

State Medicaid Director Letter on Shared Savings Methodologies Children's Hospital Association Summary

October 2013

On Aug. 30, 2013, the Centers for Medicare and Medicaid Services (CMS) released [a letter to state Medicaid directors](#) on the use of shared savings reimbursement methodologies to improve quality and reduce costs in Medicaid. Specifically, the letter outlines methodological considerations and provides technical guidance for shared savings initiatives in Medicaid. It also includes a series of questions for states to answer when submitting a shared savings proposal to CMS. In releasing this guidance, CMS emphasizes that the agency only intends to work with states on shared savings methodologies that improve care for Medicaid beneficiaries, and they are “[...] not interested, at this time, in partnering with states on shared savings proposals that are based only on cost savings and that do not improve quality and health outcomes or limit access to eligible beneficiaries.”

While the guidance does not address child-specific issues, it provides insight into shared savings programs created under existing Medicaid authority that might contain children, including children with complex medical conditions.

METHODOLOGICAL CONSIDERATIONS

This letter does not establish mandatory standards for Medicaid shared savings methodologies; rather, it lays out key structural components of a shared savings methodology that states should consider. Specifically, CMS breaks shared savings methodologies into three key concepts: the total cost of care benchmark; provider payment incentives; the period of performance during which changes are tested; and the program cost savings evaluation where savings are determined and quality improvements are considered.¹ CMS asserts that states should have three goals when developing a shared savings methodology:

- The benchmark, the cost during the performance period, and the cost trend rates are accurately established through data analysis
- Shared savings payments are made for savings attributable to the program
- Quality of care is improved and access to care is not reduced

Distribution of Payments

The methodology for payments must be comprehensive and explain the criteria for providers to receive payments, the payment calculation, and the methodology for distributing the payments to providers. In addition, it should address the percentage of savings or risk a provider can receive and the tiers associated with meeting quality measures.

¹ The benchmark, performance period, and evaluation component of a methodology are discussed in detail in the Technical Considerations section of this summary.

Actuarial Analysis

CMS asserts that an actuarial analysis is key to the development of a shared savings methodology and that it should be at least as comprehensive as the analysis used to create capitation rates. An appendix to the letter provides states with a list of questions for this analysis, and CMS urges states to share all data, documentation, assumptions and methodological components that are used to answer these questions with the agency.

Risk and Gain-sharing Arrangements

CMS states its support for approaches that do not put providers at risk in the early stages of an initiative. In addition, methodologies that put providers at risk are acceptable as long as:

- Providers may deliver care coordination services without taking part in the risk-based arrangement
- Providers know they are participating in the arrangement
- The risk calculation is clearly stated in the state plan
- Providers are not at risk for costs over which they have no control

Targeting Providers and Populations

Care coordination services (or other care improvements) must be made available to all Medicaid beneficiaries. However, the state may target a population by calculating incentive payments for a limited group, such as enrollees with complex conditions.² In addition, shared savings payments may be targeted to certain providers who are more qualified to enhance care for beneficiaries, which may be determined based on a series of criteria, such as the ability of a provider to coordinate care across the delivery system. Payments may be made to providers directly or to a network of providers that would in turn distribute the shared savings payments to individual providers within the network.

STATE SHARE REQUIREMENTS

Shared savings payments in Medicaid must be financed by a combination of state and federal funds. The state share of funding must come from a source that would otherwise be permitted for financing Medicaid, and federal dollars may not be drawn down based on calculated or “virtual” savings. In addition, federal grants must be delinked from the state financing mechanism to ensure these grants are not used as the state match for shared savings programs.

TECHNICAL CONSIDERATIONS

In an appendix to the letter, CMS discusses technical considerations for three key aspects of shared savings methodologies: the benchmark, performance periods, and program evaluation.

Benchmark

The benchmark is developed by calculating the expected Medicaid cost for individuals in the shared savings program in a given year and trending it forward over the performance period for the shared savings program. The benchmark is typically based on data collected the year before the shared savings program is operationalized, it may be risk-adjusted and it assumes the cost of the new care coordination activities.

²Value-based purchasing efforts, which may include shared savings methodologies, may not prohibit free choice of providers; limit the amount, duration and scope of services provided; or duplicate payments under Medicaid.

CMS explores a number of elements states should consider when developing a benchmark:

- **Data sources** – To develop an accurate baseline and determine if savings are a result of a program, CMS urges states to use Medicaid Management Information System (MMIS) claims data. However, states may need to supplement this data and should explain the use of all data resources to CMS.
- **Risk mitigation** – CMS advises states to implement risk mitigation strategies; however, the agency does not require the use of particular strategies because of the need for program-specific approaches to risk mitigation, which may be applied at the state or local level. CMS asserts that such strategies should address the risk that exists between the baseline and the benchmark, account for outliers, and reduce the incentive for patient selection or up-coding. Potential strategies to mitigate risk include risk corridors or adjustments to cost outliers.
- **Excluded cost** – While excluding some costs from the payment methodology may make sense based on a program’s focus, CMS expects the benchmark calculation, as well as the performance periods, to include the total cost of care. This will allow CMS to understand the potential for cost-shifting. States are also directed to develop a plan to address cost-shifting.
- **Comparison population** – States may use a comparison group of individuals to determine if a shared savings program is resulting in cost savings. CMS believes this approach may be best to determine the impact of programs that focus on a specific group of high cost-Medicaid enrollees. If a comparison population is not available, states may examine the cost of care for an attributed population before and after the intervention to determine a program’s effect. The letter indicates this approach may be appropriate for programs that address Medicaid enrollees with chronic conditions.
- **Trend projections and retrospective analysis** – To establish a benchmark, the total cost of care must be determined and adjusted for the cost growth that would have occurred in the absence of the new model of care. The approach for rebasing this benchmark must be explained to CMS and should ensure that the benchmark reflects changes in the reform effort or in Medicaid. Further, CMS asserts that a retrospective analysis of the savings data is the preferred method to calculate shared savings because it allows for adjustments to be made to the benchmark after the performance year and is likely to eliminate projection errors. Alternatively, a prospective approach may be used, which bases shared savings on trends. When using this approach, trends are expected to be:
 - Population and service-specific
 - Based on historic Medicaid expenditure data
 - Rebased annually, along with the benchmark
 - Reviewed retrospectively at a regular interval

Performance Periods

The accuracy of savings achieved in the performance period (the period when the effect of coordinated care efforts is compared with the benchmark) relies on the use of the same beneficiaries and service package that were included in the creation of the benchmark. Further, CMS directs states to estimate the likely cost savings from the program and to address the policies that will make

savings more likely.

- **Attribution methodology** – This methodology allows providers to receive credit for the impact of care coordination, but it is often difficult to establish due to changes in beneficiary coverage or provider access. One approach to attribution is a retrospective methodology, which allows attribution to occur after each performance year. This provides certainty for states but is difficult for providers because they may not know what individuals are attributed to them. A second approach is a prospective methodology, which uses prior year data to determine attribution before the performance year begins. This reduces risk for providers but may result in a less accurate savings calculation. For either methodology, CMS asserts that states must ensure:
 - The methodology is statistically valid
 - The approach considers a consistent set of data
 - The attribution method is defined
 - A description is provided of the data used for attribution, as well as the approach to evaluating the methodology

- **Minimum savings requirements** – Risk for providers and states may be reduced by establishing risk and gain-sharing thresholds. Once the established threshold of savings or losses is reached, shared savings or risk would occur. CMS asserts that the smaller the participating population, the larger the thresholds should be as measuring savings is more difficult with smaller populations.

- **Quality metrics** – To ensure that shared savings programs improve care, a quality element must be included in the shared savings methodologies. Although CMS plans to release future guidance on quality metrics in delivery system/payment reform efforts, this letter asserts that quality metrics in shared savings programs must be: appropriate for the population, demonstrate care improvements, and be consistent with the Medicaid quality strategy.

Program Evaluation

States will need to evaluate shared savings programs and make improvements based on the results of these evaluations. Specifically, states must determine how they will measure program success, the evaluation time-frame, and how evaluations will improve the program. Further, all shared savings payment methodologies in Medicaid must have an end date, which will allow for a formal review and program adjustments or termination of ineffective programs. Effective programs will be permitted to continue, but a new state plan amendment must be submitted to extend the program.