Addressing Medicare Shared Savings Program vulnerabilities

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MEDPAC

Roadmap

① **ACO background**

② Concerns with patient selection

③ Addressing selection through NPI-based benchmarks

Accountable Care Organizations (ACOs)

- ACOs are collections of providers willing to take accountability for the spending and quality of care for an assigned patient population
- Actual spending is compared to a benchmark:
  - If spending is less than the benchmark, the difference ("savings") is shared between Medicare and the ACO
  - If spending is more than the benchmark, the difference ("losses") is:
    - One-sided risk model: Losses absorbed by Medicare
    - Two-sided risk model: Losses shared between Medicare and the ACO

Medicare Shared Savings Program (MSSP)

- 517 ACOs, 11.2 million beneficiaries in 2020
- New rules went into effect in 2019
  - Two new tracks: BASIC and ENHANCED
  - Faster movement toward two-sided risk
  - In 2020, most ACOs still in one-sided models
- MSSP benchmarks will represent a blend of:
  - Spending for beneficiaries who would have been assigned to the ACO in the baseline years (the 3 years prior to an ACO's agreement period)
  - Spending in the ACO's region

Have ACO models achieved savings for the Medicare program?

- Assessment of an ACO model's savings as a whole requires a counterfactual analysis (i.e., what would spending have been if the ACO model did not exist?)
- Over all Medicare ACO models, studies estimate 1 to 2 percent savings; about 1 percent after shared savings payments
- MedPAC found (June 2019), for MSSP relative to counterfactual:
  - Slower spending growth for beneficiaries assigned to an MSSP ACO in 2013, about 1 or 2 percent through 2016 (does not include shared savings payments)
  - Beneficiaries who were switched into or out of MSSP ACOs had higher spending growth than those who were not (health event leads to higher spending and more frequent change in assignment)
- Savings are small; unwarranted shared savings payments to ACOs could put Medicare savings at risk

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Potential patient selection in MSSP

- Unwarranted shared savings possible if there is selection in the performance year relative to the baseline years
  - Bring clinicians with low-cost patients into the ACO
  - Remove clinicians with high-cost patients from the ACO
  - Keep low-cost patients assigned to ACO clinicians
  - Have high-cost patients lose assignment to ACO clinicians
- Have not seen wide-spread selection to date, but the current MSSP model is vulnerable

Potential selection of low-cost beneficiaries through annual wellness visits (AWVs)

- ACOs have higher rates of AWVs*
- ACOs are more likely to perform AWVs toward the end of the year*
- Patients who receive AWVs toward the end of the year are lower cost on average than patients who receive AWVs toward the beginning of the year*
- Use of AWVs could help retain low-cost patients in MSSP ACOs

* Analysis of MSSP ACOs in MedPAC June 2019 report

Evidence to date suggests selection effect may outweigh potential benefits of AWVs

- Among beneficiaries continuously assigned to the same ACO, average spending growth from 2014-2016 was $174 higher for beneficiaries who received their initial AWV in 2015 relative to those that did not have an AWV
- Ganguli et al. (2019) found that, from 2008-2015, AWVs had no effect on Medicare spending or service use
- Beneficiaries in MedPAC focus groups generally report that AWVs are not useful for their own care needs
- Thus far, AWVs may have more of a role in patient selection than in reducing spending growth

Results are preliminary and subject to change.

Potential selection against high-cost beneficiaries

- Are incentives large enough for ACOs to shift high-cost patients or their clinicians out of the ACO?
  - In 2017, 50 MSSP ACOs received shared savings of over $50,000 per primary care physician (PCP) in the ACO
- Beneficiaries who exited MSSP ACOs with the highest shared savings per PCP had unusually high relative spending compared to beneficiaries exiting other MSSP ACOs
- The correlation between shared savings and favorable selection is problematic, even if the selection is not intentional

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Definitions

- NPI = National Provider Identifier
  - Each clinician has one unique NPI
- TIN = Taxpayer Identification Number
  - TIN can range from single physician in a single office to a multi-state integrated delivery system with many NPIs
- MSSP ACO = a collection of one or more TINs
  - Beneficiaries are assigned to ACOs based on the TINs under which their claims are billed
- Issue: A clinician (NPI) can shift which TIN she bills under and can bill under multiple TINs

Changes in how NPIs bill through TINs not reflected in benchmark

- Benchmark = spending on beneficiaries who would have been assigned to the ACO's current list of TINs in the base years
- Performance = spending on beneficiaries who are assigned to the ACO's current list of TINs in the performance year
- CMS annually recalculates benchmarks based on the updated list of TINs submitted by the ACO
- CMS does not recalculate benchmarks based on changes in NPIs billing under the TINs

Using TIN to identify clinicians in ACO could result in unwarranted shared savings

- Individual clinicians can leave or join TIN but benchmark will not change
- In figure below, the ACO may obtain unwarranted shared savings if:
  - High-cost clinician A is removed from TIN
  - Low-cost clinician C is added to TIN

Using TIN/NPI combination to identify clinicians in ACO could also result in unwarranted savings

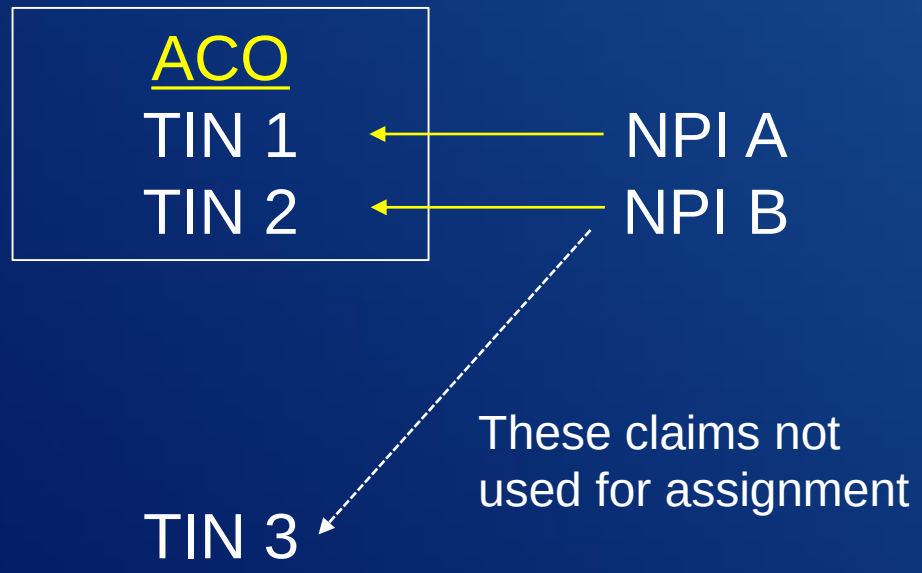
- NextGen demonstration uses TIN/NPI combination to designate participating clinicians
- CMS adjusts benchmarks when NPIs are removed from TINs
- CMS does not adjust benchmarks when NPIs outside the ACO are added to ACO TINs
- Benchmarks increase when NPIs with low-cost patients are removed from benchmarks but remain in ACO as a new TIN/NPI combination
- Benchmarks do not change when NPIs selectively bill high-cost patients using a TIN outside the ACO

Using NPI for computing ACO benchmarks may reduce unwarranted shared savings

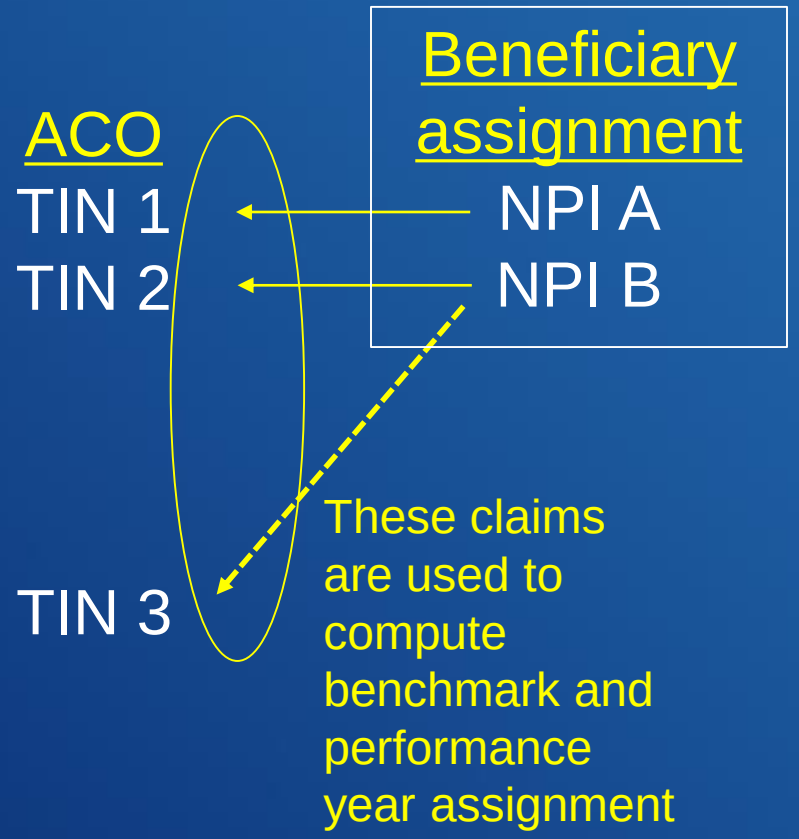
- NPI-based benchmarks would most accurately capture historical spending
- Clinicians in the performance year would correspond with clinicians used to compute benchmarks
- Would reduce selection resulting from:
  - Removing high-cost clinicians from TIN
  - Adding low-cost clinicians to TIN
  - Billing high-cost beneficiaries outside of TIN

NPI option ensures clinicians' claims are completely captured in both benchmark and performance years

Current Assignment: TIN-only



NPI Option



Summary

- ACO savings have been modest
- Unwarranted “shared savings” payments to ACOs could result in program costs that exceed MSSP savings
- To avoid putting MSSP at risk of being a net cost to Medicare, CMS needs to reduce vulnerabilities from patient selection
- To help limit vulnerabilities, both MSSP baseline and performance year spending could be computed using the performance year NPIs rather than TINs

Discussion

- Questions about the material informing the draft recommendation?
- Questions about the information on assignment to ACOs included in your mailing material?
- Other ideas for future analyses?