North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

March 1, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 1028, Legislative Building
Raleigh, North Carolina 27603

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307A, Legislative Office Building
Raleigh, North Carolina 27603-5925

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 639, Legislative Office Building
Raleigh, North Carolina 27603-5925

Dear Representative Burr, Representative Hollo, and Senator Hise:

Section 12H.18 of Session Law 2013-360 requires the Division of Medicaid Assistance (DMA) to develop a Medicaid shared savings plan in consultation with affected providers that meets certain specified criteria. The Division must also report on the development of that plan. Please find DMA's report attached, and please direct all questions concerning this report to Rick Brennan, Division of Medical Assistance, Chief Financial Officer, at rick.brennan@dhhs.nc.gov and 919-855-4123.

Sincerely,

Adam Sholar

cc: Sarah Riser
Pat Porter
Susan Jacobs
Theresa Matula
Rod Davis
Sandra Terrell

Kristi Huff
Brandon Greife
Robin Cummings

Joyce Jones
Pam Kilpatrick

reports@ncleg.net
Steve Owen

STATE OF NORTH CAROLINA SHARED SAVINGS PROGRAM

Session Law 2013-360, Section 12H.18

Prepared by
Division of Medical Assistance
NC Department of Health and Human Services

March 1, 2014

State of North Carolina Shared Savings Program

The Appropriations Act of 2013, Session Law 2013-360, Section 12H.18, requires the Department of Health and Human Services (DHHS) to consult with providers to develop a shared savings plan for implementation by July 1, 2014. The shared savings plan will provide incentives to promote effective and efficient care that results in positive outcomes for Medicaid and NC Health Choice recipients. The law requires DHHS to report on the development of the shared savings program no later than March 1, 2014.

This report will provide:

1. the shared savings legislation;
2. guidance on shared savings from the federal Centers for Medicare and Medicaid Services (CMS);
3. challenges with shared savings implementation as currently legislated; and
4. status and next steps.

AUTHORIZING LEGISLATION

Per Session Law 2013-360, the Shared Savings program is enacted as follows:

SECTION 12H.18.(a)

The Department of Health and Human Services shall consult with providers affected by subsection (b) of this section to develop a shared savings plan that the Department shall implement by July 1, 2014, with provider payments beginning January 1, 2015. The shared savings plan shall provide incentives to provide effective and efficient care that result in positive outcomes for Medicaid and NC Health Choice recipients. Payments under the shared savings plan shall be paid from funds withheld under subsection (b) of this section, and payments to members of a particular provider group shall come from the funds withheld from that group.

SECTION 12H.18.(b)

During the 2013-2015 fiscal biennium, the Department of Health and Human Services shall withhold three percent (3%) of payments for the following services rendered to Medicaid and NC Health Choice recipients on or after January 1, 2014:

- *Inpatient hospital.*
- *Physician, excluding primary care until January 1, 2015.*
- *Dental.*
- *Optical services and supplies.*
- *Podiatry.*
- *Chiropractors.*
- *Hearing aids.*
- *Personal care services.*
- *Nursing homes.*

- *Adult care homes.*
- *Dispensing drugs.*

Funds from payments withheld under this section that are budgeted to be shared with providers shall not revert to the General Fund.

SECTION 12H.18.(c)

The Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services on the development of the shared savings program established by this section no later than March 1, 2014.

GUIDANCE FROM FEDERAL PARTNERS

In order to implement the shared savings program as directed in S.L. 2013-360, the NC DHHS Division of Medical Assistance must submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS) for approval of the shared savings program. To help inform states thinking during the development of performance incentives, CMS issued a State Medicaid Director Letter (SMDL# 13-005) on August 30, 2013 on Shared Savings Methodologies.

In the letter CMS underscores its focus on quality and health outcomes for any future state shared savings programs:

"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."

CMS states that shared savings plans should:

- Incentivize improved quality and outcomes and reduce costs by sharing program savings with high performing providers;
- Encourage care coordination and practice transformation activities that improve quality and health outcomes;
- Not be based only on cost savings;
- Must improve quality and health outcomes; and
- Not limit access to eligible beneficiaries.

The CMS letter outlines the four important concepts of a shared savings program:

1. A total cost of care benchmark;
2. Provider payment incentives to improve care quality and lower total cost of care;
3. A performance period that tests the changes; and
4. 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.

The CMS letter also offers methodological considerations for calculating shared savings as well as a series of 50 questions that CMS will expect NC to answer in any shared savings proposal, including the following:

- How does the model promote better care for individuals, better health for populations, and lower costs through improved care delivery?
- Which activities must a provider conduct to receive payments?
- What quality measures will the state use as a basis to determine payment?
- Does the shared savings methodology target specific populations?
- 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?
- Are all Medicaid eligible beneficiaries included in the shared savings calculation?
- What percentage of the savings are providers and provider organizations eligible to receive?
- Are there limits on the amount of additional costs a provider may incur as a result of participation?
- How does the state plan to calculate that percentage? For instance, is the percentage tiered based on quality performance or some other factor?
- How are the claims for the shared savings payments made? Is the MMIS or some other system used to adjudicate claims?
- What are the state requirements to hold providers accountable for the required activities and/or interventions paid through the shared savings methodology?
- What processes will be used to assign, enroll, or otherwise attribute beneficiaries to providers under the program?
- Is prior year data used as a baseline to measure the effectiveness of care coordination and practice transformation activities rewarded through the payments?
- 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?
- 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?
- 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?
- 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?
- Are shared savings payments reconciled to the other payments made to participating providers?
- 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?
- How is the state ensuring that costs are not being shifted to other health care settings/programs?
- How will the state address poor performers?

CHALLENGES WITH IMPLEMENTATION

The list of questions above highlights the complexity of a shared savings program and the significant thought and planning that must be given to any plan that would meet CMS standards for approval.

While conducting research, DMA found that the main difference between the shared savings program in S.L. 2013-360 and the shared savings plans implemented by other states is its focus on achieving savings within a specific provider type versus creating incentives for savings system wide.

DMA sees four major challenges in implementing the Shared Savings program as currently legislated, discussed in detail below:

1. Difficulty implementing at least one agreed upon evidence-based intervention that improves quality and achieves savings for each of the eleven different provider types listed in legislation;
2. Timing of implementation;
3. Lack of clarity on whether incentives are to be paid across entire provider type if savings are achieved or at the individual practice level; and
4. Focus on smaller provider types that lack potential to affect overall expenditures in the Medicaid program.

ELEVEN DIFFERENT EVIDENCE-BASED INTERVENTIONS AND INCENTIVES

The legislation as currently enacted essentially requires the development of eleven (11) different shared savings programs. For each program, DMA must construct a plan that incorporates CMS' four essential concepts of a shared savings plan, including:

1. A total cost of care benchmark;
2. Provider payment incentives to improve care quality and lower total cost of care;
3. A performance period that tests the changes; and
4. 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.

For each of the eleven provider types, DMA must agree upon:

- a baseline budget starting point,
- a measurable, evidence-based intervention that improves quality,
- a measurable, evidence-based intervention that achieves savings, and
- a measurable benchmark per intervention for providers to meet in order to qualify for incentive payments.

In addition, DMA must have the capability to collect and analyze data by each intervention for each of the eleven shared savings programs by eleven provider types, and at the individual practice level within each provider type. If savings are achieved, DMA must have the capability to pay incentive payments by each of the eleven provider types at the individual practice level. DMA does not currently have the systems in place to collect and

analyze this data or make these payments. Any systems changes will require additional funding and time for implementation.

Further, in order to make the payments at the provider type level by individual practice, DMA must be able to prove that the intervention is directly attributable to the shared savings plan and is responsible for any savings generated. It is difficult, for example, to prove that extending office hours in primary care offices reduces emergency department (ED) usage when an intervention an ED implemented separately and apart from the shared savings plan may also achieve savings. Similarly, there may also be difficulty achieving savings when unrelated costs escalate, despite numerous interventions implemented by the providers.

TIMING OF IMPLEMENTATION

The current legislation provided only six months to outreach to eleven different provider types statewide to define interventions and benchmarks for incentives. Given the complexity of the program and the significant buy-in required from the provider communities, DMA feels additional time to work with providers to iron out issues would be beneficial.

The legislation also provides only six months to finalize State Plan Amendment with CMS, which is unrealistic given the level of complexity of eleven different shared savings plans in eleven different State Plan Amendments.

Similarly, the legislation provides only six months between plan implementation and the beginning of payment of incentive payments. This timeline assumes providers will be ready to implement any interventions immediately. It also assumes DMA will be able to receive and analyze data to determine incentive payments. Data will be limited given numerous documented systems issues. Further, any savings and outcomes improvements should be based on annual data - not partial year data - to account for billing lags and the seasonality of service utilization.

LEVEL OF INCENTIVE PAYMENT

The legislation does not provide clarity on whether the payments are to be made to the entire provider type or at the individual practice level. In what may derail efforts to achieve savings, many providers have expressed that they simply will not participate in the shared savings program because the legislation does not expressly say it is mandatory.

There has been an enormous amount of concern raised from the impacted provider groups of the Shared Savings Plan. Most providers fear that they may not be able to sustain a 3 percent rate reduction in the "hopes" that they can receive a percent of the money back if they meet certain benchmarks. During the November 8th meeting of the Medical Care Advisory Committee (MCAC), a member stated, "I can't offer you suggestions on how to

implement a shared savings program when I'm not even sure that I will be able to stay in business long enough to benefit from it".

If the shared savings program is voluntary, the payment of incentives would need to occur at the individual practice level to prevent free riders not implementing cost or quality improvement interventions from receiving incentive payments. Currently DMA does not have the capacity to track benchmarks at the practice level. This level of oversight and analysis may require contractor(s) to coordinate for eleven different provider types. DMA does not currently have funding for additional contractors required to implement the program.

STRAPPED SMALLER PROVIDER TYPES

Another challenge for implementation is that the shared savings plan focuses on several smaller provider types that lack potential to affect overall expenditures in the Medicaid program, including:

- dental (child only, subject to federal Early and Periodic Screening, Diagnosis and Treatment – EPSDT – requirements that require Medicaid to cover any medically necessary treatment for children);
- optical services and supplies (child only, subject to EPSDT);
- podiatry;
- chiropractors; and
- hearing aids (child only, subject to EPSDT).

To take an example of problems with achieving savings for these smaller services, consider Optical Supplies and Services. In 2011, adult optical services were eliminated; therefore optical services and supplies are allowed for children only, so all medically necessary services will be covered by federal law. There are only three opportunities for savings within the service: routine eye exams; dispensing fees, and optical supplies (eye glasses). Reducing the amount paid for routine eye exams and A 3% reduction of total paid for routine eye exams and dispensing fees in SFY 2013 amounts to only $148,360. Meanwhile, eyeglass fabrication is legislated to occur at Nash Optical plant owned and operated by the State. The federal share (65.78%) pulled down for eyeglass fabrication pays for State activities through the Department of Public Safety (DPS). Ophthalmologists, optometrists, and opticians maintain there are no further interventions that would increase savings and therefore many providers are planning to withdraw as Medicaid providers. Similar examples can be provided for podiatry, chiropractic, and hearing aid services.

STATUS AND NEXT STEPS

It is DMA's intent to outline the challenges with implementation prior to the upcoming legislative session so that the NC General Assembly may reconsider the legislation or further clarify the legislation. There are significant concerns raised by CMS and providers

about the impact it may have on access and care, the timing of implementation, problems measuring savings and making incentives payments, and the overall restructuring of Medicaid outside of a more comprehensive Medicaid reform.

However, DMA is working diligently to implement the legislation as enacted. DMA has conducted stakeholder meetings with all impacted provider groups, the Medical Care Advisory Committee, the Medicaid Reform Advisory Panel, and held a series of webinars open to the public at-large.

On December 31, 2013, DMA published public notice of the 3 percent rate reduction and implemented the rate reduction as of January 1, 2014 as legislated.

DMA is on target to meet all of the implementation deadlines legislated by the NC General Assembly.

During the next few months, DMA will work to finalize the interventions and benchmarks for each of the 11 provider types in order to implement the program by July 1, 2014 as legislated.

In order to comply with federal guidelines, DMA will submit the Shared Savings Plan SPAs by September 30, 2014, and to comply with legislation, will begin making payments to eligible providers starting on January 1, 2015.

APPENDICES

I. Timeline

II. Stakeholder Meetings

III. Stakeholder Input to Date

IV. CMS State Medicaid Director Letter SMDL# 13-005

I. TIMELINE

In response to the legislation, the Division of Medical Assistance (DMA) developed the timeline below to implement the shared savings plan.

- 11/1/13: Began meeting with Stakeholders
- 12/31/13: Publish Public Notice for 3% rate reduction
- **1/1/14: Implement rates reduced by 3% in CSC**
- 3/1/14: Report on Shared Savings Methodology to Joint Legislative Oversight Committee
- 3/31/14: Submit State Plan Amendment (SPA) for rate reduction to CMS
- 6/30/14: Publish Public Notice for Shared Savings
- **7/1/14: Shared Savings Plan Implemented**
- 9/30/14: Submit State Plan Amendment for Shared Savings to CMS
- **1/1/15: Begin payments to eligible providers for Shared Savings Plan**

In addition, a web page and email address specific to Shared Savings was established in November of 2013 as a way to share information and receive feedback:

- Information regarding Shared Savings is posted at: http://www.ncdhhs.gov/dma/plan/index.htm
- Providers and stakeholders can send questions/comments/recommendations to: DMA.NCSharedSavings@lists.ncmail.net

II. STAKEHOLDER MEETINGS

DMA has conducted stakeholder meetings with all impacted provider groups, the Medical Care Advisory Committee, the Medicaid Reform Advisory Panel, and held a series of webinars open to the public at-large. All meeting notices and materials have been posted on the DMA website.

To meet the intent of the legislation to work the stakeholders to develop the shared savings plan, DMA held the following provider education and outreach sessions:

- 11/8/13 Medical Care Advisory Committee
- 11/15/13 Federally Qualified Health Centers Think Tank
- 11/21/13 Personal Care Services Stakeholders
- 12/5/13 Medicaid Reform Advisory Group
- 12/16/13 Pharmacy
- 1/3/14 Personal Care Services Stakeholders
- 1/10/14 NC Health Facilities Association
- 1/13/14 Pharmacy
- 1/14/14 Dental Society
- 1/14/14 Hospital Association
- 1/16/14 Pharmacy

- 1/21/14 Webinar open to all stakeholders
- 1/27/14 Webinar focused on Inpatient Hospital, Physicians, and Dental
- 1/30/14 Webinar focused on Optical services and supplies, Hearing aids, PCS, Adult care homes, and Nursing homes
- 2/3/14 Webinar focused on Chiropractors, Podiatry, Dispensing drug

III. STAKEHOLDER INPUT TO DATE

DMA has conducted extensive stakeholder outreach and received extensive stakeholder feedback. Further details for each of the potential metrics and interventions are available upon request.

INPATIENT HOSPITAL

Potential Metrics/Interventions

1. Evaluate all possible alternatives to payment of diagnosis-related group (DRG) billing code outliers for extensive long term hospitalizations for extremely immature premature infants.
2. Discharge planning with follow up care to provide Acute Dialysis services for patients with acute renal failure at the Outpatient Hospital place of service.
3. Ongoing Case Management from admission through discharge with intensive discharge planning with follow up post discharge with appropriate outpatient resources.
4. Judicious monitoring of routine, standing and frequent monitoring of diagnostic studies.
5. Nutrition intervention to improve quality of patient care while reducing overall costs.
6. An interim plan for the initial year that builds on ongoing efforts (such as hospital value based purchasing, hospital acquired conditions, readmissions, etc.) currently used by other payers and utilizing aggregate Medicaid spending metrics in lieu of specific individual provider metrics.

PHYSICIAN

Potential Metrics/Interventions

1. Promote the "Be Smart" family planning program and assist with increasing the number of citizens of the eligible population to enroll in the "Be Smart" program.
2. Review billing instructions to staff to ensure correct billing to Medicaid for a visit for only vaccine administration.
3. Increase in clinical appointments to receive most of care from higher value location. Would increase preventative care measures that theoretically lower higher cost care, like Inpatient and ED admissions.
4. Home care agencies would like to explore partnering with Physicians to assist their management of chronic disease and follow up from hospital discharge - each provider type could share credit for savings.

5. Home Care agencies could dialogue with the Primary Care Physician networks - perhaps Community Care of North Carolina (CCNC) - electronically and facilitate information transfer and charting of desired metrics - medication compliance, glucose readings in cases of diabetes.
6. When patients discharge, the home care agencies could facilitate patient follow up with getting back in to see PCP post-acute facility discharge. Home care agencies do medication reconciliation now - but they could help make sure that reconciliation coordinates both with hospital and with PCP

DENTAL

Potential Metrics/Interventions

1. Increase utilization of dental sealants on permanent molars to achieve a reduction in the incidence of decay and cost avoidance.
2. Require provider attestation to being equipped to treat special needs patients.
3. Restoration of teeth rather than extraction of teeth.
4. Orthodontic providers submit Prior Approval for patients whose malocclusion comes close to meeting policy criteria for approval of comprehensive orthodontic treatment.
5. Percentage of enrollees that receive any dental service.
6. Percentage of enrollees that receive any dental treatment services.
7. Increase Percentage of enrollees that receive comprehensive or periodic exams in consecutive six month periods.
8. Increase Percentage of enrollees that receive comprehensive or periodic exams under the age of 6.
9. Additional percentage paid if provider offers digital x-rays.
10. Percentage of enrollees that receive sedation for treatment, either in office or ER.
11. Create a "pre-qualification" program for providers, to eliminate the pre-authorization process.

OPTICAL SERVICES AND SUPPLIES

Potential Metrics/Interventions

1. The provider decreases the invoice of cost for prior approved contact lenses in relationship to the last contact lenses approved for the same beneficiary.
2. The provider fabricates eyeglasses (frame and lenses) for less than the State's optical laboratory contractor average cost of $20.68.

HEARING AIDS

Potential Metrics/Interventions

1. The provider reduces cost of hearing aid or accessory in comparison to the most recent paid history for the same item.

PERSONAL CARE SERVICES (PCS) AND ADULT CARE HOMES (ACH)

Potential Metrics/Interventions

1. Measure items such as satisfaction and participation, in-service and training participation and delivery to beneficiary of educational components, as opposed to measuring medical spending or particular outcomes.
2. Alignment of the program with the CMS position that "By orienting the system around the needs and preferences of beneficiaries, successful Integrated Care Models can demonstrate improved health care outcomes and result in improved beneficiary experience, while reducing overall health care expenditures."
3. A program with a client centered approach, focusing on ADL's, best meets the purposes of Shared Savings. Ideas that have been discussed, such as falls training and nutrition information.
4. Fall prevention through the use of the NC NOVA training standard. Existing online training and in person training has been developed and successfully utilized in both the falls and nutrition areas.
5. A pilot project to assign a Pharmacist and a Nurse Care Manager to at least three (3) and up to five (5) adult care homes in Gaston and Lincoln counties to work in partnership with the ACH Administrator and a resident's health providers to perform medication reviews, medication reconciliations, and care coordination. In addition, the Transitional Nurse Care Managers in the two (2) hospitals will target all adult care home residents (who are CCNC enrolled) for transitional care processes to facilitate the resident's return to their facility.
6. Enhanced nutrition intervention.
7. Have PCS providers educate and encourage beneficiaries to get flu shots.
8. Change the PCS hours to the average per week instead of monthly hours where there may be left over hours to assign.

NURSING HOMES

Potential Metrics/Interventions

1. Expansion of Interventions to Reduce Acute Care Transfers (INTERACT), an evidenced based quality improvement program that focuses on the management of acute change in resident conditions in nursing homes.

CHIROPRACTORS

Potential Metrics/Interventions

1. Direct access to chiropractic care for musculoskeletal conditions.
2. Non-Emergency back and neck surgery is pre-screened by a doctor of chiropractic care.
3. A pilot program to assess the effectiveness of chiropractic care in reducing chronic pain patients' usage of pain killers.
4. Allow direct access to chiropractic for pregnant women with low back pain.

5. Limit chiropractic care services for Medicaid beneficiaries 13 years of age and older.
6. Using a standardized tool to document based on identified deficiencies on the date of service a care plan and functional outcome assessment for Medicaid beneficiaries 12 years of age and younger at each visit for chiropractic care services.

PODIATRY

Potential Metrics/Interventions

1. Include preventative foot care as a component of all patient assessments (physical exams).
2. Encourage care coordination and practice transformation activities that improve quality and health outcomes.

DISPENSING DRUGS

Potential Metrics/Interventions

1. Creation and maintenance of a Community Pharmacy Enhanced Services Network (CPESN) that providers ancillary services to Medicaid beneficiaries under the "Withhold" provision.