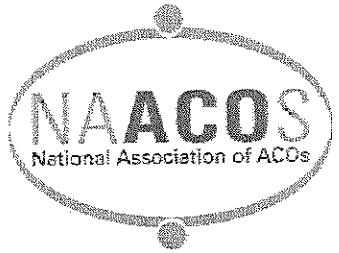
Policy Issues in the Medicare Shared Savings Program

CONFIDENTIAL

August 27, 2014

ACO Policy Issues



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Assignment

- Problems:
  - Use of assignment methodology results in significant beneficiary "turnover" in and out of an ACO's assigned population
  - Estimates of 20-30% per year (some reported higher)
  - Prospective modestly improves the stability of the population
  - Beneficiaries often come and go from the data stream due to tentative assignment to different ACOs throughout the year
  - No-utilizers always churned out
- Solutions:
  - Add optional new track of prospective alignment like Pioneer ACOs
  - Allow beneficiary "attestation" to ACO. Remain in ACO until they elect to opt out, or attributed out to another ACO
  - Keep zero utilizers in attribution
  - Allow ACOs to waive Part B copay for primary care visits
  - Allow beneficiaries to stay in the data feeds for the whole year once they have tentatively assigned (so may be in more than 1 feed)
  - Remove data opt-outs from the performance year reconciliations

Financial Benchmarks

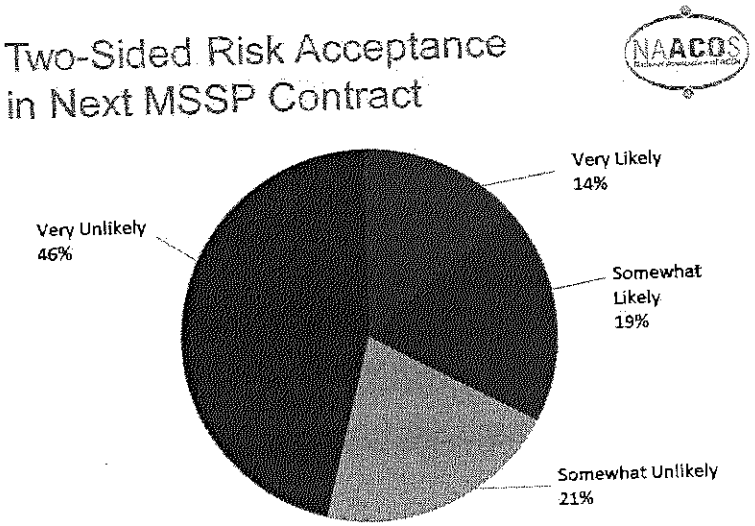
- Problems:
  - Setting trend based on all beneficiaries nationally
  - Instability of the benchmarks from attribution churn
  - Harder to find savings in low-cost areas
  - Trending is national but really varies by region
- Solutions:
  - Address the assignment issues
  - Adopt regional trending model based on changes in regional utilization and input costs such as wage index
  - Blend MA-like regional spending with historical baseline
  - Minimize policy change adjustments
  - Remove renormalization after first contract term and permit 50% of savings to carry forward

Minimum Savings Rate

- Problems:
  - MSR resulted in 25% of ACOs with savings not receiving any payment
  - Considered unfair that CMS keeps all those savings
  - Minimum Savings Rate very high for some ACOs, especially small ACOs in low-cost areas
- Solutions:
  - Eliminate MSR for 1-sided ACOs
  - Eliminate MSR for high quality or improving quality ACOs
  - Allow the three years of attribution to determine the MSR for a given ACO

Pathway to Higher Risk

- Background:
  - Less than 5% of ACOs elected 2-sided risk track, thus 95% will be required to shift to 2-sided risk in second ACO contract (year 4).
  - 2-sided risk requires insurance license and reserves in some states
  - ACOs are investing $1-3 million per year in infrastructure.
  - Due to delays in claims run-out and reconciliation, ACOs may have to decide about their second contract with only PY1 results
  - Surveys show less than a third will stay in program



Pathway to Higher Risk

- Problems:
  - How to avoid significant contraction of the ACO program
  - How to give ACOs more time to recoup their investments
  - Capital intensive state licensure requirements
  - Risk of violating bond conveniences
- Solutions:
  - Delay or remove requirement to shift to 2-sided track
  - Improve the savings model so more recoup their investments
    - Sharing rate
    - Alter quality benchmarking system
    - Reduce or remove MSR

Risk Adjustment

- MSSP uses the Hierarchical Condition Categories (HCC) to risk adjust the MSSP payments
- The scores are calculated separately for 4 groups:
  - Aged, non-disabled
  - Disabled
  - Dual eligible
  - ESRD
- Newly enrolled beneficiaries can cause the ACO's risk score to increase
- Only demographic shifts can increase the risk score of the continuously enrolled population
- Both demographics and acuity shifts can decrease the risk of the continuously enrolled population

Risk Adjustment

- Problem:
  - Unfair, one-way application of HCC risk adjustment allows all factors to decrease risk, but only demographic factors to increase
- Solutions:
  - Allow risk scores to increase for continuously assigned beneficiaries based on demographic and HCC scores

Quality Measures and Benchmarks

- Problems
  - Assumes a level of precision with measurement that supports ranking of providers when measures are imprecise
  - Quality is punitive not a positive incentive
  - There is no direct credit for improving quality
  - Unrealistic benchmarks biased toward large, experienced medical groups in PQRS
  - ACOs are included in the database for calculating the benchmarks so by definition some portion will not achieve full savings
  - Changing quality measures is costly and adds to uncertainty
  - Quality scores reduce savings rather than triggering bonuses
  - Submission process extremely burdensome
  - Major confusion around the measure definitions

Quality Measures and Benchmarks

Solutions

(1) place a moratorium on adding new measures to the quality measure set

(2) retire some measures

(3) CMS participate with NAACOS, consumer groups and other ACO stakeholders to identify a new measures set using outcome metrics that beneficiaries would understand

(4) strengthen the incentives and rewards to improve quality by:

- Allow 4 bonus points per domain for improvement of scores
- Allow ACOs to retain 50% of their share of savings regardless of the MSR if their overall quality score improves year-over-year,
- Award a 10% savings bonus to the top 10% quality ACOs
- Stabilize the quality benchmarks by updating the measure set and benchmarks no more frequently than every three years such that they would align with the three year contracting period.

Data

PROBLEMS

- No single report tells an ACO if they are above or below target
- Quarterly financial and utilization reports ($/pmpm, hosp days, etc) do not breakdown by patient and are for rolling year with no quarter breakdowns yet attribution and claims are quarterly
- Quarterly Claims (CCLF) are on a different time cycle and incomplete and have no population (denominator)
- Big gaps in claims data (eg substance abuse, opt-outs), sometimes 20% of costs
- No report helps with real-time care yet CMS has the eligibility "ping" data that would tell ACOs real-time when major event is occurring.
- NAACOS Data White Paper identified 35 data improvements and 22 were ignored, others partially addressed

Data

SOLUTIONS

- Greater ability to disaggregate the utilization/cost statistics
  - (eg, allow readmission rate drill down to the patient ID or NPI)
- Break rolling 12 month utilization/cost reports into discrete quarters
- Provide additional data fields in attribution report:
  - Address, institutional status, NPI, HHC markers, plus 10 others.
- Fill in $ gaps for missing claims by providing de-identified claims or at least total dollar value so total claims $ = expenditures in other reports and reconciliation
- Provide denominator with claims data so rates can be calculated
- Provide provider-specific de-identified claims at the start of program so ACOs can start working with providers
- Make available CMS beneficiary eligibility "ping" data to ACOs
- Reconciliation- Improve transparency and auditability by including samples of individual beneficiary cost data that are used in determining performance benchmark and results

Other

- Give ACOs flexibility in utilizing post-acute providers by allowing the waiver of the 3-day hospital requirement for SNF care
- Allow ACOs to utilize unlimited Home Care services by waiving the homebound and duration limits
- Give ACOs maximum ability to substitute tele-health care for in person care by waiving the limits on tele-health in both rural and urban ACOs.
- Do not penalize small ACOs whose attributed lives fall below 5000 because of another CMS initiative like the State Duals demo. Allow them 12 months to increase attribution before termination from program.
- Allow twice a year addition of new participating providers instead of just annually.
- Fund additional Advanced Payment ACOs