The Mechanics of Shared Savings:

Commercial Payer Models

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Learning Objectives

- This session will provide you with the knowledge to:
  - Describe the differences in components of shared savings models used by commercial payers
  - Contrast the commercial components with the Medicare Shared Savings Program Components
  - Discuss expectations of commercial payers offering shared savings contracts

"Instead of merely haggling on fee-for-service rate increases, value-based contracting may spur the two sides to butt heads over other issues. Experts predict that determining lump-sum payments, quality metrics to be used for bonuses or penalties, and arrangements for how shared savings should be spilt will be the new payment bargaining chips."

-*Modern Healthcare*, January 2015 ed.

Source:"Value-based care not likely to end financial squabbles between insurers, providers", *Modern Healthcare*, January 26, 2015

Approach/Agenda

Six Questions about commercial shared savings models:

1. Who are the major players?
2. How do the models work?
3. How do the models compare?
4. How long does it take?
5. How much is on the table?
6. What's the big rush?

Question #1

Who are the major players?

Commercial Payers Offering ACO Contracts

Cigna

Aetna

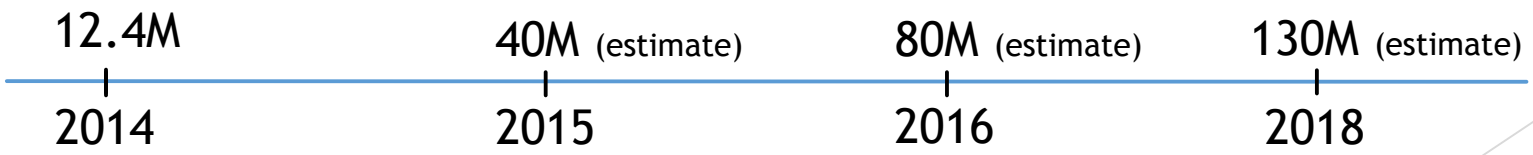
UnitedHealthcare

BlueCross BlueShield

Humana

SIIA SELF-INSURANCE INSTITUTE OF AMERICA, INC.

Number of ACO Covered Lives:



Question #2

How do the models work?

Pathway to Shared Savings

Operational Resources ⟹	Triple Aim Mission Support ⟹	Operational Contribution
PCMH Teams & External Team support: PCPs, Specialists, Rx, Hospitalists, etc.	**Delivery of cost-effective & quality healthcare at practice sites**	**Meet cost & quality performance requirements at site level**
IT Data: EMR, EHR, HIE, & MU Reporting Resources	**Cost & quality data reporting:** Dashboards, registries, & reports	**Medical Expense:** ↓ **Quality of Care:** ↑ **Population Health:** ↑
Care Management Program: Care Coordinators & Social Workers	**Population Health Management:** Patient-specific transitions, compliance, follow-ups, etc.	**Patient & Provider-specific interventions-continuum of care**
Governance & Administration: Board members, CEO, CMO, CFO, COO, etc.	**Policies & Procedures:** Clinical standards, MSE management, patient-centric culture development, physician comp. & multi-payer contracting	**Operational & Financial decision making**

Result:
SHARED SAVINGS DISTRIBUTIONS

Shared Savings Potential

There are four main reimbursement models used by accountable care organizations (ACOs), according to a survey conducted by Healthcare Intelligence Network:

- Fee for service, care coordination and shared savings: 37%
- Shared savings: 22.2%

59.2%

- Pay for performance: 11.1%
- Fee for service and care coordination: 11.1%
- Bundled/episodic payment: 3.7%

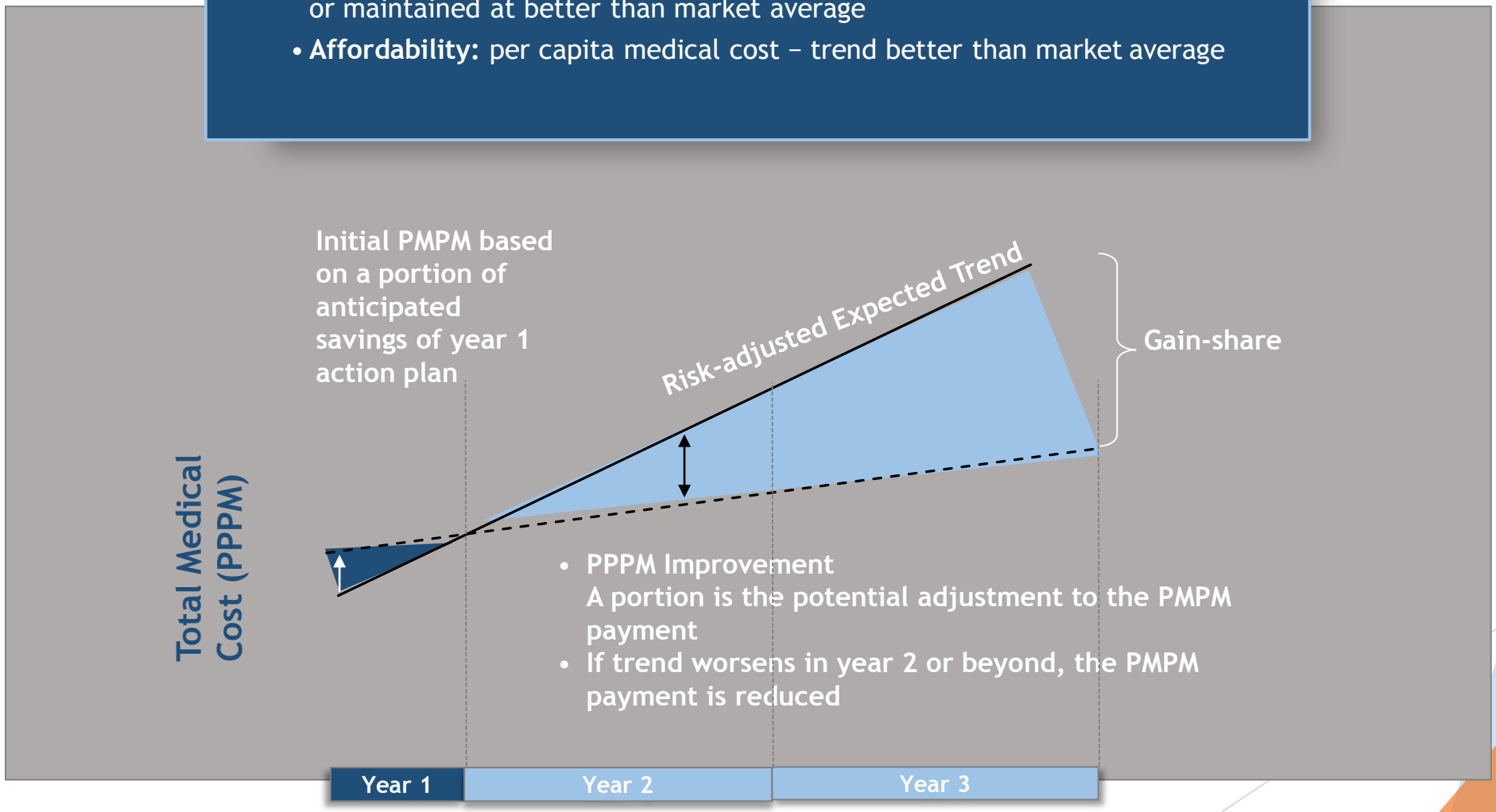
Survey data based on responses from 138 healthcare organizations participating in ACOs.

Source: Heather Punke, "Top 4 Reimbursement Models", *Beckers Hospital Review*, December 31, 2013

Commercial Payer: Shared Savings Model

Must pass elements compared to market:

- **Quality:** Evidence-Based Measures (EBM) and patient satisfaction improved or maintained at better than market average
- **Affordability:** per capita medical cost – trend better than market average



ACOMG Payment SS Example (5000 Lives)

Assumptions:

- PMPM Fees (Care Coordination): (5000 lives x $2.00) x 12 = $120,000
- ACOMG Total Medical Cost (TMC): (5000 lives x $325 est.) x 12 = $19,500,000 est.
- Base-line Trend Rate: 7%
- ACOMG Trend Rate: 2%
- ACOMG Performance Index: 50% adjustment
- ACOMG Quality Index: 1.0

Annual Payments: ACOMG SS Example

Calculation:

TMC/ACOMG Trend Rate: ($19,500,000/1.02)=	$19,117,647
TMC (Baseline) Trend Rate: (1.07 x $19,117,647)=	$20,455,882
Less: ACOMG TMC=	($19,500,000)
Total Gain Share =	$955,882
Less: Performance Adjustment (50%) =	($477,941)
Shared Savings (SS) Amount =	$477,941
Less: Quality Index Adjustment (0%) =	$0
Net Shared Savings due ACOMG=	$477,941
Care Coordination Fee (CCF): ($2.00 x 5000 lives x 12)=	$120,000

Year 1: $120,000 (PMPM: $2.00)

Year 2: ($477,941 -$120,000/2) = $417,941 (PMPM: $6.97)

Year 3: $477,941 (PMPM: $7.97)

Question #3

How do the models compare?

Shared Savings Model Comparison Matrix

Components	CMS	Commercial Payer 1	Commercial Payer 2	Comments
Risk Assumption				
Upside Risk	x	x	x	Usually 50/50 split- (10% annual decrease-CMS)
Downside Risk	x	x	x	Variable-CMS 60/40 split (75/25 CMS proposal)
Risk Adjustment				
Claims > 100K	x		x	High cost outliers
Other		x		Stop loss insurance
Attribution				
Prospective	x	x		No reconciliation
Retrospective	x	x	x	Annual reconciliation
Attribution Panel Size				
>5K	x	x	x	CMS minimum panel 5K
<5K		x	x	Depends on geo area & client

Shared Savings Model Comparison Matrix

Components	CMS	Commercial Payer 1	Commercial Payer 2	Comments
Financing				
Advanced Payments	x	x	x	Care coordination fee (CCF) pmt-varies by commercial/MA product
Minimum Savings Rate				
2-4%	x			CMS 2.0 to 3.9 depending on # of assigned members
None		x		BCR/MLR: 15% minimum
Other			x	May require CCF repayment
Quality Performance	x	x	x	Mandatory to earn savings-HEDIS+
Total Cost Performance	x	x	x	May reduce shared savings if cost is above average
Benchmarks (Targets)				
Past Performance	x	x		Based on claims history
Locale: National or Local Market			x	Based on market area claims

Question #4

How long does it take?

5 Steps of ACO Payer Contracting

Process & Estimated Timeframes	Attribution	Assessment	Benchmarking	Negotiation	Implementation
Usual est. Timeframe (days)	30 – 60	30 – 60	30 – 60	30 – 60	30 – 90
RCG est. Timeframe (days)	30	30	30	30	30

1. **Attribution-** Alignment modeling based on claims histories to produce panel size
2. **Assessment-** ACO history, organizational structure, provider membership, market position
3. **Benchmarking-** Cost & quality performance, care management program, utilization trends
4. **Negotiation-** Contract terms, legal review, risk features, shared-savings action plan
5. **Implementation-** Loading customized contracts into system and implementation meetings

Question #5

How much is on the table?

Actual Examples

ACO	PCP Size	MSSP Results (Actual)	Commercial Shared Savings (Estimated)	Multiples
Florida ACO #1	55	$6.25M	$15.2M	2.43
Florida ACO #2	175	$10.34M	$47.8M	4.62
Texas ACO	48	$1.75M	$12.1M	6.91

Question #6

What's the big rush?

Medicare ACOs on the Move

- The Obama administration (HHS) wants 30% of payments for traditional Medicare benefits to be tied to alternative payment models such as accountable care organizations by the end of 2016 and set a goal of hitting 50% by the end of 2018.
- Currently, 20% of Medicare payments for traditional beneficiaries are made through alternative payment models….
- It is the first time HHS has set specific goals for overhauling the payment system for standard Medicare beneficiaries.

(Source: "HHS sets goals for expanding new Medicare payment models", Modern Healthcare, January 26, 2015)

Commercial ACOs on the Move

- A group of the top U.S. health systems, payers and stakeholders announced Wednesday the formation of the Health Care Transformation Task Force, a private-sector alliance
- The alliance plans to improve the ACO model, develop a standard system for bundled payments and improve high-cost care, according to a statement. The group already released Wednesday a set of recommendations to improve ACOs
- The 28-member Task Force includes 20 insurers and provider organizations such as Partners HealthCare and Trinity Health, committed to put 75% of their businesses in the next 5 years into value-based payment arrangements, which will hold providers accountable for the cost of care, quality of care and health of the population (Triple Aim)
- Payers involved include Aetna, BCBS of Massachusetts and Blue Shield of California.

Source:"20 major health systems, payers pledge to convert 75% of business to value-based arrangements by 2020", *Beckers Hospital Review*, January 28, 2015

Tipping point to action

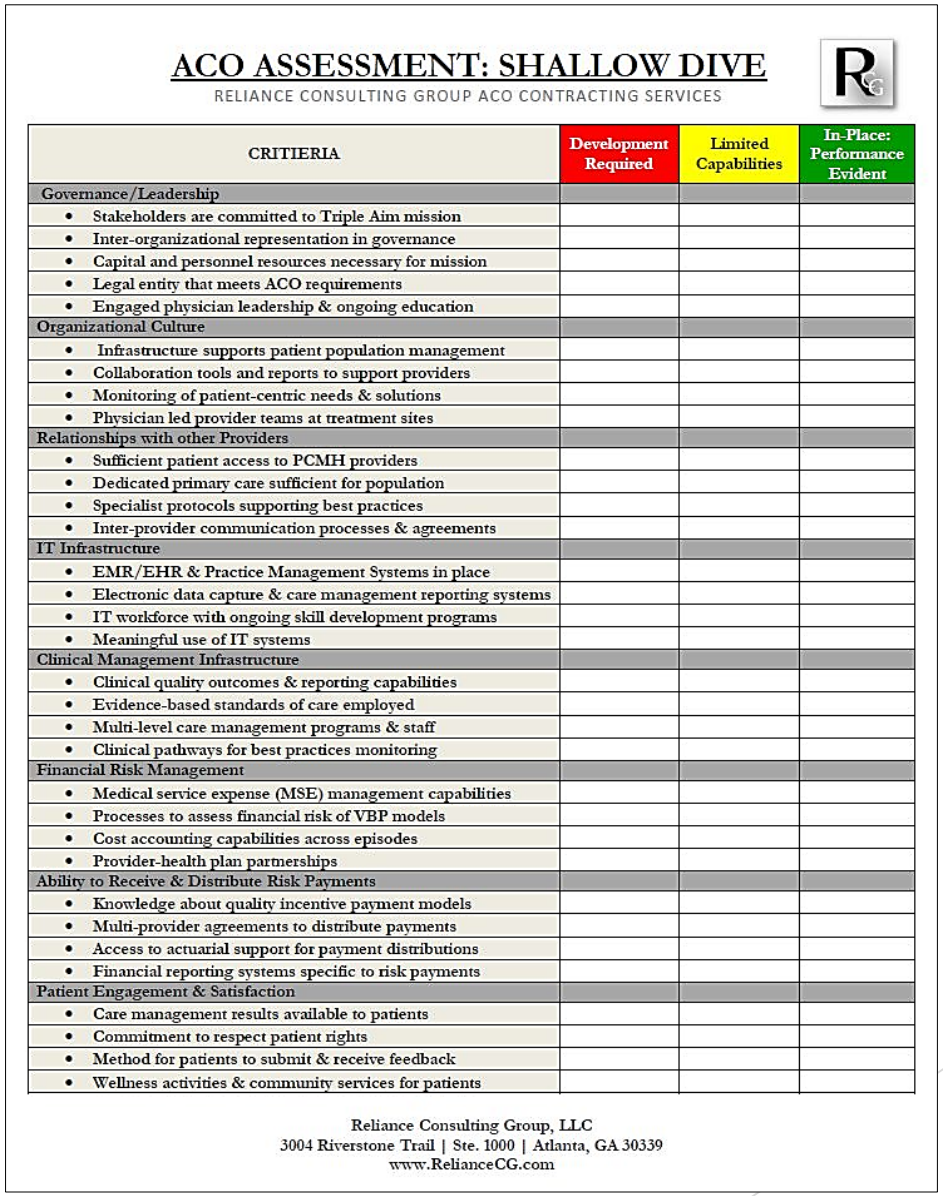
- "A lot of the systems we work with struggle with not knowing when to transform and make changes for the future," says Igor Belokrinitsky of Strategy&
- "A lot of them have said, 'Once 50% of payments are value-based, that will be enough to push us over the edge and get us to change the way we provide care.' And this will get them past the tipping point."
- Although, Mr. Belokrinitsky believes HHS' overhaul plan is lacking in some areas. "[The HHS plan] sets a very noble and a very necessary goal, but it doesn't necessarily tell health systems how to get there," he says.

(Source: "Plans for Medicare payment overhaul receive mixed reviews", Ayla Ellison and Kelly Gooch, Becker's Hospital CFO, January 27, 2015.)

Free ACO Tools

Available at:

www.RelianceCG.com



ACO ASSESSMENT: SHALLOW DIVE

RELIANCE CONSULTING GROUP ACO CONTRACTING SERVICES

CRITIERIA	Development Required	Limited Capabilities	In-Place: Performance Evident
Governance/Leadership			
• Stakeholders are committed to Triple Aim mission			
• Inter-organizational representation in governance			
• Capital and personnel resources necessary for mission			
• Legal entity that meets ACO requirements			
• Engaged physician leadership & ongoing education			
Organizational Culture			
• Infrastructure supports patient population management			
• Collaboration tools and reports to support providers			
• Monitoring of patient-centric needs & solutions			
• Physician led provider teams at treatment sites			
Relationships with other Providers			
• Sufficient patient access to PCMH providers			
• Dedicated primary care sufficient for population			
• Specialist protocols supporting best practices			
• Inter-provider communication processes & agreements			
IT Infrastructure			
• EMR/EHR & Practice Management Systems in place			
• Electronic data capture & care management reporting systems			
• IT workforce with ongoing skill development programs			
• Meaningful use of IT systems			
Clinical Management Infrastructure			
• Clinical quality outcomes & reporting capabilities			
• Evidence-based standards of care employed			
• Multi-level care management programs & staff			
• Clinical pathways for best practices monitoring			
Financial Risk Management			
• Medical service expense (MSE) management capabilities			
• Processes to assess financial risk of VBP models			
• Cost accounting capabilities across episodes			
• Provider-health plan partnerships			
Ability to Receive & Distribute Risk Payments			
• Knowledge about quality incentive payment models			
• Multi-provider agreements to distribute payments			
• Access to actuarial support for payment distributions			
• Financial reporting systems specific to risk payments			
Patient Engagement & Satisfaction			
• Care management results available to patients			
• Commitment to respect patient rights			
• Method for patients to submit & receive feedback			
• Wellness activities & community services for patients			

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Q & A

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