Health Industry Forum

Key Policy Issues in the Evolution of Medicare ACO Programs

June 3, 2014

7 ACO Policy Issues

1. Assignment
2. Financial Benchmarks
3. Minimum Savings Rate
4. Pathway to Higher Risk
5. Risk Adjustment
6. Quality Measures
7. Data

MSSP Issue #1: Assignment

- ACO defined as a collection of Medicare-enrolled tax ID numbers (TINs) practicing as a group practice arrangement or network.
- **Two step assignment process**, first step based on **plurality** of primary care services (allowed charges) provided by primary care physicians, second step based on primary care services provided by other ACO professionals, including specialists, NPs, PAs, and CNSs.
- **Preliminary prospective determination with final assignment determined at year-end.**
- **Primary care physicians** defined as family practice, general practice, geriatrics and internal medicine.
  - **Primary care codes** include: 99201- 99215, 99304-99340, 99341-99350, G0438, G0439 and G0402, as well as FQHC/RHC revenue codes 0521, 0522, 0524, and 0525
- ACO participant TINs upon which beneficiary assignment is dependent (not just primary care physicians) must be **exclusive to one ACO**. Other ACO participants (e.g., hospitals) could participate in multiple ACOs. Or physicians billing under separate TINs.

MSSP Issue #1: 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 attribution only 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:
  - Use of a beneficiary enrollment model
  - Use of a hybrid beneficiary "attestation" and assignment model
  - Once attributed, cannot drop out unless assigned to another ACO
  - 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)
  - Allow ACOs to waive Part B primary care copays

MSSP Issue #2: Financial Benchmarks

- Start with most recent 3 years of per-capita Medicare Parts A and B FFS expenditures for attributed beneficiaries during that period.
  - 3-month claims "run-out" period to calculate the benchmark.
- Spending truncated at 99th percentile of per capita spending.
- Beneficiary risk and growth trend adjusted across 3 base years, with full risk adjustment for newly assigned beneficiaries.
- Excludes incentive payments for Physician Quality Reporting System, eRx, and EHR "meaningful use" program, even those for hospitals.
- Excludes teaching and disproportionate share payments.
- Updates the benchmark by absolute dollar growth in national per capita FFS Parts A and B spending.

MSSP Issue #2: Financial Benchmarks

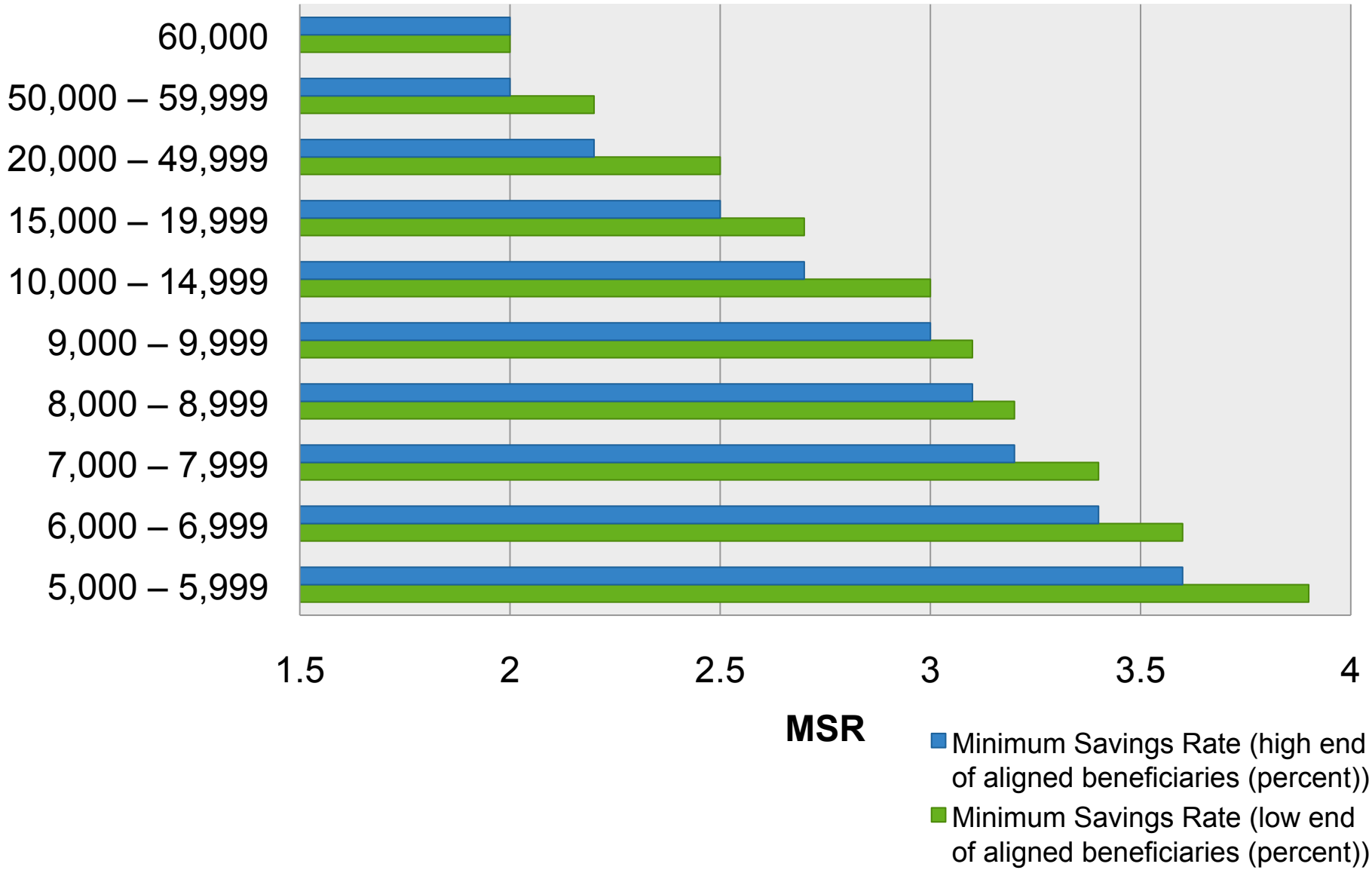
- Problems:
  - Setting trend based on all beneficiaries nationally
  - Instability of the benchmarks from attribution churn
  - Harder to find savings in low-cost areas
  - Trending is national but really varies by region
- Solutions:
  - Address the assignment issues
  - Set the trend based on an attributable population
  - Adopt regional trending model
  - Prospectively set the targets
  - Minimize policy change adjustments
  - Remove renormalization

Medicare Issue #3: Payment Model – Minimum Savings Rate

- One-sided (shared savings only) risk model
- Caps savings at 10% of benchmark
- Threshold of 2%-3.9% depending on size of population
- Once MSR met, share up to 50% of first dollar savings depending on quality scores

- Two-sided risk (shared savings and losses)
- Up to 60% shared savings
- First dollar savings/loss after 2% MSR surpassed
- Caps savings at 15% of benchmark
- Caps losses at 5% in year 1, 7.5% in year 2, and 10% in year 3

Minimum Savings Rate (MSR) by number of aligned beneficiaries



MSSP Issue #3: Payment Model – Minimum Savings Rate

- Problem:
  - 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
- Solution:
  - Eliminate MSR for 1-sided ACOs
  - Reduce MSR for 1-sided ACOs
  - Modify MSR for low/high cost areas

MSSP Issue #4: Payment Model - 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.

ACO Performance * Interim 2012 results	Total Savings as a Percent of the Target	Total Savings per Beneficiary
ACOs Generating Shared Savings (N=29)	**5.90%**	**$660**
ACOs Positive but within Corridor (N = 25)	**1.30%**	**$134**
ACOs Negative but within Corridor (N = 29)	**-1.10%**	**-$95**
ACOs Negative outside Corridor (N = 31)	**-5.30%**	**-$536**

MSSP Issue #4: Payment Model - 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

MSSP Issue #5: 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 eligibles
  - 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

MSSP Issue #5: Risk Adjustment

- Problem:
  - Unfair application of risk adjustment that allows all factors to decrease risk, but only certain factors to increase
- Solution:
  - Allow risk scores to grow for continuously assigned beneficiaries
  - Use demographics only
  - Research new methods

MSSP Issue #6: Quality—Measures

Measure Category	Number of Measures	Measure Steward (Owner)	Data Collection Mode
Preventive Health 8 Measures	3	NCQA (2 HEDIS measures)	GPRO Data Collection Tool
	2	AHRQ	GPRO Data Collection Tool
	2	AMA-PCPI	GPRO Data Collection Tool
	1	CMS	GPRO Data Collection Tool
At Risk Population 12 Measures	5	MN – Community Measurement	GPRO Data Collection Tool
	4	NCQA (2 HEDIS measures)	GPRO Data Collection Tool
	3	CMS / AMA-PCPI	GPRO Data Collection Tool
Patient/Care Giver Exp 7 Measures	7	AHRQ	Clinician Group CAHPS Survey
Care Coordination / Patient Safety 6 Measures	2	AHRQ ACSC	Claims
	1	CMS	EHR Incentive Program Reporting (Meaningful Use)
	1	CMS	Claims
	1	NCQA (not a HEDIS measure)	GPRO Data Collection Tool
	1	AMA-PCPI/ NCQA	GPRO Data Collection Tool
Shared Savings			

Pay for performance will be phased in over the ACO's first agreement period as follows:

- Year 1: Pay for reporting applies to all 33 measures.
- Year 2: Pay for performance applies to 25 measures. Pay for reporting applies to eight measures.
- Year 3: Pay for performance applies to 32 measures. Pay for reporting applies to one measure that is a survey measure of functional status. Measure for percentage of PCP meeting EHR certification is weighted double.

MSSP Issue #6: Quality—Scoring

- Benchmarks based on PQRS and ACO data
- Performance below the minimum attainment level for a measure will receive zero points for that measure.
- Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale based on the level of performance.
- Those measures designated as all or nothing measures will receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met.
- Performance at or above 90 percent or the 90th percentile of the performance benchmark earns the maximum points available for the measure.
- The overall score is applied to the savings potential to determine an ACO's share of the savings (e.g. 80% overall score x 50% = 40% of savings).

MSSP Measure	MSSP Benchmark 90th percentile PY 2014-2015	MSSP Summary Statistic 90th percentile PY 2012	NCQA HEDIS Medicare HMO 90th percentile MY 2012[1]	NCQA HEDIS Medicaid HMO 90th percentile MY 2012[1]	CDC's Healthy People Goal 2020[7]
#9 – ASC Admissions: COPD or Asthma in Older Adults	0.0%	0.76%	No reasonable comparison publicly available, given CMS' customization[2]		
#14 - Influenza Immunization [6mos.+]	100.00%	70.62%	78.70% (MY 2011[3,4])	n/a (child only)	6mos-17yr: 80.00% 18yr.+: 90.00%
#15 - Pneumococcal Vaccination [65+]	100.00%	81.05%	83.10% (MY 2011[3, 4])	n/a (child only)	65yr.+: 90.00%
#16 - Adult Weight Screening and F/U [18+]	100.00%	75.80%	95.40%[5]	84.40%[5]	Adults: 53.60%[5]
#19 - Colorectal Cancer Screening[6] [50-75]	100.00%	86.53%	77.00%	n/a	50-75yr.: 70.50%
#20 - Mammography Screening[6] [40-69]	99.56%	76.03%	82.20%	62.90%	50-74yr.: 81.10%

MSSP Issue #6: Quality—Benchmarks

- Problems:
  - Assumes a level of precision with measurement that supports ranking of providers
  - 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
  - Quality scores reduces savings rather than triggering bonuses
  - Submission process extremely burdensome
  - Major confusion around the measure definitions
- Solutions:
  - Reset the benchmark expectations
    - » Remove arbitrary flat percentage benchmarks
    - » Use additional data sources for benchmarks
  - Allow improvement in quality scores to count equally to achieving the benchmarks

MSSP Issue #7: Data

- Part A and B data drive benchmark and reconciliation.
- Application – CMS provides estimated attribution list to determine # of lives and benchmark
- Quarterly ACO requests and receives claims data and attribution at that point in time
- At end of P1, after claims run-out, ACO receives who was finally attributed to ACO and their final benchmark
- Using the claims data they retrospectively try to explain what patients contributed to the over/under and why their denominator changed by 30-50% over the year
- No data is real-time to help manage patient care

MSSP Issue #7: Data—included informaiton

1. Cost and utilization
   - Aggregate data reports on quality and utilization at the start of the agreement period based on the historical beneficiaries used to calculate the benchmark, and *quarterly* thereafter (most recent 12-mo).
2. Attribution
   - ACO can request a list of attributed beneficiaries included in the benchmark and at the end of each performance period:
     - » Name,
     - » Date of Birth,
     - » Sex, and
     - » Health Insurance Claim Number (HIC)
3. Claim Feeds
   - Subject to a beneficiary “opt-out”, an ACO can request *monthly* Part A, B and D claims data for potentially assigned beneficiaries for purposes of evaluating performance, quality, and population-based activities.
4. Reconciliation Reports
   - Annually 6-9 months after the end of the each performance period

MSSP Issue #7: Data—Problems

- 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.

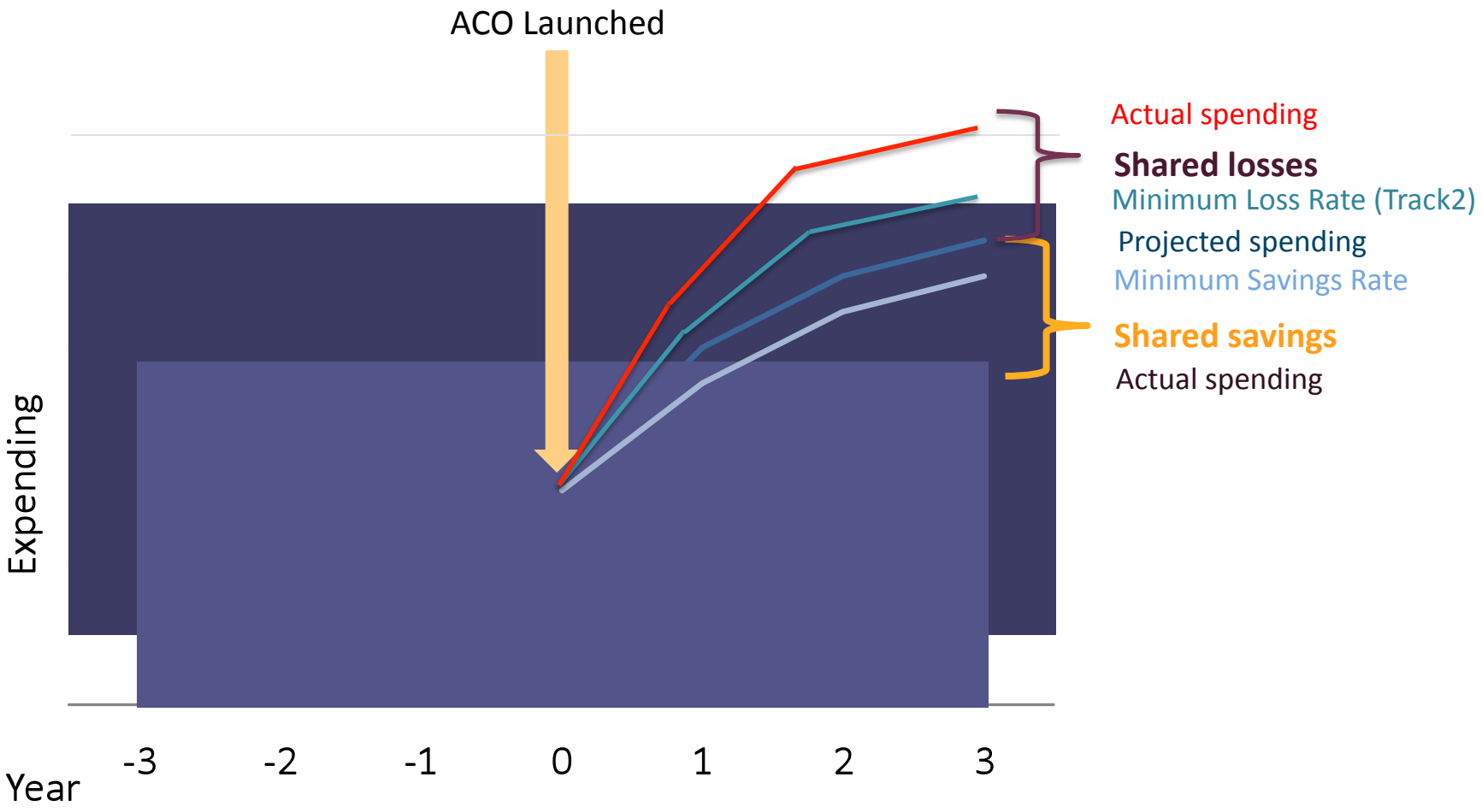
MSSP Issue #7: Data—Solutions

- 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


Questions?

APPENDIX

Medicare Issue #3: Payment Model



More About the Measures (Annual Measurement)

- Data sources for the measures range from Medicare's payor claims data, medical record data and beneficiary survey data
- Most of the non-survey measures will rely on CMS' Group Practice Reporting Option (GPRO) web-based tool to submit results for samples of eligible beneficiaries:
  - Pre-populated with data available from claims
  - ACO would need to enter supplemental data from medical records
- Additionally, CMS is committing in their final rule to do additional quality monitoring on an on-going basis, using their claims to identify:
  - Patterns of avoiding at-risk beneficiaries
  - Misuse / underuse or overuse of services over time
- CMS finalized the use of the Clinical Group CAHPS and will administer and pay for the data collection on behalf of contracted ACOs for first two years
- All measures will be reported on calendar year cycles, and measures for CY2012 are required for ACOs electing interim payment; for CY2013 for others starting in 2012.

Scoring of Quality Performance

- Performance Scoring (for Years 2 and 3; mock for Year 1)
  - CMS sets benchmarks at beginning of each reporting year using FFS and ACO data
  - Points are assigned to each measure (and summed by domain) based on performance related to the MSSP benchmark
  - The minimum attainment level is set at 30% or the 30th percentile of the performance benchmark (must achieve this for one measure per domain)
    - » If an ACO fails to achieve the minimum attainment level on *all* measures in a domain, it will not be eligible to share in any savings generated
    - » ACOs must score above the minimum attainment level determined by CMS on 70% of the measures in each domain
  - Domain scores are determined by dividing the actual points by the maximum potential points to determine a % of performance
  - The overall score is applied to the savings potential to determine an ACO's share of the savings (e.g. 80% overall score x 50% = 40% of savings)

CMS 33 Quality measures

	Domain	Measure Title	NQF Measure #/ Measure Steward	Method of Data Submission	Pay for Performance Phase In R = Reporting P=Performance		
					Performance Year 1	Year 2	Year 3
AIM: Better Care for Individuals							
1.	Patient/Caregiver Experience	CAHPS: Getting Timely Care, Appointments, and Information	NQF #5, AHRQ	Survey	R	P	P
2.	Patient/Caregiver Experience	CAHPS: How Well Your Doctors Communicate	NQF #5 AHRQ	Survey	R	P	P
3.	Patient/Caregiver Experience	CAHPS: Patients' Rating of Doctor	NQF #5 AHRQ	Survey	R	P	P
4.	Patient/Caregiver Experience	CAHPS: Access to Specialists	NQF #5 AHRQ	Survey	R	P	P
5.	Patient/Caregiver Experience	CAHPS: Health Promotion and Education	NQF #5 AHRQ	Survey	R	P	P
6.	Patient/Caregiver Experience	CAHPS: Shared Decision Making	NQF #5 AHRQ	Survey	R	P	P
7.	Patient/Caregiver Experience	CAHPS: Health Status/Functional Status	NQF #6 AHRQ	Survey	R	R	R
8.	Care Coordination/ Patient Safety	Risk-Standardized, All Condition Readmission*	NQF #TBD CMS	Claims	R	R	P
9.	Care Coordination/ Patient Safety	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ Prevention Quality Indicator (PQI) #5)	NQF #275 AHRQ	Claims	R	P	P
10.	Care Coordination/ Patient Safety	Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)	NQF #277 AHRQ	Claims	R	P	P
11.	Care Coordination/ Patient Safety	Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment	CMS	EHR Incentive Program Reporting	R	P	P
12.	Care Coordination/ Patient Safety	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #97 AMA-PCPI/NCQA	GPRO Web Interface	R	P	P
13.	Care Coordination/ Patient Safety	Falls: Screening for Fall Risk	NQF #101 NCQA	GPRO Web Interface	R	P	P
AIM: Better Health for Populations							
14.	Preventive Health	Influenza Immunization	NQF #41 AMA-PCPI	GPRO Web Interface	R	P	P

CMS 33 Quality measures
(Continued)

	Domain	Measure Title	NQF Measure #/ Measure Steward	Method of Data Submission	Pay for Performance Phase In R = Reporting P=Performance		
					Performance Year 1	Year 2	Year 3
15.	Preventive Health	Pneumococcal Vaccination	NQF #43 NCQA	GPRO Web Interface	R	P	P
16.	Preventive Health	Adult Weight Screening and Follow-up	NQF #421 CMS	GPRO Web Interface	R	P	P
17.	Preventive Health	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #28 AMA-PCPI	GPRO Web Interface	R	P	P
18.	Preventive Health	Depression Screening	NQF #418 CMS	GPRO Web Interface	R	P	P
19.	Preventive Health	Colorectal Cancer Screening	NQF #34 NCQA	GPRO Web Interface	R	R	P
20.	Preventive Health	Mammography Screening	NQF #31 NCQA	GPRO Web Interface	R	R	P
21.	Preventive Health	Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years	CMS	GPRO Web Interface	R	R	P
22.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent)	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
23.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100)	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
24.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
25.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Tobacco Non Use	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
26.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): Aspirin Use	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
27.	At Risk Population - Diabetes	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)	NQF #59 NCQA	GPRO Web Interface	R	P	P
28.	At Risk Population - Hypertension	Hypertension (HTN): Blood Pressure Control	NQF #18 NCQA	GPRO Web Interface	R	P	P

CMS 33 Quality measures
(Continued)

	Domain	Measure Title	NQF Measure #/ Measure Steward	Method of Data Submission	Pay for Performance Phase In R = Reporting P=Performance Performance Year 1	Year 2	Year 3
29.	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100 mg/dl	NQF #75 NCQA	GPRO Web Interface	R	P	P
30.	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #68 NCQA	GPRO Web Interface	R	P	P
31.	At Risk Population - Heart Failure	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #83 AMA-PCPI	GPRO Web Interface	R	R	P
32.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol	NQF #74 CMS (composite) / AMA-PCPI (individual component)	GPRO Web Interface	R	R	P
33.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	NQF # 66 CMS (composite) / AMA-PCPI (individual component)	GPRO Web Interface	R	R	P

*We note that this measure has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012.