



SMDL# 13-005
ICM# 3

August 30, 2013

RE: Shared Savings Methodologies

Dear State Medicaid Director:

This letter is the third in a series that provides states with guidance on designing and implementing care delivery and payment models that improve health, improve care, and reduce costs within state Medicaid programs. The first two letters are SMD #12-001 and 12-002. In those letters, we described the framework for Integrated Care Models (ICMs) and pathways that states may use to implement ICMs in the Medicaid state plan or, as needed, through appropriate program waivers and demonstrations. This letter focuses specifically on reimbursement methodologies that can be adopted in the context of ICMs to incentivize improved quality and outcomes and reduce costs by sharing program savings with high performing providers.

SHARED SAVINGS IN MEDICAID

Many states are interested in testing shared savings methodologies in the Medicaid program as a means to promote higher quality at an overall lower cost. CMS has had a series of discussions with states as part of the Medicaid and CHIP Value Based Purchasing Learning Collaborative about these issues. States and CMS share the goal of ensuring effective delivery system models that properly reward providers for efficiency and quality. Since shared savings methods are new and evolving, this guidance is intended to inform states' thinking as they consider developing performance incentives reimbursed through program savings, and not to prescribe just one approach to designing such incentives. Over time, we intend to offer examples of approved shared savings methodologies to share state experiences with the models and to describe practices that have proven to be effective. We will work with states to collect and make this information available. We ask that states share the results of evaluations, reports and other data that can help all interested parties understand how shared savings methodologies work to improve care and lower costs. Work along these lines is proceeding in a few states.

BACKGROUND

In previous letters we have discussed how the structure of a state's coordination and care transformation efforts will affect whether activities are implemented under a Medicaid state plan benefit or through a waiver authority. For instance, states may be interested in targeting efforts at specific populations with complex care needs or testing delivery models in targeted regions before implementing initiatives statewide. All of these decisions will affect which Medicaid authority a state uses to implement shared savings and components of the payment methodology.

We refer specifically to the second letter within this series [“Policy Considerations for Integrated Care Models”](#) (SMDL #12-002) for states that seek additional guidance on structuring ICMs.

Several states are at the forefront of driving quality improvement incentives in Medicaid fee-for-service and managed care delivery systems. Their approaches to rewarding providers that better coordinate care and improve quality through payment incentives align with similar efforts in the Medicare program as well as the private health insurance market. As state Medicaid agencies develop new incentive models that calculate payments based on Medicaid savings, they have sought guidance from CMS on Medicaid authorities and federal expectations for designing and implementing the models.

Within this letter we offer states methodological considerations that factor into any shared savings proposals, as well as technical guidance and a series of questions that CMS will expect states to answer as part of their proposals. Importantly, we expect shared savings methodologies to encourage care coordination and practice transformation activities, such as those discussed in SMDL #12-002, that improve quality and health outcomes. CMS is 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. The services and/or activities to coordinate and transform care delivery for Medicaid beneficiaries and the quality metrics that are the basis for the shared savings payments will be defined in either the state plan or waiver documentation under a Medicaid benefit category.

METHODOLOGICAL CONSIDERATIONS

Shared savings calculations can be complex and potentially place states and CMS at risk if the calculations and trends are inaccurate or if the calculations are not routinely rebased to reflect changes to Medicaid programs and the efficiencies that have been gained through better coordination and improved quality. The analyses that informed the Medicare Physician Group Practice Demonstration, the Pioneer Accountable Care Organizations (ACO) model, and the Medicare Shared Savings Program ACOs are potential resources to help states develop similar shared savings initiatives under Medicaid programs. However, we recognize that Medicaid enrollees are often different from Medicare enrollees and states are not required to develop methodologies that mirror any of these programs. With that in mind, this letter provides information on the key structural components of a shared savings payment methodology and, as enclosures to the letter, technical design considerations and questions that states should review prior to submitting a proposal to CMS. We expect states to consider each of the methodological components described this letter as they develop a proposal for CMS to review, but we are not defining approval criteria or requiring specific standards that states will need to meet for approval. We do not foresee a “one size fits all” approach to shared savings and at this time believe it is too early to determine if there are criteria and universal standards that can apply to all Medicaid models. Our goal is to work in partnership with states to develop methodologies that mitigate risk, realize potential rewards associated with shared savings methodologies, and may be replicated nationally.

Essential Concepts of Shared Savings

A shared savings methodology typically comprises four important concepts: a total cost of care benchmark, provider payment incentives to improve care quality and lower total cost of care, a performance period that tests the changes, and an evaluation to determine the program cost savings during the performance period compared to the benchmark cost of care and to identify the improvements in care quality. In some instances the provider payment incentives in the second step will be determined through the evaluation step. We have discussed changes in care delivery at length in this and in other letters, and below we provide information on the baseline benchmark, the performance period and the evaluation components. As states design shared savings methodologies, key goals should be to ensure that:

- data analysis is used to determine that benchmark cost, performance period cost and the associated trend rates are accurate; and
- shared savings policies, such as saving thresholds, minimum savings rates, and target populations (as discussed in the attached Technical Considerations for Shared Savings) work cohesively to help ensure that shared savings payments are made only for true savings attributable to the program and not for random variations in total cost of care.
- Beneficiary access shall not be reduced and quality of care shall be improved.

Distribution of Payments

As with any Medicaid incentive payment, a state shared savings reimbursement methodology must clearly describe:

1. the criteria that providers must meet to receive incentive payments,
2. the actual payment calculation, including any caps on shared savings or risks, and
3. the methodology for distributing shared savings payments (including all of the applicable variables described within this letter).

The methodology must be comprehensive, meaning that an individual could reasonably calculate provider payments based on the information in the Medicaid state plan, waiver documentation, or contracts. Shared savings typically include the percentage of the savings (or risk) that a provider is eligible to receive and, as applicable, any tiers associated with meeting quality measures. The eligible percentage of savings that may be shared should directly link to the population attributed within the methodology and the savings and risk thresholds, which we describe in more detail below.

Actuarial Analysis

Generally, the development of a shared savings methodology will require an analysis at least as thorough as the analysis for developing capitation rates. We strongly encourage states to conduct an actuarial analysis to ensure the proposed methodologies are sound and forecast to continually improve quality and lower costs. CMS, in collaboration with our Office of the Actuary (OACT), has provided a list of considerations as an enclosure to this letter that should help position states to think through critical policy decisions. States should fully consider the

questions within this list and be prepared to provide CMS with supporting data and documentation on the benchmark calculation, trending assumptions and all other methodological components described in the enclosure. Providing this information with the submission of a shared saving methodology proposal will help expedite the review process.

Risk and Gain-sharing Arrangements

The term “shared-savings” implies that providers will receive incentive rewards for care improvements that result in Medicaid program savings. The Medicare Physician Group Practice Demonstration is an example of a program that recognized bonus payments when providers presented savings above a certain threshold and also met specific quality goals. Under the Demonstration, providers that did not achieve savings above the threshold were not penalized or placed at risk for their efforts (other than for the costs they incurred to improve care). This arrangement proved valuable even though the majority of providers within the demonstration did not demonstrate enough savings to receive a shared savings incentive because there were still measurable improvements in the quality of care provided by the demonstration providers. In the initial stages of state reform efforts, CMS supports gain-sharing arrangements that do not place providers at risk but that strive to achieve quality improvement and lower cost.

Some states may be positioned to place ICM providers at risk for some portion of the total cost of care for attributed beneficiaries if the Medicaid costs associated with the beneficiaries continue to rise beyond expectations. These types of arrangements are described within the Medicare Pioneer ACO model and the Medicare Shared Savings Program regulation. A methodology that allows for gain-sharing and risk offers states and CMS some confidence that the program will not result in unanticipated costs. Generally, risk-based provider payment arrangements may be approved in the Medicaid state plan under the conditions that: providers are not compelled to enter into a risk arrangement as a condition of delivering care coordination services, providers are made aware that they are participating in the risk arrangement, the state plan clearly articulates the basis of the risk calculation, and no provider is at risk for costs over which the provider has no affect or control.¹ To ensure that a provider is not at risk for costs that are not affected by, or over which the provider has no control, states should employ an attribution methodology that appropriately links a provider’s actions to the payment methodology.² Additional details on attribution are described below.

Targeting Providers and Populations

As states contemplate shared savings payment methodologies within the context of their overall health reform agendas, they will need to consider the providers that will be eligible to receive incentive payments and the populations that these providers serve. We have discussed in

¹ “Risk-based arrangements can also be authorized under the state plan in conjunction with section 1932(a) authority. The conditions listed here do not apply to that authority.”

² We note that Medicare ACO models allow groups of providers to share risk. Such arrangements are also allowable under certain Medicaid Integrated Care Models as described in SMD #12-002. In those instances, the qualified provider may be a network or organization of Medicaid providers that is responsible with providing coordinating, locating and monitoring services. Individual providers within the network or organization may share risk through agreements that are outside of the Medicaid authorized payment methodology paid directly to the network or organization (the Medicaid ICM provider). However, one network or organization may not be held at risk for the inefficiencies or another network or organization.

previous letters that states must ensure that value-based purchasing efforts do not infringe upon regulations defining free choice of providers and amount, duration and scope of services provided. We have also noted that states should ensure that there are no duplicate payments made under the Medicaid program and other federal initiatives such as the Financial Alignment Models to Integrate Care for Medicare-Medicaid Enrollees.³ These are basic Medicaid principles that must be considered in the context of shared savings incentives and covered benefits.

The methodology for calculating shared savings incentive payments does not need to consider all of the individuals who receive care coordination or other care improvements from the providers. There is significant flexibility in how states design the incentive payment calculations in order to focus the goals of the purchasing effort and maximize value. For instance, a state could cover coordinating, locating, and monitoring services to all individuals eligible under the Medicaid state plan as an integrated care model but only calculate the shared savings incentives based on individuals with high cost and complex care needs. Note that this flexibility assumes that a state has a base methodology in the state plan to pay for care coordination with the shared savings payments functioning as a performance bonus. States should also assure that individuals who are not considered within the shared savings calculation nevertheless have sufficient access to care coordination services.

Similarly, shared savings incentive payments may be limited to providers with higher levels of qualification (such as an enhanced ability to report quality measures or an organizational capacity that coordinates care across the delivery system) that have the capability to meet care coordination or improvement goals. States will need to carefully consider and articulate the qualification of providers that are eligible to participate in shared savings payments to ensure that they can provide the accompanying care coordination or other care improvements. At this time, we anticipate that states will be interested in rewarding individual primary care practices directly, or recognizing networks of providers that are organized through a single provider entity, which will pass down savings to individual providers within the network. Either model is supportable through one or more of the implementation options described above.

State Share Requirements

Payments associated with shared savings require an appropriate source of the state share consistent with the financial partnership rules set forth in sections 1903(a) and 1905(b) of the Social Security Act. Although provider payments under a shared savings model are calculated based on achieving reductions in estimated payments that would otherwise have been made, this does not change the fact that those provider payments (whether base payments or incentive payments) are made from both state and federal funds. In order to draw down federal matching funds, the state must contribute a recognized non-federal share of state or local funds. The calculation of savings may not be counted as a “virtual” state funding source and used to draw federal financial participation (FFP). Further, the source of the state share may not be derived from other federal grant sources, so states will need to ensure that federal grant awards are

³ CMS announced the Financial Alignment Models to Integrate Care for Medicare-Medicaid Enrollees on July 8, 2011 (SMDL 11-008), which offered states the opportunity to partner with CMS to test models for improving care and lowering cost between Medicare and Medicaid.

delinked from the permissible state or local funds that are used to draw down FFP for Medicaid expenditures.

CONCLUSION

We look forward to working with states to develop and learn from shared savings quality incentive payments within the Medicaid program. As you continue to consider and implement transformational efforts, we are available to provide assistance in navigating the policy options and the tools available to you. If you have any questions, please contact Kristin Fan, Acting Director of the Financial Management Group at: 410-786-4581.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc:

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Attachment A

Shared Savings Resource Materials

Information on the Medicare Shared Savings: Accountable Care Organization Program: <http://innovations.cms.gov/initiatives/ACO/index.html>

Pioneer Accountable Care Organization Model: <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>

Medicare Physician Group Practice Demonstration Design: Quality and Efficiency Pay-for-Performance: http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Demo_Design.pdf

Physician Group Practice Demonstration Bonus Methodology Specifications: http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Payment.pdf

Physician Group Practice Demonstration Evaluation Report to Congress: http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_RTC_Sept.pdf

Considerations for the Benchmark

The Medicaid total cost of care benchmark is established using historical data to calculate expected Medicaid expenditures for the covered populations attributed in a baseline period and then trending them into the performance period to establish a benchmark. For each Medicaid beneficiary that is counted within the methodology for a given performance period, a state should consider all of the comparable Medicaid service expenditures for those individuals from the baseline year. Typically, to establish the baseline, a state should use complete data from the year prior to the start of the performance period since prior year data reflects the most recent state Medicaid policies. The baseline data are trended forward and may be risk-adjusted to establish the benchmark. States will likely find it appropriate to segment baselines and trends based on specified population characteristics in order to account for variations in expenditures associated with each population. The resulting calculations are the benchmarks against which the performance period will be measured. The baseline should assume costs associated with the care coordination activities (or other projected new service costs) that are expected to result in savings.

Data sources: It is crucial that the baseline accurately reflect the total cost of Medicaid care and trend those costs forward using valid data sources. If the baseline or benchmark is inaccurate or founded on flawed data, the shared saving performance period may not reflect true costs savings (or risk) associated with the care model. We advise states to use paid claims data from the Medicaid Management Information System (MMIS) as the data source for the total cost of care. The MMIS paid claims data should capture all Medicaid payments for the baseline year for each beneficiary. If the MMIS does not include all necessary data, states may need to draw on other supplemental resources to calculate the full range of cost. CMS will need to understand all of data resources that states use in the baseline and benchmark calculations.

Risk Mitigation: To minimize risk avoidance based on selection bias, we advise states to incorporate appropriate risk mitigation strategies to the total cost of care to account for outliers, minimize incentives for patient selection and diagnosis or procedure up-coding, and otherwise adjust for risk between the baseline and benchmark to achieve a more confident savings measurement. This is necessary when the population used to establish the baseline is different from the population that will be in the performance period. Risk mitigation strategies could include the application of risk corridors, or adjustments to high cost and/or low cost outliers and be applied at the state or local level. We do not mandate the use of specific risk strategies as these are likely to be program specific and the adjustments may be appropriate to apply at the state or local level.

Excluded Cost: States may be interested in excluding certain costs from consideration in the payment methodology based on the design of the care coordination incentive effort. This may make sense if states are targeting improvements within certain delivery systems, in specific care settings or for certain populations. For example, if a state focuses on improving coordination in primary care with a goal of reducing higher cost inpatient admissions or emergency visits, it may not make sense to include costs related to long-term home and community based care as part of the payment incentive calculation.

Where costs are excluded from the payment calculation, there may be some risk of artificial savings due to shifts in cost to the excluded services or delivery systems. To understand this potential, we expect that states will calculate the benchmark and performance periods to include the actual total cost of care rather than only those costs that are measured and reimbursed as part of the shared savings payment methodology. States should also have an action plan to address cost-shifting through, for example, suspension of the payment methodology or adjustments to the care incentive.

Comparison Population – To best understand whether the care coordination activities are driving program savings, states may consider monitoring comparison groups that have similar characteristics to the attributed populations in the shared savings methodologies. Such an approach may be optimal if the methodology limits attribution to a particularly high-cost cohort instead of the state’s general Medicaid population. For example, if assignment is triggered at discharge from a specific acute care episode or diagnosis, a comparison population may be the best available method to accurately project the cohort’s expected expenditures absent the intervention. If the comparison population is an appropriate proxy for the attributed population, this measure should guard against asymmetry and anti-selection, simply stated: poor results based on incomplete information. In this regard, the comparison group, which would not receive care coordination services, provides a reasonable basis to understand whether program savings within the performance period are the result of the new care coordination effort or based on other factors.

Some states may implement care coordination on a statewide basis or with respect to individuals with chronic conditions and there may be challenges in finding comparable, non-participating populations. In those instances, states could consider the pre/post total cost of care of the attributed populations within the methodology as a suitable basis to determine that savings and quality improvement resulted from changes in care delivery that are provided to the attributed populations and that are incentivized through the model.

Trend Projections and Retrospective Analysis: Once a state establishes the total cost of care baseline, trend factors should be applied to project the cost growth that would have occurred in the absence of the new care model that the state is incentivizing. This establishes the benchmark. Considering the dynamic nature of Medicaid programs, the baseline cost data should be rebased to integrate changes associated with reform efforts or other state Medicaid program changes, such as rate increases or decreases, which were not in effect during the baseline period. If such changes are not considered within the state’s methodology, the benchmark will no longer align with the performance data. A state’s shared savings methodology should clearly describe the timing and basis that the state will use to rebase during the performance periods.

One approach to calculating shared savings is to rely on a retrospective analysis of the savings data. This is the preferred but not required approach. This method would likely eliminate issues related to projection errors that states may encounter in the above model, which projects the benchmark through trend data to establish a savings target, but makes no adjustments based on actual experience to calculate savings. Similar to the Medicare ACO Shared Savings Program, a state could retrospectively review the savings experience of the attributed population to a comparison population and other relevant information that may impact the performance period and make necessary adjustments to the benchmark at the end of the performance year. Since the

information is based upon actual experience, rather than projected, a more accurate benchmark can be established.

States may also opt to take a prospective approach to calculating shared savings using appropriate trends. Generally, states will be expected to develop trends that are population specific and service specific and based on actual, historic Medicaid expenditure data. The trends, in combination with targeted savings projections in the performance period, will provide states with a reasonable understanding of the cost savings target (and anticipated expenditures) related to the methodology. These trends and the benchmark should be rebased annually to consider all adjustments to the state Medicaid program that occur throughout the year. Examples of adjustments that may impact the total cost of care include: modifications to program rates and benefits and other delivery systems improvements or program expansions. In addition, states should retrospectively review the trends at a regular interval, such as annually, to determine whether the projections were in line with real cost growth. As states rebase the benchmark, the retrospective review will help determine any necessary adjustments to the trending data to account for flaws in the original projections.

Considerations for the Performance Periods

The performance period measures the impact of the new care coordination efforts against the total cost of care benchmark. To ensure that program savings are accurate, it is important that the performance period calculation include the same service package and beneficiaries that were included to establish the benchmark. States should use data to project the potential cost savings associated with the care coordination and quality efforts that are measured through the methodology, ideally incorporating such information in the design phase as the various policy options (e.g. risk adjustment, minimum savings requirements, group size requirements, sharing percentages, etc.) are modeled and chosen to maximize the probability the program will result in net savings for the state. Adjustments to the baseline, benchmark and actual performance should also be consistent to account for any program changes that impact the total cost of care.

Attribution Methodology: Attribution is the method by which a state can reasonably credit the activities of a care coordination provider to beneficiary care outcomes and program cost. States may face challenges in determining an appropriate attribution methodology because beneficiaries may lose coverage throughout the baseline and performance years or may not have consistent access to a particular care provider. Some of these issues may be addressed through a retrospective attribution methodology (required of participants in the Medicare ACO shared savings program) where final attribution is determined after each performance year. The retrospective method will likely result in more accurate beneficiary attribution and savings calculations. Retrospective attribution will also reduce risks to states because the final calculation is based on actual data instead of projections. This does create a measure of uncertainty for providers because they will be less certain of the beneficiaries attributed to them in the performance period. An alternative to retrospective attribution is a prospective approach where attribution is based on prior year data and established prior to a performance year. This method reduces risk to some providers because they know the extent of patients attributed to them and can target interventions to particular patients, but it may not result in as accurate a savings calculation and associated payments and could have unintended adverse effects on patient care.

We are not prescribing a methodology for attribution as part of this guidance. However, attribution methodologies should be statistically valid and consider a consistent set of data. CMS expects states to define the method for attribution, describe the data that will be used for the determination and the basis for evaluating the methodology. As discussed in the various Medicare shared savings initiatives, states could use a utilization statistic, such as a proportion of primary care codes rendered within the year by a particular provider, as the basis for attribution.

Minimum Savings Requirements – States may wish to implement symmetrical risk and gain-sharing thresholds to minimize the risk associated with the methodologies to both states and providers. While the objective of a shared savings methodology is to incentivize better care at lower cost, the reality is that not every provider may achieve program savings. This is particularly true when the attributed populations within a methodology are of limited size, as statistical variation in annual expenditures will generally grow as group size decreases. Minimum savings thresholds allow states to offset some of the risk associated with population variability and the difficulty states may have in accurately projecting service expenditures in the performance year. For instance, a state’s methodology may not allow for shared savings (or risk) unless a provider demonstrates savings (or losses) exceeding an established percentage of the projected targeted expenditures. Generally, it is advisable that the thresholds grow as the attributed population decreases in number or as variability otherwise increasingly effects the confidence of measuring savings within the attributed population. CMS will be interested in understanding how states make this determination.

Quality Metrics

We plan to release additional guidance on quality metrics as part of this State Medicaid Director’s Letter series on new Medicaid care models and payment reform initiatives. We emphasize that shared savings payment methodologies must include a quality component that ensures that savings are the result of care improvements and not due to restrictions on necessary care or some other unintended result. The quality metrics that a state includes as part of a shared savings methodology should be appropriate for the attributed populations, vigorous enough to demonstrate incremental or sustainable improvements in care, and consistent with the state’s Medicaid program quality strategy. The state plan methodology should describe how the quality metrics impact the ability of providers to share in savings, such as through a tiered structure that considers quality targets to adjust the savings percentages a provider is eligible to receive.

Program Evaluation

CMS expects that all states will evaluate the effectiveness of shared savings methodologies and make any necessary adjustments to improve programs based on the result of the evaluations. Before approving the shared savings methodology, CMS is interested in understanding the criteria that states will use to measure program success, the time-frame for evaluations, and how states will use the evaluations to improve shared savings incentives. We are interested in learning from the results of evaluations so that we may help other states design effective models and develop national policy on care delivery improvements. Of particular interest to CMS are:

Attachment B – Technical Considerations for Shared Savings Methodologies

- whether the performance and savings determinations within the model were sufficiently accurate to result in actual net savings for the state, and description of populations for whom it was found particularly difficult to accurately measure savings,
- whether the methodology incentivized providers to alter care practices or to introduce new care practices that appear related to better quality and lower cost in order to meet savings thresholds and improve quality,
- the sustainability of shared savings models and continued quality improvement,
- the particular effects of one care coordination model as compared to another,
- the impact of poor performers on a state’s overall delivery systems and strategies to address the poor performers,
- states’ potential program changes if all providers achieve the quality and savings targets,
- the sufficiency of data to evaluate the incentives and quality measures,
- best practices and lessons that may help in developing replicable models.

Because of shared saving methodologies are relatively new, states must include an end date within the approved payment methodology to allow states to evaluate the success of the incentive payment based on data that has been collected on quality improvements and cost savings that have been achieved. While we expect states to provide ongoing quality, cost of care and other relevant data that demonstrates the effectiveness of their shared savings incentives, a methodology “sunset” will provide an opportunity for CMS and states to work through a formal review process to make adjustments or end programs that are not achieving desired results. States are expected to share the outcome data with CMS and explain how the findings demonstrate success or a decision to modify or discontinue the payment incentive. A “sunset” does not preclude a state from continuing to reimburse for shared saving incentives that are effective; rather, a state will simply need submit a new state plan amendment (SPA) to modify the sunset to a future date if the review results in the conclusion that the model is achieving the desired effect.

Questions States Should Consider for Medicaid Shared Savings Methodologies

Basic Program Design

1. How does the model promote better care for individuals, better health for populations, and lower costs through improved care delivery?
2. Describe how, if relevant, the model will consider Medicaid changes related to the Affordable Care Act, including the Medicaid eligibility expansion in 2014?
3. Does the model align with other changes to the state’s Medicaid program? This could include modifications to payment for Medicaid providers, additional efforts to coordinate care, transform practices and/or promote quality.
4. A description of covered Medicaid services that are paid (all or in part) through the shared savings methodology is required to authorize FFP for shared savings payments under the Medicaid program.
 - a. Under which Medicaid authority will the state reimburse shared savings? For guidance related to options for integrated care model implementation, see: SMDL 12-002 “Policy Considerations for Integrated Care Models.”
 - b. Which services or activities is the proposal requesting to be matched? (e.g. care coordination through an Integrated Care Model (ICM), Health Homes for Enrollees with Chronic Conditions, Primary Care Case Management Contracts, etc.)
5. Does the proposal describe an allowable funding source for the non-federal share of the payments per the statutory requirements of 1903(w)(6)(A) as implemented in 42 CFR 431.51?

Participating Providers

6. Which providers are eligible to receive payment under the shared savings methodology? Are certain providers within these designations targeted? (e.g. primary care practices, mental health and substance abuse providers, long-term care service and support providers, patient-centered medical homes, accountable care organizations).
7. How does a provider qualify for a payment?
8. Which activities must a provider conduct to receive payments?
9. Which quality measures will the state use as a basis to determine payment?

10. If providers are targeted:
 - a. Are they targeted through provider qualifications or contracts?
 - b. How will a state define eligible providers?
 - c. How does the proposal address freedom of choice?
11. If there is a hierarchical structure, such as a network or ACO relationship and are the roles clearly defined to describe each entity's responsibilities and how the levels work together to coordinate care and improve quality?
12. Is provider participation mandatory or optional? If participation is mandatory, are the risk-sharing arrangements consistent with statutory requirements on reimbursement for specific provider types? (For example, the statute requires that total reimbursement to FQHCs and RHCs under an Alternative Payment Methodology may not be less than these providers would have received under the Prospective Payment System.)
13. Are participating providers required to participate in a risk sharing arrangement in order to qualify for payment? Risk sharing arrangements should be described in the proposal, along with the authority under which the state will implement the arrangement.
14. Will shareable savings or risk be determined at the statewide, carrier/network, or provider practice level (or some combination of the above)?

Populations within the Model

15. Are all Medicaid eligible beneficiaries included in the shared savings calculation?
 - a. Is beneficiary participation mandatory?
 - b. What is the process to inform beneficiaries that their health costs and information will be used in the shared savings methodology?
16. Does the shared savings methodology target specific populations?
17. How does the proposal address state-wideness when populations are targeted? Note – state plan services described under a benefit category must be available state-wide, however, as long as all eligible individuals may receive services under the benefit category, the shared savings calculation may target specific populations.

18. If the shared savings methodology accounts for costs of targeted populations, how are beneficiaries selected (e.g., by age, by condition, by event)?

Methodological Considerations

Actuarial Analysis

19. Did the state conduct an actuarial analysis to assess the validity of the shared savings structure and explain the data, assumptions, and methodology used to develop its analysis? Generally, it should be expected that the development of a shared savings methodology will require analysis at least as thorough as the analysis for developing capitation rates.

Mechanics of the Payment

20. What method will the state use to determine the shared savings amount and distribute payments to providers?
- a. How often are payments made to providers? When are these payments made (within 30 days after the end of the fiscal year, etc.)?
 - b. Will provider risk be one-sided, two-sided, or both (e.g. one-sided in initial years, transitioning to two-sided in later years)?
 - c. What percentage of the savings are providers and provider organizations eligible to receive?
 - d. Are there limits on the amount of additional costs a provider may incur as a result of participation?
 - e. How does the state plan to calculate that percentage? For instance, is the percentage tiered based on quality performance or some other factor?
 - f. Will there be a minimum savings percentage that must be met in order to prevent payment due to random variation?
 - g. How are the claims for the shared savings payments made? Is the MMIS or some other system used to adjudicate claims?
 - h. What are the state requirements to hold providers accountable for the required activities and/or interventions paid through the shared savings methodology?
 - i. On which line of the CMS-64 will the state report shared savings expenditures?

Attribution Methodology

21. What processes will be used to assign, enroll, or otherwise attribute beneficiaries to providers under the program?
 - a. How many beneficiaries must be attributed, enrolled, or assigned in the program to determine statistical validity of the data and outcomes?
 - b. How will the program account for beneficiaries who enter or leave Medicaid during the year? (Please note: the actuarial estimates should address this question as well.)
 - c. What is the minimum number of beneficiaries required to be attributed, enrolled, or assigned per provider to determine statistical validity of the data and outcomes?

Comparison Population

22. Will the shared savings methodology compare performance to a comparable population that is not included within the methodology in order to assess whether the activities reimbursed through the model result in program savings?
 - a. If so, how is this population selected?
 - b. Are there potential differences in the populations that need to be considered when developing comparisons?
 - c. Are there any potential anti-selection issues to consider?

Baseline Data

23. Is prior year data used as a baseline to measure the effectiveness of care coordination and practice transformation activities rewarded through the payments?
 - a. With what level of confidence are the retained measured savings projected to outweigh costs from uncertainties (such as claim variation; selective participation; trend bias; etc.)?
 - b. Has the data been risk adjusted for valid comparison with current performance?
24. Is the state measuring total cost of care for individuals in the delivery system or is it only measuring cost in a specific setting, such as in the PCP setting?

Attachment C – Questions States Should Consider for Medicaid Shared Savings Methodologies

25. Does the baseline calculation include all program health costs within or exclude certain claims or services?
26. Does the baseline calculation account for supplemental provider payments that are made in addition to fee for services payments? How are the supplemental payments accounted for in the calculation?
27. How does the calculation treat and consider long-term services and supports?
28. What is the basis for excluding claims or services?
29. Has risk adjustment been designed to minimize the incentive for diagnosis “upcoding” by providers who might otherwise seek to influence the measurement of shared savings by adjusting their diagnosis coding practices?
30. Should the baseline data be segmented to reflect specified population characteristics?

Data Trending

31. What trending factors does the state propose to use to adjust the baseline expenditures and what underlying data were used as the basis of the trend?
 - a. Will there be different trending rates based on eligibility categories?
 - b. Will there be different trending rates based on service categories?
32. Should the trend data be segmented to reflect specified population characteristics?

Performance Period

33. Does the performance period calculation include all program health costs within or exclude certain claims or services? Do the included claims and services align with the benchmark calculation?
34. What is the basis for excluding claims or services? (Generally, the shared savings measurement should adjust or otherwise account for changes in covered services from the base to performance period.)
35. For the purpose of calculating program savings, would the proposal limit the inclusion of high cost claims above a certain dollar amount? Is this accounted for in the actuarial estimate of savings?
36. How does the plan account for other plan changes?

37. Are shared savings payments reconciled to the other payments made to participating providers?
 - a. Are shared savings payments net of care coordination PMPMs or any other payments?
 - b. How are risk sharing adjustments made in the payment to providers?
38. What strategies will the state use to minimize incentives for providers to select less costly patients?
39. What strategies will the state put in place to account for outlier patients?

Rebasing the Baseline Calculation

40. How will the baseline data be rebased after an appropriate period of time to account for any delivery system reforms that have been fully integrated?
41. How often and when will the baseline data be rebased?

Measuring Success: Components of an Evaluation

42. What evaluative measures other than cost savings will the state use to determine program success?
43. What process will the state have to evaluate the effectiveness of the shared savings payments?
44. What program modifications or corrective actions will the state implement if the program is not functioning as expected? When will the state take action to modify the program?
45. What evidence, research, or theory is the state employing to ensure that chosen quality measures are indicators of program effectiveness?
46. How is the state ensuring that costs are not being shifted to other health care settings/programs?
47. If process measures are included as performance metrics, what positive contributions to program effectiveness will the process measures indicate?

Attachment C – Questions States Should Consider for Medicaid Shared Savings Methodologies

48. What data measures will be used to ensure that providers are actually transforming their method of care delivery?
49. What thresholds or other criteria are considered successful transformation?
50. How will the state address poor performers?