



Disease Management Association of America

Medicare Health Support Performance Terms for Phase II

DMAA Position

In order for the MHS program to expand beyond the pilot phase and still achieve the program goals of quality improvement, beneficiary satisfaction, and financial savings, CMS should use its available authority to adjust financial performance targets and risk assumption levels for Phase II to meet the evolving program environment.

Background

The development of Phase I required CMS to develop policy without the benefit of precedent and with possible financial risk to CMS through the implementation of a new care model.

Phase I performance terms, i.e., five percent net savings targets, 100% fee risk, and individually negotiated quality standards, were established to match the unique and underlying opportunities associated with beneficiaries diagnosed specifically with congestive heart failure and/or high risk diabetes.

Both the statute and the solicitation recognized the link between savings opportunities and the specific disease populations served. Specifically, the statute requires that, "the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served."¹ The solicitation defended the creation of customized performance standards to demonstrate compliance with this statutory provision, stating, "Evidence from research and private sector experience suggests that chronic care improvement programs may produce measurable improvements in quality and health status and yield net reductions in health care spending for these subgroups [CHF, diabetes, and COPD] by lowering their hospital admission rates and emergency service use..."²

Phase I performance, risk assumption and the financial security standards also served as gating mechanisms to provide CMS greater assurance that applicants would have both the capabilities and financial resources to achieve the desired results.

Finally, Phase I awards were unique in that financial performance was measured by a net reduction of expenditures compared to a randomized control group.

¹ Section (f)(1)(B)(i) of Public Law 108-173, the Medicare Prescription Drug, Improvement and Modernization Act (MMA).

² Federal Register, Vol. 69, No. 79, Friday, April 23, 2004, page 22068.

DMAA Position Rationale

Other DMAA policy documents advocate that the Secretary should expand the MHS program nationally to a broader number of beneficiaries living with other chronic illnesses. DMAA believes that the performance standards should also adapt to this broader population in Phase II.

This paper discusses proposed adjustments relating to two performance concepts:

- 1) Quality and financial performance targets
- 2) Risk Assumption relating to performance guarantees

1) Financial and Quality Performance Targets

As part of the program expansion, Phase II would require elimination of the randomized control group design. The results of Phase I pilots and the subsequent expansion to a broader beneficiary population will eliminate the need for control groups.

Regarding financial performance targets, DMAA advocates budget neutrality as the Phase II financial performance goal in lieu of the five percent (5%) net reduction guarantee. Three fundamental differences between conditions in Phase I and Phase II require this programmatic change.

First, the underlying legislative statute did not specify a percent savings target beyond budget neutrality.³ Rather, as stated above, it provided the Secretary with the flexibility to determine the appropriate savings targets. In effect, this language acknowledges that the program would evolve over time. A budget neutrality standard is appropriate.

Second, Phase II will operate in a more developed chronic care management market. The state of the industry as a whole has become more certain, organizations have published peer-reviewed papers touting outcomes, and the Phase I pilots will have demonstrated experience that can serve as a proxy for all others. Organizations in the industry are more financially stable, many have scalable infrastructure, and have more years of care management experience, thus reducing the need for CMS to use such high risk as a gating mechanism.

Third, in the absence of Phase II control groups, financial performance measurement will be less precise. The statute itself recognizes and acknowledges that the fee risk calculation would be measured against estimated savings, versus actual savings.⁴

DMAA is prepared to work collaboratively with CMS to construct alternative, actuarially sound performance measurement methodologies that do not require a control group.

³ Section (f)(4) states, "Budget neutral payment condition. –Under this section, the Secretary shall ensure that the aggregate sum of Medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the Medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs."

⁴ Section (f)(3)(B)(ii) states, "...the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this title attributable to implementation of such agreement."

DMAA has embarked on a multi-stakeholder, consensus-based effort to identify best financial outcomes methodologies that includes URAC, The Joint Commission, NCQA and other major payors, among others. DMAA hopes that the result of this effort will assist CMS and other chronic care management purchasers to contract with increased confidence. Nonetheless, DMAA encourages CMS to develop a Phase II methodology in an open, transparent manner that looks to the current state of measurement in the industry today.

In addition, DMAA strongly supports continued emphasis on quality improvement measurements as a key performance metric. In fact, MedPAC's June 2006 report on chronic care improvement in Medicare, recognized that some conditions may not yield savings in limited time horizons, and as such, quality improvement and satisfaction may be more appropriate measures of a program's value. The report questioned whether financial performance standards, such as savings guarantees and risk assumption provisions, were in the best long term interest of the Medicare program. DMAA supports MedPAC's overall recommendations on performance measurement and risk assumption. The MedPAC report suggests that CMS should still hold organizations at financial risk during the initial contract term phases, and then consider shifting away from the intensity of those standards once a program is mature and seeks to improve clinical and financial outcomes for conditions with a longer cost-savings horizon.

2) Phase II Risk Assumption

DMAA agrees with the principle that organizations should be held accountable for performance with respect to services provided under cooperative agreements. Nevertheless, DMAA believes that it is not in the best interests of the Medicare program to maintain the same levels of risk assumption in Phase II.

The current risk assumption standards have negative consequences on both CMS and MHSOs. These consequences will be magnified in a Phase II national program expansion and could affect the industry's ability to roll-out and implement an expanded Phase II program. For example:

- CMS would likely pay lower fees if the risk assumption provisions were not so dramatic. Additional costs, resulting in higher Phase I fees, are associated with underwriting risk, whether an organization is self-insured and/or seeks to obtain reinsurance. The potential scale of Phase II means that CMS could pay millions of dollars less for care coordination services, resulting in greater savings to the Medicare Trust Fund.
- Phase II risk assumption standards could be more closely aligned with pay-for-performance principles. MHS is a pay-for-performance initiative, and as such, upside risk sharing should be encouraged to balance the downside risk to ensure consistency with CMS' long term policy goals, as discussed further below.
- Current risk assumption standards create adverse financial consequences for MHSOs due to revenue recognition and external reporting issues, as well as access to capital. The current risk structure, expanded on a larger scale, would present a true earnings and shareholder hardship for companies and could discourage many from participating. It is in CMS' interest to encourage healthy,

stable companies, so beneficiaries do not experience disruption or gaps in services.

While the underlying statute requires CMS to fully recover fees in excess of estimated savings (Section (f)(3)(b)(ii))⁵, DMAA believes there are a series of policy changes CMS can make to mitigate the negative effects of such heavy risk assumption standards. These policy changes can be made within the parameters of the statute and without compromise to CMS's policy goal of creating strong incentives for organizations to perform and bid responsibly.

First, CMS could lower the overall level of risk assumption by adjusting the financial performance threshold to budget neutrality. Other contract terms can be inserted in the event of an organization's failure to meet savings targets based on the unique characteristics of a given population.

Second, CMS can provide a more precise definition of the term "fees." DMAA proposes that the term "fee" include only those monies used for the execution and management of the program. This definition would exclude any premium added to fees for the assumption of risk. Within this concept CMS would exclude the portion of a fee related to the "risk premium" and administrative costs that are not used for the direct provision of services to beneficiaries (e.g., surveys, evaluations).

DMAA believes CMS has the authority to define the "at risk" portions of fees because the program's budget neutrality requirement is based on aggregate program costs, not individual cooperative agreements.⁶ The statute defines budget neutrality as two distinct categories of cost: 1) program "benefit" expenditures; and 2) fees paid to MHSOs.⁷ Since neither operational costs nor the risk premium are used for benefit expenditures or for direct provision of services to beneficiaries, a case can be made for excluding them from the budget neutrality calculation.

Precedent for reducing fee risk can be found in many state Medicaid contracts. For example, the states of Missouri, Illinois and Florida have chronic care programs for their fee-for-service Medicaid programs with guaranteed net savings with less than all of the fees subject to payback. For example, the state of Illinois has guaranteed net savings

⁵ "(ii) Financial risk for performance.--In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this title attributable to implementation of such agreement"

⁶ Section (f)(4) states, "Budget neutral payment condition. --Under this section, the Secretary shall ensure that the **aggregate sum of Medicare program benefit expenditures** for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the Medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs."

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above zero percent with 50% of total fees subject to payback for non-performance. CMS can look to these contracts as examples where states maintained financial protection and partnered successfully with organizations without excess risk burden.

CMS could also use its additional flexibility in Phase II to pay organizations beyond a per member per month basis in order to construct a number of different financial arrangements whose net effect would be to lower the risk assumption thresholds. For example, CMS may want to consider an approach that allows for the sharing of program savings or upside bonus payments to organizations achieving targets well beyond the expected range. Such arrangements can offset the inherent costs of bearing risk. Precedent for this approach can be found in the Care Management for High Cost Beneficiaries and Physician Group Practice demonstrations and is in alignment with pay for performance tactics. This arrangement is also consistent with the state of Florida's chronic care program: *Florida: A Healthy State*.

DMAA believes that the above steps to mitigate the impact of the statute's risk assumption provisions. Even then, however, the amount of risk borne by MHSOs would still be very substantial relative to standard industry practices.

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