NY State Innovation Testing Grant Financial Analysis Narrative, 7/16/2014

OVERVIEW

If the Plan is implemented, the State would create $3.1 billion (B) in value from 2015 to 2018: $1.6 B re-invested in the delivery system as care coordination fees and outcomes-based payments, $1.5 B accruing to consumers, health insurance purchasers, and program sponsors as surplus supporting improved affordability of coverage, access to care, and the business competitiveness of New York State.

POPULATIONS ADDRESSED

Our model targets all New Yorkers, stratified here for modeling purposes by payer groups:[*]

- **All fully insured and self-funded plan members** (not including state employees). 9.5 million (M) members enrolled in commercial plans at an average $442 PMPM.
- **New York State Health Insurance Program** (NY-SHIP) for State and Local Government for active employees. 1.2 M NY-SHIP members enrolled at an average $512 PMPM.
- **Medicare-covered lives**. 3.3 M Medicare enrollees (including those who are dual eligible with Medicaid) at an average PMPM cost of $980.
- **Medicaid-covered lives**. 5.4 M Medicaid enrollees (1.8 M targeted, after accounting for the exclusions detailed below) at an average PMPM cost of $697.
- **Medicaid expansion lives**. 663,000 enrolled thus far at an assumed $697 PMPM on average.
- **Child Health Plus (CHP)**. 295,000 children currently enrolled at $167 PMPM on average.

Within Medicaid, we have excluded groups not directly addressed by the initiatives included in the Plan or accounted for in savings projections from inflight initiatives. In addition, the dual eligible population is counted in Medicare savings and investments, for reasons detailed below.

- **Dual Eligible for Medicare and Medicaid** (~700,000 lives). These lives are included in the Medicare segment and excluded from Medicaid because Medicaid dual eligible expenses tend to be for services other than medical care and not included in APC impact analysis.
- **Other Special Needs Populations** (~970,000 lives). These lives, including those with severe and persistent mental illness (SPMI) and developmental disabilities (DD), are attributed to inflight Medicaid Redesign Team initiatives and accounted for in the Global Cap.
- **Delivery System Reform Incentive Payment** (DSRIP) program beneficiaries (~2.1 M lives excluding DD, SPMI and Duals). Although DSRIP and SHIP will have a synergistic effect on Medicaid patient care, we conservatively avoid "double counting" savings generated by DSRIP by excluding Medicaid patients attributable to safety net providers. Other Medicaid patients who receive the predominance of their care from non-safety net providers – even if part of a Performing Provider System – are included, on the basis that multi-payer support for APC is instrumental to a strong business case for these providers to build APC capabilities.
- **Uninsured** (~1.0 M lives, accounting for latest NYSoH enrollment). Conservatively, we do not explicitly include costs associated with the uninsured, anticipating they may be more

[*] Enrollment figures, PMPY estimates, and projections thereof are based on data from HealthLeaders Interstudy, Truven Commercial Snapshot, CMS NHE data, NY-SHIP, SNL NAIC, NY DOH, and Kaiser Family Foundation.

difficult to reach with the Plan's cost-savings initiatives. In addition, the cost of care for the uninsured is functionally subsumed and distributed among the aggregate insured population.

Baseline health care spending for in-scope populations is projected to grow from $112 B in 2015 to $121 B by 2018 before accounting for the impact of the Plan, based on ~1% projected annual growth in enrollment, and ~4.3% projected annual growth in spending per capita.†

SAVINGS MODEL AND ASSUMPTIONS

Pace of Adoption: By 2018, we project that Standard or Premium APC providers will care for 63% of the population. By 2020, we aspire for 90% payer adoption, 90% primary care provider (PCP) participation, and over 80% of payments to be value-based. By 2016, 40% of PCPs, including independent, employed, and system-affiliated PCPs, will participate, increasing to 75% by 2020, with an additional 15% in pay-for-performance (P4P, pre-APC) models.

Gross Savings: APC providers in total cost of care (TCC) gain sharing models are projected to reduce spend 7-10% over 5 years, consistent with successfully implemented, similar models in the State and elsewhere. For providers in P4P models, we assume 2-4% impact. For both, we assume a ramp-up, starting with 0.0-0.5% impact in Year 1 for TCC and P4P models.

Shared Savings: Based on value-based payment models in the State and other markets, we assume 30-60% of savings generated (net of care coordination fees) will be reinvested in the delivery system as bonus payments and/or shared savings payments. If and how to offer these, in what proportion and rate, will be determined independently by payers; we presume they will be paid directly by payers and represent an offset to savings. Here, we assume they represent 0.5-1% of total cost of care, consistent with levels elsewhere. The balance of upfront investments and retrospective gain-sharing will likely differ across payers and providers. We assume baseline costs are recalculated on average every 2 years, consistent with models elsewhere.

Program Investments: Investments contemplated in the Plan are estimated at $508 M through 2018, to be funded through grant funding, investments by payers and providers, and spending from state general revenues. Of this, the State will invest $214 M for provider transformation support, clinical workforce development and other costs; over 90% is already committed. The Budget narrative details the planned sources/uses of funds required to achieve the SHIP goals.

SAVINGS AND RETURN ON INVESTMENT

Total Savings: The Plan generates $3.1 B in gross value creation – half reinvested in providers and other upfront investments, and $1.5 B as net surplus. The gross value is the difference between baseline projected spending and estimated spending as a result of SHIP savings. The Plan will potentially reduce the annual increase in spending by 0.9 percentage points. In subsequent years, we project further reductions, bringing health care cost growth closer in line with New York's economic growth. Total investments are $508 M, of which 50% is incremental (not committed). Net savings turn positive in 2017 ($186 M) and are a cumulative $1.0 B for 2015-2018. Annual net savings then increase to $3.7 B in 2020 and $7.2 B in 2022.

Medicare: Gross savings to Medicare are projected at $1.2 B through 2018: $0.5 B as supplementary provider payments, $0.7 B net surplus before investments. Medicare investments total $12 M, primarily as practice transformation support. The cumulative ROI remains $0.7 B through 2018. Over time, annual net savings increase to $1.5 B in 2020 and $2.8 B in 2022.

† All financial projections are represented as net present value on 2015 dollars at a 2.76% discount rate.

Medicaid and CHP: Gross savings to Medicaid and CHP are projected at $0.5 B through 2018: $235 M as supplementary provider payments, $280 M as net surplus before investments. Medicaid/CHP-specific investments are $35 M, which supports workforce programs and APC practice transformation efforts proportionate to Medicaid/CHP member population size. The cumulative ROI would be $246 M through 2018. Annual net savings then increase to $0.7 B in 2020 and $1.3 B in 2022.

Federal ROI: Federal return includes 100% of savings to Medicare, 100% from Medicaid expansion and the proportion of federally-funded CHP (65% historically). Gross savings is $1.3 B through 2018: $0.6 B supplementary provider payments, $0.7 B net surplus before investments. Even assuming that without SIM, 30% of payers and 50% of providers participate with 30% cost savings potential, the surplus accrued (less than $50 M) is a fraction of SHIP potential. Federal investments are $181 M through 2018, including the SIM grant and Medicare investments. Compared to the base case, the grant catalyzes $556 M cumulative federal net savings. Annual net savings then increase to $1.6 B in 2020 and $3.0 B in 2022.

State ROI: State return includes 100% of savings to NY-SHIP, 100% to Medicaid, and the proportion of state-funded CHP (35% historically). Gross savings is $727 M through 2018: $360 M supplementary provider payments, $365 M net surplus before investments. State investment is $214 M, including Medicaid/CHP investments detailed above, $6 M in NY-SHIP investments, and $172 M in other State investments – of these, over 95% is already committed, including for SHIN-NY, APD, and PHIPs. Net savings accumulate to $150 M by 2018, then increase to $0.5 B in 2019, $0.9 B in 2020, and $1.6 B in 2022.

BASIS FOR SAVINGS

Overview: Our analysis is based on published literature that describes preconditions for impact and a cost savings range of 7-10%. The literature is varied but we studied success cases to understand the likely cost savings impact in the best-implemented scenarios. We conclude that less successful programs had design or implementation shortcomings resulted in less impact.

Wasteful Spending Addressed: According to the IOM, $765 B or 30% of total U.S. healthcare expenditure is wasteful and unnecessary (*IOM*, 2010). Of that, our model directly targets the 15.8% of spending on unnecessary and inefficiently delivered services, and missed prevention opportunities; and partially addresses the 11.8% due to excessively high administrative costs and prices. The remaining 3% attributed to fraud is the only driver that is not addressed by APC.

Lessons from Evidence: The literature indicates that successful population-based models can reduce medical costs by 7-10%. Cost savings range from 0.5-12% across 1-6 year time frames. Some programs achieved savings after short time periods (Oklahoma Medicaid, 8% at 3 years; CareOregon, 9% at 3 years); others sustained them over longer periods (Geisinger ProvenHealth Navigator and Health Partners, 7% and 8%, respectively, at 6 years), and some achieved higher savings in short periods (Community Care of NC, 15% at 4 years). Population sizes ranged from 45,000 to 4.1 M members. (*PCPCC*, 2010-2012; *Health Affairs*, 2011; *Milliman*, 2011).

Drivers of Savings: The most common drivers were reduced hospital activity, as measured by ED visits, inpatient admissions, and readmissions. Nearly all programs reduced hospital activity; some like HealthPartners reported 40% reductions in ED visits and readmissions rates (*PCPCC*, 2010 & 2012). Improvements in population health and prevention often tracked as well: HealthPartners increased the percent of covered diabetic patients receiving optimal care by 129% and the percent of patients receiving optimal heart disease care by 48% (*PCPCC*, 2012).

New York State Innovation Model
Actuarial Certification of Financial Analysis
July 16, 2014

I, Bradley J. Davis, Senior Consulting Actuary, am associated with the firm of Wakely Consulting Group. I am a member of the American Academy of Actuaries and have been retained by the State of New York to render an actuarial certification of the state's State Innovation Model (SIM) Financial Analysis. I meet the Academy qualification standards for rendering this certification.

I have examined the financial projection model and calculations used in determining New York's projected savings generated through their SIM. In my opinion, the financial projection model satisfies the following requirements:

(a) The projection methodology is actuarially sound, and

(b) The assumptions and results are reasonable for their intended purpose.

In accordance with ASOP 23, I relied upon data prepared by Hope Plavin, Director of Planning, Office of Quality and Patient Safety at New York State Department of Health. I have reviewed the data for reasonableness, but I did not conduct a formal audit of the data. This data provided by Ms. Plavin, included, but was not limited to the following:

- Baseline population and growth rate statistics
- Baseline medical costs and projection trends
- Payer and provider SIM participation rates
- Annual SIM impact on medical costs (savings) assumptions
- Shared savings payment amounts
- Care coordination fees
- Program investment and expense values and allocation between Federal and State Gov't

Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this certification.

Sincerely,

Bradley J. Davis
Fellow, Society of Actuaries
Member, American Academy of Actuaries

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