENT TO VALUE PURCHASING

A parallel movement was also taking place in California's healthcare system during the 1990s and early 2000s. Major healthcare purchasers, in both the private and public sectors, wanted to become "value" purchasers and were placing a greater emphasis on quality and transparency. They wanted to know the benefits they received from the premium dollars they spent.

Plans, providers, and payors continue the struggle today to work out the right mix between cost and quality, and between transparency and administrative efficiencies. In an ideal situation, there is no conflict between these goals. However, the central problem remains: capitation is highly effective at optimizing utilization but almost always results in less accurate service level information being reported from the service provider upstream to the health plan and offers providers little insight into healthcare outcomes. The challenge to make informed and effective purchasing decisions is reflected in the evolution of capitation, risk sharing, and performance in Medi-Cal managed care.

RISK SHARING IN LOCAL PUBLIC PLANS TODAY

The local public plans use the variety of reimbursement and risk-sharing methods described above. While most still pay capitation to PCPs, subcontracting IPAs or medical groups, and subcontracting HMOs, fee-for-service payment is common for targeting preventive services. Most plans still have retained shared savings programs in some form, and all plans have programs to improve quality scores and encounter reporting. Local public plans usually employ mixed models that incorporate elements of the above. Statewide, approximately 30% of Medi-Cal members are in subcontracting networks of contracted HMOs. Another 40% are in networks where only the PCP is capitated. The remaining 30% are in capitated IPAs. The share of members enrolled in the HMO's network used to be over 50% statewide, but a number of health plans moved many of their subcontracting HMO lives into more limited capitated networks. For example, LA Care created a network in which IPA or medical groups were capitated and delegated for

professional services, with shared savings accounts for most other services. This network now complements LA Care's HMO network and has over 300,000 lives under contract.

Today, California's public plans use both the direct and indirect "sharing" programs. Those public plans in northern California plans, structured like the Santa Barbara COHS, have altered their "direct" shared risk and/or shared savings programs to "indirect" programs like P4P to achieve incentives for utilization, quality, and encounter reporting. These programs can be called indirect because they reward providers for utilization targets being met that suggest that costs are being saved. On the other hand, most of the public health plans in southern California have retained shared savings programs in which they do not capitate full financial risk to subcontractors, and only pay providers if costs savings are actually achieved. These plans have also added quality and encounter based programs.

FQHCs participate in both types of programs. For example in Los Angeles the FQHCs have formed an IPA that contracts with both the Commercial Plan and the LI. There is shared savings (direct) program in both plans. There are also other incentive/P4P programs available. FQHCs participate in both just like any other provider.

Figure 4: Shared Risk/Incentive Methods

	Shared Risk/Incentive Criteria					
Incentive Criteria / Provider Network	Shared Risk Pools	Safety Net Utilization	Grievance	CAHPS	HEDIS	Encounter Reporting
PCP	Yes	Yes	Yes	Yes	Yes	Yes
IPA/Medical Group	Yes	Yes	Yes	Yes	Yes	Yes
Dual Hosp-IPA Cap/PHO	No	Yes	Yes	Yes	Yes	Yes
HMO	No	Yes	Yes	Yes	Yes	Yes

III. APPROACHES TO RISK SHARING FROM AROUND THE COUNTRY

Approaches to shared savings and risk sharing vary depending on the market, target population, and providers' ability to manage risk. Under shared savings arrangements, providers have the incentive to reduce healthcare spending below a specified target to be rewarded with a percentage of achieved savings. Typically, shared savings approaches are used in conjunction with downside or risk-sharing arrangements that hold the provider at risk for loss of payments if specified targets are not met.

COMMERCIAL MARKET: COMBINING UPSIDE AND DOWNSIDE RISK ARRANGEMENTS

The commercially insured market has a long history of experimenting with risk sharing, shared savings, pay for performance, capitation, and global fee payment arrangements. While shared savings is not a new concept, shared savings arrangements within an accountable care framework are being newly tested. The self-insured market[1] has been developing innovative payment reform models to achieve the Triple Aim: bend the cost curve, drive improvements in patient care, and improve population health.

In 2010, Blue Shield of California, Dignity Health, and Hill Physician Medical Group formed an accountable care organization (ACO)[2] with a goal of reducing healthcare spending and improving care quality for a defined population covered by the California Public Employee Retirement System (CalPERS). This ACO set an annual global budget reflecting total expected health spending in five service categories[3] for 41,000 members. In this case, the payment structure for providers did not change: Blue Shield continued to pay Hill Physicians and Dignity Health based on negotiated fee-for-service (FFS) or capitated payments.

However, the plan and providers had a financial stake in achieving savings given that there would be a distribution of savings or losses at the end of the fiscal year. CalPERS received an up-front reduction in the premiums they would normally pay Blue Shield to reflect the difference between the expected cost and the target budget. Between 2010 and 2011, the ACO is estimated to have achieved approximately $20 million in cost savings, including $5 million shared among the partners and $15.5 million in premium credits to CalPERS. This arrangement also achieved a 12% reduction in inpatient days and a reduction of readmissions within 30 days of discharge—from 5.4% in 2010 to 4% in 2011 (Luippold, 2013).

Currently, in the commercial insurance market, a shared savings strategy—with upside risk only—is not viewed as a sustainable cost reduction strategy. In markets where providers have little experience in managing risk and payment is predominantly FFS, upside-risk-only shared savings models are a good starting point for one to three years. Payors may also provide additional funding to assist providers with start-up costs necessary for developing essential infrastructure to support risk and care management functions (referred to as "care management fees").

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[1] A self-insured group health plan (or a "self-funded" plan as it is also called) is one in which the employer assumes the financial risk for providing healthcare benefits to its employees.

[2] An ACO is generally defined as a group of healthcare organizations, including primary care physicians, specialists, hospitals, and payors, that accepts collective accountability for the cost and quality of care delivered to a defined population of patients.

[3] Facility services, professional services, mental health services, pharmacy, and ancillary services.

Premier, an alliance of more than 2,800 U.S. hospitals, recently conducted a survey of its Partnership for Care Transformation (PACT) Population Health Collaborative, which launched in 2010. The PACT effort is designed to assist member health systems that are interested in developing the necessary capabilities to launch an ACO or those that are already ready to implement ACOs in local markets. This study found that shared savings arrangements are more often accompanied by downside risk arrangements for commercial markets than for the Medicare market. Premier speculates that this is because "commercial payors have bottom line obligations, and are less tolerant than public payors of losses."

However, commercial payors also recognize that providers cannot move to global capitated payments overnight and that incremental changes, building on existing reimbursement models, are needed to allow providers the time to gain experience in managing care for a designated patient population. Payors seek provider partners that are both willing and able to invest in the infrastructure and capabilities to engage in alternative payment models, including shared savings and risk-sharing arrangements. Premier's survey found that payors were willing to engage in a shared savings (upside only) arrangement in the early years of ACO adoption to allow for testing of new delivery models. This approach can enable providers and payors to make up-front investments in developing the necessary infrastructure for managing the total cost of care, reorganizing care delivery, and achieving real clinical transformation (Premier, 2013).

MEDICARE: STRUCTURE OF THE MEDICARE SHARED SAVINGS PROGRAM

Shared savings as a payment strategy has gained momentum over the last several years, especially with the creation of the Medicare Shared Savings Program (MSSP) for ACOs under the ACA. The concept predates the ACA: under the Centers for Medicare and Medicaid Services (CMS) Physician Group Practice demonstration project (PGP), which ran from 2005 to 2010, participating physician groups received shared savings payments from Medicare if they met certain quality targets and exceeded a savings threshold of 2%. Only a minority of providers were able to achieve any cost reductions, but most of them consistently demonstrated improvements against quality measures (Wilensky, 2011). Under the ACA, the MSSP was launched in 2012, building on the lessons of the PGP program. In addition to offering eligible providers upside risk, the MSSP is structured to include the option of taking downside risk. Specifically, ACOs can choose to follow one of two tracks:

1. Track 1 is a one-sided approach that allows eligible providers to receive bonus payments if their Medicare spending is below a set target that varies depending on the patient population. Participation in this track is limited to one year, after which the ACO must transition to Track 2 if it is to continue participation.
2. Track 2 is a two-sided approach that also allows eligible providers to receive bonus payments resulting from spending that is lower than expected. However, in cases where the spending exceeds the target, providers also share in the excess costs.

Given the prevalence of direct FFS payment in the Medicare market, the MSSP is a marked step in moving away from pure volume-based payment to rewarding value. The MSSP provides incentives not only to reduce costs but also improve quality by requiring participating ACOs to report performance based on 33 quality measures. (CMS, Medicare Shared Savings Program Final Rule, CMS-1345-F, 2011.)

MEDICAID: INTEGRATING NEW PAYMENT ARRANGEMENTS IN A MANAGED CARE CONTEXT

The Medicaid market has traditionally used risk-sharing arrangements with managed care organizations (MCOs) and providers. A survey of Medicaid managed care plans in 2001 found that 76% of MCOs used some type of risk-sharing arrangement with their providers. This included global capitation in which a delegated entity assumes the professional and hospital services risk for most or all services for a designated patient population; or professional services capitation in which a delegated entity takes the risk associated with the total cost of care for primary and specialty services as well as related professional services such as laboratory or radiology. Under global capitation, plans tended to transfer more of the state-capitated payments (about 73%) to the provider than under the professional services capitation arrangement (about 44%) (Draper, 2003.)

As in the Medicare and commercial markets, experimentation with shared savings is also occurring in the context of ACO structures in Medicaid. Several states have used the MSSP model as a basis for developing their own ACO programs, but they have made adjustments given the differences in population and the managed care context under which most Medicaid programs operate. Adjustments are made to aspects of the shared savings calculation methodology, including treatment of high-cost healthcare claims and how the targets are selected (as discussed in Section IV below).

The MSSP program does not allow Medicare Advantage plans to participate as eligible ACOs. States did not wish to adopt a similar policy approach for Medicaid, given that 75% of Medicaid beneficiaries in the United States are enrolled in managed care. Nevertheless, aligning ACO initiatives with existing MCO arrangements requires a careful balancing act that takes into consideration how shared savings payments are structured in a capitated environment. For example, if an ACO achieves cost reductions, savings can be shared with the MCO, which, in turn, can determine how to distribute those savings to contracted providers. However, if the ACO effectively reduces overall Medicaid spending, capitated rates to the MCO in subsequent years will also be reduced.

IV. STRATEGIC STEPS FOR SHARED SAVINGS PROGRAMS

Several strategic steps are essential in designing a shared savings program. To improve the chance of adoption, sustainability, and long-term success, payors, providers, and relevant stakeholders such as state Medicaid agencies need to work collaboratively to make decisions. Typically, while state agencies have shared savings program efforts, successful strategies recognize that plans and providers are important partners that must be at the table to evaluate options and make design decisions. In this section, we lay out those steps, highlighting considerations for the Medicaid population, and drawing on examples from Medicare, Medicaid programs in other states, and the commercial markets.

Figure 5: Steps to Designing a Shared Savings Program

- ⇒ **STEP 1:** Assess the current environment and goals of shared savings programs.
- ⇒ **STEP 2:** Determine the role of provider partners.
- ⇒ **STEP 3:** Determine the target member population.
- ⇒ **STEP 4:** Determine the minimum panel size.
- ⇒ **STEP 5:** Develop a patient attribution methodology.
- ⇒ **STEP 6:** Establish the benchmark.
- ⇒ **STEP 7:** Determine the method for calculating and distributing savings.
- ⇒ **STEP 8:** Establish quality-of-care metrics and targets.

⇒ STEP 1: ASSESS THE CURRENT ENVIRONMENT AND GOALS OF SHARED SAVINGS PROGRAMS

The design and structure of a shared savings payment program vary depending on the current environment in which they are applied and the articulated goals of the shared savings program.

Current payment and delivery environment: Assessing the current environment requires payors, providers, and stakeholders to address several key questions early in the process, such as:

What is the existing reimbursement system? Are providers currently reimbursed on a pure FFS basis, or are they partially or fully capitated?

- Are there pay-for-performance incentives that can be built upon?
- Are there existing performance measures being collected and/or reported (e.g., structural, process, and/or outcome measures for quality of care or efficiency)?
- Are there medical home initiatives that can be built upon?

- What current state and federal initiatives can be built upon? How can any new MCO or community shared savings programs align and comply with existing state and federal requirements?
- What are the infrastructure gaps that need to be addressed? For example, are the health IT systems sufficient to support patient identification and outreach efforts?
- Are plans for future investments aligned with programmatic goals? For example, if the goal is to reduce avoidable emergency room (ER) visits and inpatient readmissions for children with pediatric asthma, are the investments aligned to develop necessary IT systems that support changes to the clinical work flow (e.g., alerts to the PCP when a child has an ER visit or inpatient admission)?

Goals of a shared savings program: Identifying the goals of any payment and delivery system reform effort begins with asking stakeholders to articulate their overarching goals and make the case for how the selected payment model will help them attain those goals. For example, if the goal is to drive health improvements for specific subpopulations, the payment model may first be tailored for those populations. The New Jersey Medicaid ACO demonstration project was designed with a clear intent to address the problem of "super-utilizers" within a specific geographic area. Once the community articulated that as a clear goal, the program was designed accordingly. All claims (especially those that could be considered "outliers") were included in the analysis of providers' performance. From the community's perspective, this was a necessary step to give providers incentive to address the needs of super-utilizing beneficiaries.

Once programmatic goals are articulated, payors, providers, and stakeholders benefit by addressing fundamental questions regarding the desired payment and delivery system model, including:

- What is the desired organizational structure? Is the goal to reorganize the system into an ACO (i.e., as a separate legal entity with clear governing body)? Is the goal to work within current organizational structures, for example maintaining managed care organization contracts with network providers? Or is the goal to test hybrid structures with state payments going to both MCOs and ACOs?
- What is the desired delivery model in terms of integration and patient-centeredness?[4] For example, is the goal to move toward a medical home model or a patient-centered medical home (PCMH) recognized by the National Committee for Quality Assurance (NCQA)? Is the goal to integrate and/or coordinate all services (e.g. inpatient, outpatient, pharmacy, lab, mental health, post-acute care, and long-term care support services)?

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[4] The Institute of Medicine identifies patient-centeredness as a core component of quality healthcare. Patient-centeredness is defined as: "[H]ealth care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care." (Institute of Medicine. Envisioning the National Health Care Quality Report. Washington, DC: National Academies Press; 2001.)

⇒ STEP 2: DETERMINE ROLE OF PROVIDER PARTNERS

The success of a shared savings program will depend on balancing the need for provider participation with the need for contracting with providers who are ready and able to make care delivery and system changes to meet the performance thresholds and program requirements.

MCOs seeking provider partners benefit from first assessing the characteristics of their contracted providers and their readiness to enter into arrangements. Figure 6 shows provider selection criteria that commercial payors apply to provider partners for ACO-type arrangements based on a 2011 AHIP survey.

Figure 6: Provider Selection Criteria for Private-Sector Initiatives in Care Delivery and Payment Reform Model Design

Criterion	Description
Clinical integration/ network adequacy	Strong focus on primary care with added capacity to provide full spectrum of clinical services, including primary and specialty care either from within the organization or through affiliations/partnerships with community physicians and facilities.
Leadership	Presence of a strong, forward-thinking leadership and culture of commitment to accountable care.
Long-term relationship	Willingness of provider groups to accept long-term arrangements of three years or more.
Health IT infrastructure	Existence of strong health information technology (HIT) infrastructure. This includes adoption of electronic health records (EHRs), patient registries, alerts and reminders, and other IT architecture that enables timely data exchange with other providers involved in patient care and with the health plan; robust data exchange capabilities include the ability to share administrative data such as referrals, prior authorization requests, and claims as well as clinical data such as diagnosis, physician orders, tests and lab results, and medication lists.
Data analytics	Quality data and analytic capabilities that allow providers to access and use information in a timely fashion to support the clinical work flow. At minimum, patient registries are needed to understand which patients are in need of more intensive monitoring and care management.
Patient panel size	Panel sizes that are sufficiently large to ensure reliable measurement of quality and cost; minimum patient panel size requirements typically exceeded ACA minimum requirements of 5,000 patients for the Medicare Shared Savings Program.

Source: Adapted from Higgins, et al. 2011.

The Medicaid population includes the most vulnerable, including persons with disabilities and populations with special needs. Shared savings arrangements in the Medicaid market are often tested with practices that are also undergoing transformation to operate as a medical home or within a medical neighborhood. State agencies and MCOs recognize that practices and health systems that are willing to make the concerted effort and investment to reorganize care management and support systems into a medical home model have a better chance at successfully caring for Medicaid patients.

Typically, shared savings arrangements include medical groups, practices, and their primary care providers or specialists who may see a patient for most of their care (e.g., a cardiologist for a patient with coronary artery disease). Hospitals and health systems may also be included in such arrangements, especially those hospitals where participating providers have privileges. Medicaid MCOs may also consider including safety net providers that are already in their network, are considered high-performing systems, or meet readiness criteria. Shared savings arrangements with certain provider types, such as FQHCs, need to comply with federal and state reimbursement rules. At this time, the Medicare ACO in California led by a group of FQHCs in the Redwood Community Health Coalition (Sonoma and Napa Counties) is just beginning.

⇒ STEP 3: DETERMINE TARGET MEMBER POPULATION

A critical step for developing shared savings arrangements is defining the population for which providers are accountable. For the Medicaid population, MCOs should consider which eligibility categories should be included:

- Adults aged 18 to 64 with children who do not have a disability
- Pregnant women
- Children with a disability or special needs
- Adults aged 18 to 64, with or without children, with a disability or special needs
- Elderly persons, 65 or older

In addition, MCOs should consider whether to exclude populations that are included in other federal or state initiatives, such as the dual-eligible population included in the CMS financial alignment model to integrate care for Medicare and Medicaid enrollees.

When considering which populations to include, MCOs may wish to start with a specific patient population and then expand to other populations once the payor, providers, and the state agencies have gained experience.

⇒ STEP 4: DETERMINE MINIMUM PANEL SIZE

A robust panel size is necessary to ensure that shared savings calculations have some level of confidence. Payors need to be confident that calculated savings are the result of true savings achieved by providers' efforts as opposed to random variation. MSSP requires that at least 5,000 Medicare beneficiaries be

assigned to an ACO to be considered eligible for the program. Commercial shared savings programs vary—from a minimum of 1,000 assigned members to 15,000. (Some commercial shared savings plans may not specify a minimum but only large groups are currently participating.)

Medicaid programs also vary. New Jersey sets a geographic area for participation and requires a minimum of 5,000 members to be assigned. Minnesota uses a three-tiered structure: the first includes ACOs with 1,000 to 2,000 members; the second, 2,000 to 5,000; and the third, 5,000 and above. Each tier is subject to different rules for calculating savings (e.g., treatment of outliers, discussed below). Maryland, under its Multi-Payer Patient Centered Medical Home Program—which includes both commercial and Medicaid MCO members—does not have a minimum, but averages close to 2,000 per practice group. Successful tactics for establishing minimum panel size require actuarial analysis based on historical healthcare use and costs of the eligible patient population. Payors, providers, and other stakeholders need to work collaboratively to evaluate the trade-offs of achieving provider participation versus the potential of paying bonuses as a result of statistical variation.

⇒ STEP 5: DEVELOP PATIENT ATTRIBUTION METHODOLOGY

Patient assignment methodology development is a time-consuming effort and requires leadership to make up-front decisions that reflect the goals of the shared savings program. Assignment for Medicaid members who are enrolled in a managed care plan and have an assigned PCP is straightforward. For Medicaid members who do not have an assigned PCP, retrospective assignment may be required.

Under MSSP, CMS assigns beneficiaries retrospectively to ACOs based on where they receive specified evaluation and management services (e.g., primary care and preventive) for the most recent 12-month period. Specifically, CMS takes a two-step process:

1. Beneficiaries are assigned based on PCP visits. A beneficiary is assigned to the associated ACO that accounts for the largest amount of total Medicare allowable charges for that beneficiary's primary care services.
2. CMS reviews the claims for the remaining beneficiaries who have had a primary care service from a non-PCP (including specialists and nurse practitioners) and assigns them to the associated ACO based on total allowable charges.

When first released, the MSSP method of retrospective attribution met with criticism by provider groups that argued they would not know which Medicare beneficiaries they were accountable for managing until at least six months after each year during the three-year contract. CMS addressed this by providing information on which beneficiaries would have theoretically been assigned to the ACO based on historical data. CMS argued that the retrospective method incentivized ACOs to drive healthcare improvements for *all* Medicare beneficiaries rather than just those attributed to them.

In the commercial market, member attribution methods vary based on the plan type. For an HMO plan, a member typically already has a primary care provider assigned. For preferred provider organization (PPO) plans, members are assigned based on claims history for primary care visits for at least 12 months. Blue Cross Blue Shield of Illinois and Advocate Health Care jointly developed a confidential methodology, looking back over a 24-month period. They also included a tie-break algorithm (Bailit et al., 2012).

Medicaid programs typically have most of their memberships assigned to a primary care provider or, where applicable, a medical home.

The Minnesota Health Care Delivery Systems (HCDS) demonstration uses a four-step process for assignment:

1. Assign the member to the healthcare home for which a claim has been submitted.
2. Assign the member based on office visits with a primary care provider.
3. Assign the member based on any office visit (regardless of specialty).
4. Assign the member based on a plurality of ER visits. (Note: This step will not be used in the first year.)

Performance will be assessed only for those who were enrolled for a six-month continuous period or a nine-month noncontinuous period. Minnesota also excludes the dual-eligible population and those with less than full Medicaid benefits.

Payors, providers, and other stakeholders must collectively determine member attribution methods that they agree are fair and reasonably representative of the population providers can effectively manage.

⇒ STEP 6: ESTABLISH THE BENCHMARK

Establishing the benchmark or the total cost of care (TCOC) by which performance will be measured requires determining the measurement period, the services that are within scope, and the services outside of scope.

CMS recommends that state Medicaid agencies that are considering implementing a shared savings program should use complete data from the year prior to the start of the performance period because those data reflect the most recent Medicaid policies. The next step is to trend that baseline data to the current performance year based on medical expenditure growth rates using actuarially sound methods. Making adjustments based on the risk profile of the target population may also be necessary. This is especially relevant if the population that is used to develop the baseline is different from the target population upon which providers' performances will be measured (Mann, 2013). Some shared savings models based on medical home models have used their own populations' past performances as benchmarks, with no risk adjustment, because the risk mix is not likely to change substantially from one year to the next (Ballit, 2011). The MSSP risk-adjusts both the baseline expenditures and the performance year expenditures on the CMS Hierarchal Condition Category (CMS-HCC).

Services included in the total cost of care (TCOC) calculation should be transparent to participating providers. A strategy for encouraging participation is to set varying rewards for a broader definition of TCOC and/or allowing for a phase-in approach.

Vermont required "Core Services" (as seen in Figure 7) to be covered the first year but also allowed providers to opt to include services beyond them (such as pharmacy and mental health services) for an additional potential reward payment. Those services beyond Core Services are required to be included in the TCOC by Year 3.

Figure 7: Services Included in the TCOC Calculation for Vermont's Medicaid ACO

Core Services Required in Year 1	Services Beyond Core Services (optional in Year 2; required in Year 3)

• Inpatient hospital
• Outpatient hospital
• Nursing facility (will be very limited based on the four enrollment categories selected)
• Physician (primary care and specialty)
• Nurse practitioner
• Nursing
• Ambulatory surgery center
• Clinic
• Federally Qualified Health Center
• Rural Health Clinic
• Chiropractor
• Podiatrist
• Psychologist
• Optometrist
• Optician
• Independent laboratory
• Home health
• Hospice
• Personal care
• Therapies
• Prosthetic/orthotics
• Medical supplies
• Durable medical equipment (DME)
• Emergency transportation
• Dialysis facility
	• Pharmacy
	• Dental services
	• Nonemergency transportation
	• Services administered by the Vermont Department of Mental Health through designated agencies (DAs) and specialized services agencies (SSAs), such as:
	    o Community rehabilitation and treatment (CRT) services for adults with serious mental illness
	• Adult outpatient services for adults with mental health service needs who do not meet CRT clinical eligibility criteria
	    o Emergency mental health services
	    o Children's mental health services
	    o Residential treatment services
	    o Targeted case management
	• Services administered by the Vermont Division of Alcohol and Drug Abuse Programs through a preferred provider network, such as substance abuse treatment services
	• Services administered by the Vermont Department of Disabilities, Aging and Independent Living, such as:
	    o Home- and community-based services
	    o Targeted case management
	    o Services for individuals with developmental disabilities
	• Services administered by the Vermont Department for Children and Families
	• Services administered by the Vermont Department of Education

Services for which the provider is not held accountable should be excluded from the benchmark. Examples of excluded services are organ transplants and out-of-area services. Commercial payors may exclude specific services, such as pharmacy, because they may be carved out to a pharmacy benefit manager (PBM) for their self-insured members. For the Medicaid population, mental health and substance abuse disorders services may be excluded because they are typically carved out to county providers or behavioral health organizations. Exclusions may be necessary to align the shared savings program design with goals. For example, if Medicaid MCOs and states are primarily focusing on improving care coordination to reduce avoidable admissions, readmissions, and ER visits, they may exclude long-term care support services from the TCOC benchmark.

Care management fees that include capacity building payments made upfront to providers (e.g., investments such as care management support tools, health information exchange capabilities to support care coordination or embedded care managers) are excluded from calculations. Other payments such as lump sum disproportionate share payments to safety net hospitals and/or medical education payments to academic health centers can also be excluded.[5] These exclusions are judged to be reasonable because they are made to providers to incentivize certain investments or to recognize services made to the underserved or the uninsured.

⇒ STEP 7: DETERMINE THE METHOD FOR CALCULATING AND DISTRIBUTING SAVINGS

When designing the savings and distribution calculation method, payors are interested in minimizing risk of overpayment that is due to random variations. Providers—particularly those that accept downside risk—are reticent to enter into arrangements that do not limit their potential losses. In addition, beneficiaries and consumers benefit when a system is designed to minimize risk avoidance behavior. As discussed, risk mitigation strategies include setting a minimum number of attributed lives to a practice or performance unit. Other important levers include setting a minimum savings rate, adjustment of data to remove outliers, especially those who are high-cost, and risk-adjusting the performance period data.

Minimum savings rate: A minimum savings rate (MSR) is the threshold providers must achieve in order to be eligible for savings payments and is usually defined as a percentage of the benchmark. MSRs may vary depending on shared savings model (e.g., whether the provider is taking upside and downside risk; services included in the TCOC; or the year of performance measured). Minnesota uses a 2% rate for its MSR regardless of the model, whereas the Vermont Medicaid ACO program uses 2% for the Two-Sided Model but varies the MSR (from 2% to 3.9%) based on population size for its One-Sided Model. Commercial payors employ MSRs of 2% to 5%.

Treatment of outliers: Outliers have the potential to skew calculations and exaggerate "true" performance and potential payment or withholds. Thus, decisions regarding how outliers will be treated need to be

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[5] Disproportionate share hospital (DSH) payments are payments to qualifying hospitals that serve a large number of underserved and uninsured individuals. Medical education payments include direct medical education (DME) payments (which cover the direct cost of graduate medical education such as stipends and fringe benefits for residents, and salaries and fringe benefits for faculty) and indirect medical education (IME) payments (which cover expenses associated with treatment of severely ill patients and the additional costs related to teaching residents in approved graduate medical educational training programs). DSH, DME, and IME payments are made by Medicare and Medicaid.

transparent. The MSSP method excludes costs for beneficiaries that fall above the 99th percentile of national Medicare spending and truncates patient total claims at approximately $100,000. Vermont's Medicaid ACO program uses a similar methodology. As mentioned, New Jersey does not eliminate outlier claims as their program was designed to "hot spot," capturing information about high-cost patients while incentivizing providers to manage their TCOC. Minnesota uses a tiered structure that depends on panel size: for ACOs with 1,000 to 2,000 attributed members, the TCOC cap is $50,000; for those with 2,000 to 5,000 members, the cap is $200,000; and for those with more than 5,000, the cap is either $200,000 or $500,000 (depending on the ACO's choice).

Adjusting the savings: Risk adjustment to the savings calculations may be required, especially as the risk mix changes over time. Payors commonly use risk adjustment tools such as the CMS-HCCs, Verisk Health's DxCG Solution, Prometheus payment methodology, Johns Hopkins' Adjusted Clinical Groups (ACG) risk-scoring method or Milliman Advanced Risk Adjusters (MARA). Medicaid programs have also used the Chronic Illness and Disability Payment System (CDPS), which measures variation in risk among seniors and disabled populations. Minnesota's HCDS demonstration uses the ACGs and New Jersey uses the CDPS. Vermont's Medicaid ACO program relies on the CMS-HCC.

Amount of savings/losses: Payors, providers, and stakeholders must also come to an agreement on the amount eligible for shared savings/losses, the distributions of shared savings/losses, and caps or limits on the savings or losses. They may include:

- Eligible savings or losses: Once the MSR is met, the first dollar of savings is typically eligible for shared payment.
- Distribution of shared savings or losses: Provider and payor distribution of the savings or losses vary, with provider sharing rates ranging from 20% to 80%.
- Shared savings cap: Caps of the shared savings payout vary. Vermont's Medicaid ACO uses 10% of the benchmark as the sharing cap for ACOs in the One-Sided Model and 15% for those in the Two-Sided Model.
- Shared losses limit: Limits on losses are useful, particularly in the early years. Vermont limits potential losses to be shared in the first year at 5%. In Year 3, that limit increases to 10%.

⇒ STEP 8: ESTABLISH QUALITY OF CARE METRICS AND TARGETS

When designing performance targets, it is important to build in quality-of-care metrics so that providers do not have perverse incentives to reduce healthcare use at the cost of patient safety or quality. Ideally, targets should be designed to incentivize improvements in quality over time rather than delivering the status quo.

The MSSP only allows ACOs to share in savings if they meet quality performance standards in the measurement year. CMS requires ACOs to report on 33 quality measures organized by four key domains:

- Patient/caregiver experience (7 measures)
- Care coordination/patient safety (6 measures)

- Preventive health (8 measures)
- At-risk population:
  - Diabetes (1 measure and 1 composite consisting of five measures)
  - Hypertension (1 measure)
  - Ischemic Vascular Disease (2 measures)
  - Heart Failure (1 measure)
  - Coronary Artery Disease (1 composite consisting of 2 measures)

These measures are nationally recognized, and are aligned with the National Quality Strategy. Claims-based measures are calculated by CMS using ACO-submitted claims. Measures that are survey-based (e.g., the CAHPS measure, "How Well Your Providers Communicate") are collected through a CMS-administered survey.

Payors and providers benefit if the quality metrics included in performance targets avoid duplication of effort. Where possible, Medicaid MCOs should consider building on national and state efforts to measure quality of care, relying on nationally recognized metrics, and leveraging existing vehicles to report measures. If quality-of-care data are not currently collected, starting with measures that can be calculated based on claims would be appropriate. Other measures that require surveys or EHR-based clinical data may be more appropriate in later years, once providers have developed the capacity to do so.

Tying payments to quality-of-care measures should be done in a manner that encourages reporting, allows for infrastructure development, and ultimately pays for performance improvement over time. A phased-in approach may be best, especially in markets with providers not accustomed to quality-of-care measures reporting. For example, in the early phases of a shared savings program, the performance target can be set such that the provider is eligible for savings if it just reports on all required measures. The next year, payments would be made if it reports on all measures and meets minimum quality scores on a subset of measures. In the year after that, payments are made only if providers achieve minimum quality scores on all quality measures. In addition, some payors use a "gate and ladder" approach such that the percentage of payment is tied to the quality score—the higher the quality score, the higher the payment. This is done so that there is room for quality improvement (and the corresponding rewards for that improvement) over time, thus avoiding a plateau effect.

V. KEY LESSONS LEARNED AND LOOKING AHEAD

Based on our review of the literature, discussions with experts, and our collective experience and knowledge, we summarize below a few key lessons learned:

- Shared savings arrangements (upside only) are regularly used by California health plans. However, shared risk arrangements where providers are exposed to downside risk are not allowed by DMHC unless the provider group is licensed to assume risk under California law.
- Shared savings arrangements have been combined, and in some cases have been replaced, with pay for performance and other incentive programs.
- Payment methodologies and incentive programs need to be designed to fit the existing capabilities of community providers in order to improve the chance of adoption, sustainability, and long-term success. Payment methodologies and incentive programs affecting publicly sponsored members will need to work collaboratively with state Medicaid agencies, health plans, and providers when such programs require regulatory approvals.
- Shared savings and risk-sharing strategies need to be considered in the larger context of payment and delivery system reform, including efforts to drive clinical transformation and to create a culture of accountability. Shared savings program designs should align with reform efforts such as those providing incentives for quality improvement.
- A key lesson learned from ACO experience is the importance of patient engagement and activation, especially for those with chronic conditions. Engaged and activated patients are associated with healthcare delivery improvements, including reductions in duplicative and unnecessary diagnostic testing, reduced elective surgeries, and improved medication adherence.
- Any payment and delivery system transformation effort, such as shared savings programs, must be supported by health IT infrastructure, data exchange, and data analytics. Data analytics capabilities allow those participating in shared saving programs to make sense of the data collected and translate that information into actionable performance improvement initiatives.
- Health plans must make timely evaluations of payment arrangements and methodologies to help determine whether effective programs should be adjusted or expanded, or discontinued if ineffective.
- In the case of federal and state demonstration projects, evaluations of the effectiveness of payment arrangements and delivery models are needed (e.g., methodologies used to calculate the benchmark, apply risk adjustment, calculate the savings amounts, etc.).
- Plans and providers must reach agreement on the evidence-based, achievable process and outcome quality measures for which they will be held accountable. The agreement must be aligned with strategies to facilitate data collection and streamline metric calculations and reporting.

CAVEATS AND LIMITATIONS

This paper is designed to be a background paper based on experience, interviews with a few key experts, and a review of key literature. This paper is not designed to be an exhaustive literature review or analysis. While a literature search of the academic, government, and industry literature was conducted, this is not intended to be systematic review.

There are a variety of payment models used by payors and providers today. As mentioned, this report focuses on those related to shared savings programs. Other payment models that seek to move payment systems from volume- to value-based payments are not discussed in detail here. Notably, payment models that seek to change consumer behavior directly (such as reference pricing or value-based benefit designs) are not discussed here as they would not have direct relevance to the Medicaid market.

VI. APPENDICES

APPENDIX 1: CURRENT LANDSCAPE UNDER MEDI-CAL

The model used in any one county is based on the interaction of federal and state laws and policies, the preference of the county board of supervisors, and the local market. California currently has three models of managed care:

Two-Plan Model: In nine counties, Medi-Cal managed care is organized under the “Two-Plan Model,” in which DHCS contracts on an at-risk, capitated basis with two different managed care plans: a state-licensed, county-sponsored, local public plan, called a "Local Initiative," and a competing, licensed commercial plan. A multicounty Local Initiative can be formed through the joint action of more than one county board of supervisors.

County Organized Health System: A second managed care model is the County Organized Health System (COHS), which is a single public plan, established by the county board of supervisors and governed by an independent commission. Two or more counties may also jointly form a single COHS. Unlike the circumstances in which Local Initiatives are developed, a COHS serves the entire Medi-Cal population of its region, without a commercial plan competitor. Six COHSs operate in 14 counties and serve about 1.3 million beneficiaries.

Geographic Managed Care: The third model is the geographic managed care (GMC) model, in which DHCS contracts with several commercial plans in a county to serve Medi-Cal beneficiaries. The GMC model exists only in Sacramento and San Diego counties, with six participating commercial plans, covering approximately 619,000 beneficiaries. This background paper is concentrating on the public plan experience, but the commercial plan experience in the Two-Plan Model and in GMC is similar.

APPENDIX 2: LOCAL PUBLIC PLANS

Local Initiatives	Counties Served
Alameda Alliance for Health	Alameda
CalViva Health Plan	Fresno, Kings, and Madera
Contra Costa Health Plan	Contra Costa
Health Plan of San Joaquin	San Joaquin
Inland Empire Health Plan	Riverside and San Bernardino
Kern Health Systems	Kern
LA Care Health Plan	Los Angeles
Santa Clara Family Health Plan	Santa Clara
San Francisco Health Plan	San Francisco

County Organized Health Systems	Counties Served
Cal OPTIMA	Orange
CenCal Health	San Luis Obispo and Santa Barbara
Central California Health Alliance	Merced, Monterey and Santa Cruz
Gold Coast Health Plan	Ventura
Health Plan of San Mateo	San Mateo
Partnership HealthPlan of California	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo

VII. GLOSSARY

Term	Definition
Bundled payments	Payments to the provider based on the expected costs for clinically defined episodes of care, which may involve several practitioner types, settings of care, and services or procedures over time. An example is payment to orthopedic surgeons for entire episodes of care related to total knee replacement surgery including presurgery prep, inpatient stay, surgery, and related ongoing follow-up. Payments may be made as a single payment to a provider or to providers associated with the episode of care. Also known as episodic-based payments.
Capitated payments	A payor pays a fixed dollar amount to providers for the care that patients receive in a given time period, such as a month or year. Non-risk-adjusted capitation and global payments may create incentives to reduce appropriate or necessary healthcare utilization because payments would be the same for all members in a region without regard for their expected healthcare utilization. Therefore payments may be adjusted for risk, based on factors such as the member's age, sex, and health status, in order to avoid risk selection. The specific services covered by the capitated payment may vary. Non-specified services would typically remain reimbursed under fee for service. Also known as global payments.
Fee for service (FFS)	Providers receive a payment rate from the payor for every unit of service they deliver. This payment model does not take into account quality, efficiency, or outcomes. Reimbursement rates are usually negotiated or specified by the payor.
Health care service plan	Under the Knox-Keene Health Care Services Act, the California Department of Managed Health Care (DMHC) licenses and regulates "health care service plans." Health care services plans are defined as any person who arranges for the provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees. Health care service plans are typically HMOs, although there are some preferred provider organization (PPO) and point of service (POS) plans regulated by DMHC. (Health and Safety Code §1345(f).)

HMO	A health maintenance organization (HMO) is a “closed-provider panel” plan that limits coverage to those providers in a designated panel (other than in emergencies). The plan member is typically required to select one of the panel’s primary care physicians, who serve as referral points to specialty care. The primary care physician, by agreeing to participate in the HMO’s network, agrees to abide by the utilization management requirements and the capitation, fee schedules, or other reimbursement approaches specified by the HMO.
MCO	Managed care organizations (MCOs) are health insurance organizations that use a variety of technics and mechanisms to reduce unnecessary healthcare costs, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with healthcare providers; and the intensive management of high-cost healthcare cases.
Pay for performance	Base payments are typically FFS but additional payments are tied to financial incentives for physicians and other healthcare providers based on meeting performance measures typically focusing on quality, efficiency, or outcomes.
Risk-bearing organization (RBO)	According to Cal. Health & Safety Code § 1375.4 (g), a risk-bearing organization (RBO) is a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides healthcare services, but does not include an individual or a health care service plan, and that does all of the following: • Contracts directly with a health care service plan or arranges for healthcare services for the health care service plan's enrollees • Receives compensation for those services on a capitated or fixed periodic payment basis • Processes and pays claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization.

Shared risk (downside risk)	A scheme in which providers accept some financial liability for not meeting specified financial or quality targets. Examples include loss of bonus, baseline revenue loss, loss for costs exceeding global or capitation payments, or withholdings that are retained and adjusted to fee schedules. Base payments in a shared risk program can be FFS.
Shared savings (upside risk)	A scheme in which providers are offered a percentage of net savings. Savings are achieved when providers reduce actual healthcare spending below an expected and specified spending or healthcare use target for a specified patient population in a defined period of measurement. Quality targets are also typically specified defined. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and may vary based on provider performance.

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