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TO: Connecticut Health Care Cabinet
FROM: Megan Burns, Marge Houy and Michael Bailit
DATE: September 1, 2016
RE: Why Shared Risk Payment Models Should be Considered by the Cabinet

I. Introduction

The fee-for-service payment system produces increased volume of highly priced services, high-margin services, and services that may not be necessary, and in fact, might be harmful. In addition, it creates disincentives for providers to focus on prevention, and on lower-priced services like primary care and behavioral health care. Connecticut's Medicaid program has begun moving away from fee-for-service by launching the PCMH+[1] program which adopts a value-based model of care delivery and payment. DSS estimates that 25-30% of beneficiaries will have their health care services delivered under this model starting in 2017.

The PCMH+ program provides an important initial experience with total cost of care accountability by providing the opportunity for shared savings without risk. In fact, if the PCMH+ program had not been in place, our Straw Proposal would have suggested starting the Consumer Care Organizations (CCOs) in a non-risk based shared savings arrangement because we think that is the right way to begin to transition to a new value-based model. However, there are several reasons why we believe the PCMH+ program should be considered only as the first step, and not the only step toward improving the quality of health care and reducing cost growth. This memo describes the reasons why our Straw Proposal started at shared risk, and then offers examples of how shared-risk contracts work with primary care providers and ACOs.

II. National Landscape of Risk-Based Payment Models

Nationally, payers and providers are rapidly engaging in risk-based payment models. Risk-based contracts are proliferating in the commercial insurance market. According to an analysis of 85 ACO arrangements, commercial insurers are more likely to engage in risk-based payment models with ACOs than Medicare or Medicaid. One of the most well-known commercial shared-risk programs is the Blue Cross Blue Shield of Massachusetts "Alternative Quality Contract" model that has been operating since 2009, and which has been proven to reduce costs and improve quality.[2]

However, the biggest driver of increasing provider contractual risk is the federal government. Congress and CMS have created strong financial incentives and absolute

[1] Formerly called the Medicaid Quality Improvement and Shared Savings Program (MQISSP).
[2] Seldman J, et al. "Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract." Avalere. March 2015.

requirements for Medicare providers to move into shared-risk payment arrangements. The following four examples demonstrate the federal government's influential role:

1. In 2013 CMS began testing an episode-based payment through its Bundled Payment for Care Improvement Program (BPCI), in which numerous hospitals and physician groups in Connecticut are participating on a voluntary basis. Provider-borne risk for these episodes is being phased in over time. While BPCI still continues, CMS has moved more recently to require participation in a shared-risk episode-based payment model for many hospitals performing joint replacement, including those in the New Haven-Milford and Norwich-New London metropolitan statistical areas. Last month, CMS announced new mandatory shared-risk episode-based payment programs for heart attack and cardiac bypass surgery, and the expansion of the mandatory joint replacement model.

2. CMS is testing an ACO-based payment model that holds providers accountable for the total cost of care on a shared-risk or full-risk payment model through its Next Gen ACO program. As of now, no Connecticut providers are participating in the Next Gen payment model, however, the Connecticut State Medical Society has applied for the program.

3. In 2017, CMS will begin operating a five year advanced primary care medical home model (CPC+) in 10 states and 4 regions[3] in which primary care practices are at risk for losing money based on the practices cost and quality measures.

4. Congress has directed CMS to provide strong incentives to move all Medicare-participating physicians into alternative payment models. In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) made three major changes to the way physicians are paid through the Medicare program:

   (1) it ended the Sustainable Growth Rate, a controversial cost control measure that was deeply flawed;
   (2) it combined existing quality programs into a new Merit Based Incentive Payment System (MIPS); and
   (3) it instituted incentive payments for participation in "eligible" advanced alternative payment models beginning in 2019.

Under the proposed regulations,[4] in order for physician payment increases to be beyond 0-0.5%, physicians will need to join MIPS and face up to a 9% increase or decrease in their payments based on their quality performance, or participate in a "qualifying" alternative payment model. Qualifying alternative payment models must

[3] Including the neighboring states and regions of: Rhode Island and the North Hudson-Capital Region of New York.
[4]The final rule is expected in "early fall 2016."

base payment on quality measures comparable to those in MIPS, require the use of certified EHR technology and either put physicians at more than "nominal risk" for cost or be a medical home model expanded under CMMI authority. Physicians who participate in qualifying alternative payment models will be exempt from MIPS and receive a 5% annual incentive payment between 2019 and2024. One of the defining characteristics of these qualifying or "advanced" alternative payment models is that the provider must bear more than nominal risk.

CMS is also greatly influencing states through new Delivery System Reform Incentive Payment (DSRIP) programs (see 8-29-16 memo on 1115 waivers and DSRIP for more information), which require as a condition of participation that states move Medicaid providers into alternative payment models. For example, New York's DSRIP program calls for 50-70% of provider payments to be through some type of shared-risk arrangement at the end of its five-year program.

It is within this context that we recommend the Cabinet consider shared risk payment models for Connecticut's Medicaid and state employee health benefit programs. The next section details our rationale for this recommendation.

III. Rationale for Shared Risk Recommendation

Our CCO proposal seeks to build upon the PCMH+ program. The PCMH+ program gives FQHCs and Advanced Networks[5] the opportunity to share in any savings the practice is able to generate on the total cost of an individual's care.[6] The CCO model builds upon PCMH+ by requiring providers to organize themselves in such a way that would allow better care coordination across the continuum of multiple providers and increase accountability among all providers, and in particular, among the highest cost providers (e.g., hospitals and specialists). The CCO model in the Straw Proposal starts at shared risk because we anticipate that practices will have the opportunity to begin to operate in a value-based environment through the PCMH+ program. In health plan interviews we conducted in March, we learned that one large commercial plan has contracted on a shared savings basis with 75 percent of PCPs in its network. Further, we recommend that CCOs that are formed by providers that have not had substantial experience in the PCMH+ program or another shared savings program start with an upside only shared savings contract before moving to shared risk.

Our CCO proposal seeks to focus on a broader population than does PCMH+. The PCMH+ program focuses only on a portion of the Medicaid population. For FY 2017 it is estimated that 25-30% of beneficiaries will have their health care services delivered under this model. The beneficiaries *excluded* from this model are more traditionally

[5] Advanced Networks refers to integrated delivery systems, large medical groups and clinically integrated networks where the affiliated primary care practices are or are working toward PCMH certification.
[6] The PCMH+ shared savings calculation excludes hospice, long-term services and supports and non-emergency medical transportation. This practice is consistent with most state Medicaid shared savings programs.

considered high-risk. The Straw Proposal's CCO model focuses on the non-dually eligible Medicaid population, including those with multiple chronic conditions, *and* the state employee population.[7] If Medicaid and the Comptroller contract with Advanced Networks and FQHCs using aligned structures and philosophies, the concepts of value-based payment will impact more providers and more of their patients than is currently intended for PCMH+.

Shared savings programs have tended to yield limited change in provider behavior and savings. Results from the second and third years of the Medicare Shared Savings Program (MSSP) showed that only a quarter and 31% earned savings during each of the two years, respectively. This was accompanied by an improvement in average quality performance on 84 percent of the quality measures reported.[8,9] The limited benefit of shared savings arrangements was also confirmed for us by recent interviews with Medicaid health plans across the U.S that are operating shared savings programs.

Recognizing these limitations, CMS is creating greater incentives for Medicare SSP participating providers to migrate to Track 3 or to transition to the Next Generation ACO program, both of which introduce significant risk sharing.

The payment model we propose for the CCO would follow Medicare's lead by giving providers greater incentive to change the way they deliver care, emphasizing care coordination for those most in need.

According to economic theory, individuals have a greater response to a risk of loss, than they do to the possibility of reward. Applying that to health care, it's reasonable to expect that providers will be more responsive to improving care delivery if they are in a shared risk arrangement, rather than in a shared savings arrangement. In fact, CMS recognizes this and included in its new advanced primary care medical home model CPC+ a prepaid incentive payment that is at risk based on utilization and quality measures. CMS noted that "prepayment of the incentive capitalizes on the behavioral health economics theory of loss aversion, thereby heightening practices' focus on the utilization and quality measures."[10]

Because we recognize the PCMH+ program is an important first step, our Straw Proposal was targeted at building upon PCMH+ to a more advanced payment model and delivery system improvement approach. We believe there is opportunity in Connecticut to reduce overall health care cost growth in the state, but it will be difficult

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[7] Careful consideration needs to be made as to whether the long-term care expenses of the dual-eligible population be incorporated into the CCO model in later years.
[8] Introcaso, D and Berger, G. "MSSP Year Two: Medicare ACOs Show Muted Success." *Health Affairs Blog*, September 24, 2015
[9] "Physicians and health care providers continue to improve quality of care, lower costs." CMS Press Release. August 25, 2016.
[10] Sessums, L et al. "Medicare's Vision for Advanced Primary Care: New Directions for Care Delivery and Payment." *JAMA* June 28, 2016; 315(24):2665-2666.

to achieve with a Medicaid shared savings program alone and without an aligned strategy from state government's biggest purchasers.

IV. Examples of Shared Risk Programs

Along the continuum of value-based payment are various shared-risk models where providers share in savings if the cost of services are below a pre-determined budget and share in losses if costs are above the budget. This memo first provides an example of a shared risk program employed with primary care providers, and then an example of a shared risk program employed with integrated entities (ACOs). Both of these examples incorporate behavioral health services to a varying degree, and hospital and specialty spending.

These are provided solely as examples, and not recommendations. The Straw Proposal does not specifically articulate the details of the payment model, nor do we believe should the Cabinet recommendations. If the Cabinet and then the legislature choose to pursue a shared-risk model, a significant amount of collaborative work will be required to define the payment model.

A. Shared Risk on Total Cost of Care with Primary Care Providers

In 2014, Massachusetts's Medicaid (MassHealth) program instituted a new payment model, the Primary Care Payment Reform Initiative (PCPR). PCPR is a three-year payment model pilot, ending December 2016, designed to support primary care practices that operate under the principles of a Patient-Centered Medical Home and, optionally, are able to deliver integrated behavioral health services. It currently has 62 primary care practices and approximately a quarter of non-managed care enrollees (~90,000). Full cost and quality results will not be available until the conclusion of the program.

Primary care practices that voluntarily contracted with MassHealth receive a risk-adjusted, capitated payment for primary care services for an attributed population. Providers also share in any savings or losses on spending on all non-primary care services, referred to as "total cost of care" (TCOC). In this manner, primary care providers are freed from the strictures of fee-for-service payment through an enhanced capitation rate (and are nominally at financial risk for the primary care services they provide), and are also at risk for the TCOC.

The model breaks down to the following three components:

1. **Comprehensive Primary Care Payment (CPCP)[11]:**
    a. The CPCP is the capitated payment that each primary care provider receives for primary care services. The base rate of the CPCP consists of

[11] Sources: Executive Office of Health and Human Services, Commonwealth of Massachusetts. Request for Applications for the Primary Care Payment Reform Initiative. March 7, 2013. Primary Care Payment Reform: Applicant Meeting. Presentation delivered by MassHealth, November 2013.

the average PMPM billing of primary care services plus funding for non-billable transformation costs ("Medical Home load").

i. At the option of the contracting entity, behavioral health services can be included in the base rate. Primary care providers have the option of choosing three payment levels to support the practices' level of behavioral health integration.
   - Tier 1: no separately billable behavioral health services are included in the CPCP
   - Tier 2: family consultation, case consultation, diagnostic evaluation, couples / family treatment, individual and group treatment, inpatient-outpatient bridge visits are included in the CPCP
   - Tier 3: all services in Tier 2, plus medication visits, medication administration, and psychological testing are included in the CPCP

b. The base CPCP is then risk-adjusted to reflect the health status of the members attributed to each primary care provider.[12]

c. Finally, the base CPCP is adjusted once more to account for attributed members' expected service utilization outside of the contracted-entity. This allows the payer to pay the contracted primary care provider only for the primary care services it is likely (based on historical data) to provide to the member, and mitigate the possibility of overpaying primary care providers on the capitated payment amount.

2. Quality Incentive Payment:

a. There is an annual incentive payment given to the primary care providers based on their performance on primary care metrics. In the first year of the program, incentives were awarded for reporting quality metrics only. In subsequent years, primary care providers have been eligible to receive incentives for both reporting and performance.

b. Quality metrics are focused on primary care activities, including, for example, adult prevention and screening, depression screening, ADHD medication management for children, access, care coordination, and certain measures focused on chronic illness care.

3. Shared Risk on Total Cost of Care (TCOC):

a. For the first year of the program, all participants were in a shared savings arrangement based on their TCOC for non-primary care, including specialist and hospital care. TCOC includes long-term supports and services, at the option of the provider.

b. In the second two years of the program, all participants have had to move to one of two different downside risk tracks, unless they were able to

[12] The PCPR program utilizes a customized version of Verisk Health's primary-care specific grouper, PCAL, to risk-adjust the capitated primary care payment.

provide good cause for staying in the upside-only track.[13] The two risk tracks vary the risk from 0-6% and vary the savings up to 6%.

The downside risk tracks are structured as follows:

i. Risk Track 1 (Shared-Risk): Providers that choose this risk track receive or owe 60% of the difference between the actual spend and the budget unless:
   1. the difference between the actual spend and budget is less than **1**% of the budget, in which case no savings are accrued and no losses are incurred, or
   2. the difference between the actual spend and the budget is more than **10**% of the budget, in which case savings and losses are capped at six percent of the actual spend.

Table 1. Level of Savings under Risk Track 1[14]

Target Spend	*Actual Spend*	*Savings variance $$*	*Variance as % of Target Spend*	*Provider Risk Share*	*MassHealth Risk Share*
100.00	*115.00*	*(15.00)*	*15%*	*(6.00)*	*(9.00)*
100.00	*110.00*	*(10.00)*	*10%*	*(6.00)*	*(4.00)*
100.00	*105.00*	*(5.00)*	*5%*	*(3.00)*	*(2.00)*
100.00	*101.00*	*(1.00)*	*1%*	*0*	*(1.00)*
100.00	*99.00*	*1.00*	*-1%*	*0*	*1.00*
100.00	*95.00*	*5.00*	*-5%*	*3.00*	*2.00*
100.00	*90.00*	*10.00*	*-10%*	*6.00*	*4.00*
100.00	*85.00*	*15.00*	*-15%*	*6.00*	*9.00*

ii. Risk Track 2 (Transition to Shared Risk): Providers that choose this risk track receive or owe 60% of the difference between the actual spend and the budget unless:
   1. the difference between the actual spend and budget is less than **2**% of the budget, in which case no savings are accrued and no losses are incurred, or
   2. the actual spend exceeds the budget by over **5**% of the budget, in which case the provider's losses are capped at **3**% of the budget, or
   3. the actual spend is lower than the budget by over **10**% of the budget, in which case the savings are capped at **6**% of the budget.

[13] In Massachusetts any provider taking on nominal risk must obtain a certificate from the Department of Insurance to be a "risk-bearing provider organization."

[14] Executive Office of Health and Human Services, Commonwealth of Massachusetts. Request for Applications for the Primary Care Payment Reform Initiative. March 7, 2013.

B. Shared Risk on Total Cost of Care with ACOs[15]

Minnesota's Medicaid program developed the Integrated Health Partnership (IHP), which is a payment model in support of providers that voluntarily come together as ACOs to provide care that achieves the Triple Aim. There are two versions of the IHP model: (1) the "virtual IHP" supports primary care providers that are not supported by a hospital or integrated delivery system; and, (2) the "integrated IHP" is designed for integrated delivery systems that provide a broad spectrum of outpatient and inpatient care through a common financial and organizational entity. This memo focuses only on the "integrated IHP" model.

Integrated IHPs are paid for services on a fee-for-service basis, unlike primary care practices in the Massachusetts example, and are then held accountable for their performance against a risk-adjusted TCOC target for an attributed population.

1. **Total Cost of Care Target**: The Target TCOC is expressed as a per-member-per-month target based on historical claims trended forward. The TCOC is calculated as follows:

    a. **Included Services**: The Target TCOC consists of approximately 35-45% of all claims incurred in the population.[16] Specifically, it includes: a broad range of primary care, hospital inpatient and outpatient care, chemical dependency services, mental health services, hospice, home health, pharmacy, vision, rehabilitation services, laboratory and radiology. Excluded from the Target TCOC are long-term care services and supports, dental care, DME, transportation, child welfare case management, and intensive and residential mental health and chemical dependency services. Notably, ACOs contracting with the state under this model may propose additional Medicaid covered services for inclusion in the TCOC target.

    b. **Base TCOC**: The Base TCOC is initially established on claims incurred during a recent time period, called the "base year." The Base TCOC is then adjusted by excluding cases that fall outside of pre-determined thresholds to remove "catastrophic" cases from the calculation of the

[15] Sources: Memo from FORMA Actuarial Consulting Services, LLC to Minnesota's State Medicaid Director. January 17, 2013. Minnesota Department of Human Services Health Care Administration. Request for Proposal for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnership (IHP) Demonstration. April 25, 2016.

[16] Memo from FORMA Actuarial Consulting Services, LLC to Minnesota's State Medicaid Director. January 17, 2013.

PMPM TCOC value.[17] The Base TCOC is then risk-adjusted using the Johns Hopkins ACG risk adjustment tool.

c. **Expected Trend**: Once the Base TCOC is calculated, a "trend factor" is applied to it to account for the expected increases in spending across the attributed population during the performance period.

d. **Adjusted Target TCOC**: The Adjusted Target TCOC is the final PMPM to which a provider's performance will be compared. The Adjusted Target TCOC consists of the Base TCOC, the Expected Trend and then one final adjustment to remove any "catastrophic cases" and for any change in the relative risk of the attributed population between the base year and the performance period.

2. **Risk Sharing:** Integrated IHPs are in a shared savings-only model in the first year of the contract, and must move to downside risk in the second and third years of the contract. The components of the risk sharing model are as follows:

   a. **Minimum Performance Thresholds:** IHPs must meet a minimum performance threshold of 2% before they are eligible to share in any savings or be at risk for any losses. Meaning, the Performance TCOC must be at or above 102% of the Adjusted Target TCOC in order to be at risk for losses and at or below 98% of the Adjusted Target TCOC in order to receive any savings distributions.
   b. **Proportion of Savings or Losses:** For the first two years of the program, the IHPs share equally in savings or losses with the state / MCO. In the third year of the program, different distributions of earned savings or experienced losses can be proposed by the IHP. Savings and losses are calculated back to the first dollar, after meeting the minimum performance threshold, meaning if a provider's performance is 97% of the adjusted TCOC, it is eligible to keep the negotiated share of the 3% saved.
   c. **Shared Savings and Shared Risk Caps:** IHPs are given the opportunity to propose their preferred risk sharing cap, with some parameters set by the state. The parameters are as follows:
      i. **Year 1:** The provider can choose its savings cap, up to the maximum cap set by the state, which is 85% of the Adjusted Target TCOC. The maximum threshold must be the same in Year 1 and Year 3. This is important because in Year 3, the risk must be symmetrical and therefore, if a provider chooses 85% as its savings cap, it will also be at risk for a negotiated portion of all losses up to 115% of the adjusted TCOC.

[17] The predetermined thresholds vary by size of the population. For populations of 1,000-1,999 attributed patients, the maximum annual claims per patient (claims cap) is $50,000. For populations of 2,000-4,999, the claims cap is $100,000; and for populations greater than 5,000 the claims cap is $200,000.

ii. **Year 2:** Asymmetrical risk capping is accepted in Year 2, so long as the ratio of the shared savings cap is 2:1 to the downside risk cap. In other words, if the provider chooses to cap risk its risk at 106% above the adjusted TCOC, its savings cap would be set at 88% of the adjusted TCOC (which is 3 percentage points below the state cap).
iii. **Year 3:** Symmetrical risk capping is required in Year 3 and as mentioned above, IHPs are able to propose different distributions of earned savings or experienced losses.

3. **Performance on Quality:** Performance on quality measures affects the portion of shared savings for which a provider is eligible. In the first two years, performance will affect 25% of the shared savings a provider is eligible for (i.e., 12.5% of total savings) first based on reporting, and then based on performance. In the third year, 50% of the provider's portion of shared savings (i.e., 25% of total savings) is based on quality performance. The state determines the minimum and maximum level of quality performance and which measures will be included in the payment program.

The MN IHP program has 19 ACOs, nearly 350,000 beneficiaries and close to 9,000 providers participating in the program. Providers saved $14.8 million compared to trended targets in 2013, and estimated $61.5 million in 2014. Quality targets have been met by all providers in 2013.

V. Conclusion

Shared savings is an important first step for value-based payment programs to get both providers and payers comfortable with operating in a non-fee-for-service environment. We believe that shared risk programs, however, provide the necessary incentives to motivate true delivery system change and quality improvement.