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Critical Issues in Performance Evaluation for Medicaid ACOs

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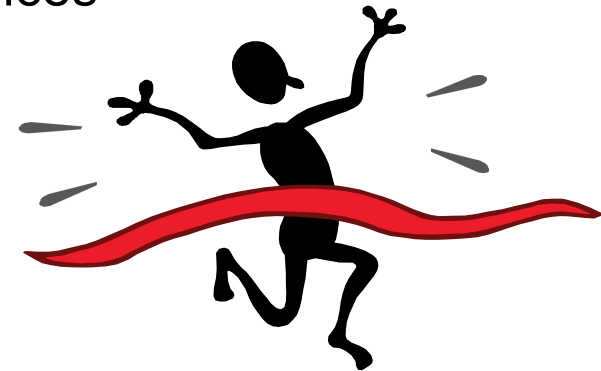
Discussion paper

- Medicaid ACO Demonstration Project in NJ
 - Technical assistance from Rutgers Center for State Health Policy (CSHP)
- Discussion paper
Proposed Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project
- Comments to acocomments@ifh.rutgers.edu



Medicaid ACOs

- Major goals
 1. Reduce cost growth
 2. Improve healthcare quality/patient experiences
 3. Improve access to specific services
- How do we know goals are met?
 1. Rigorous academic evaluation
 2. Predetermined performance measures & rules
- Themes
 1. Don't let the perfect be the enemy of the good
 2. Don't let Theme #1 be the enemy of the good
Tolerance for imperfection \neq low standards



Key principles of ACO performance evaluation

1. Accuracy
 2. Fairness
 3. Simplicity
 4. Transparency
 5. Timely administration
- Technical decisions
 - Analytic tradeoffs



Medicare Shared Savings Program (MSSP)

- Proposed rules → public comment → final rules
- Medicare ACO
 - Responsible for defined group of Medicare patients
 - Rewards for reducing Medicare spending (i.e., keep a share of savings generated)
 - Must meet quality standards
- Useful template for Medicaid ACOs
- Many details require modification

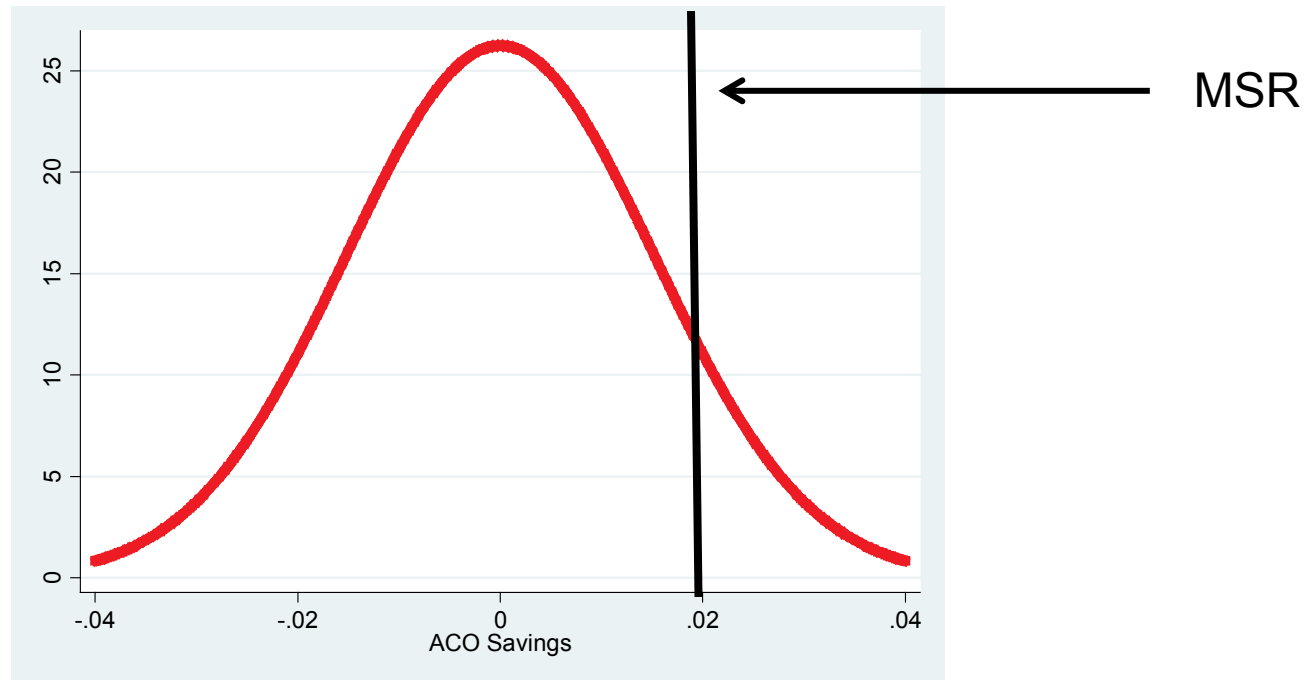


Measured savings in MSSP

- Per capita spending @ baseline for ACO patients
 - Weighted average of 3 most recent years
 - “Trended forward” for national rate medical inflation (Medicare FFS)
 - “Updated” by projected Medicare FFS spending growth nationally
- ACO savings rate (ASR)
$$\text{ASR} = (\text{Baseline} - \text{Performance year}) / (\text{Baseline})$$
- All spending \$ risk adjusted using Hierarchical Condition Categories (Currently used in Medicare Advantage)
- Separate trending & updating by eligibility category
- Medicare ACOs must report & meet quality standards
 - 33 measures
 - If not, shared savings payments to ACO adjusted downward

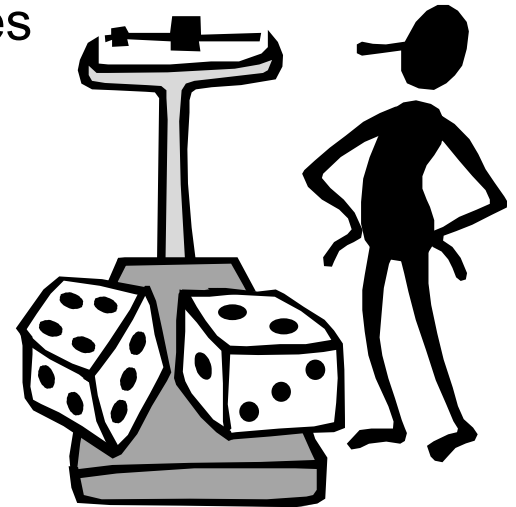
The problem of “normal variation”

- ACO spending could \uparrow or \downarrow due to random factors
 - MSSP protects Medicare from “false savings” (\downarrow)
 - ACOs not protected from “false spending increases” (\uparrow)
- Establish **minimum savings rate (MSR)** for savings to “count”



Risk bearing in the MSSP

- One-sided model
 - ACO keeps part of savings generated
 - $\leq 50\%$ depending on quality & other standards
 - No risk of financial loss for spending increases
- Two-sided model
 - ACO keeps part of savings generated
 - $\leq 60\%$ depending on quality & other standards
 - Penalties for spending increases: $(100 - \text{savings}\%)$
 - ACOs opting for one-sided model must switch to two-sided model after 1st contracting period (3 years)



Adapting the Medicare Approach for Medicaid ACOs

Technical issues for Medicaid ACO evaluation - 1

- Data requirements
 - Medicaid FFS claims (Similar to MSSP)
- Data from managed care organizations
 - MSSP excludes managed care
 - Won't work for Medicaid
 - Encounter data (capitation payments)
- Trending & updating ACO baseline spending
 - State-level Medicaid trends & projections (Similar to MSSP)
 - Potential eligibility strata: duals; aged, blind, disabled; etc.

Technical issues for Medicaid ACO evaluation - 2

- Risk adjustment
 - Chronic Illness & Disability Payment System (CDPS) common in Medicaid MCOs
 - Not applicable to all patients
 - Modified adjusters needed
- Expansion population in 2014
 - No baseline Medicaid history
 - Need to create one from existing data (current enrollees, hospital charity care, etc.)
- Enrollment churning
 - Calculations on monthly rather than annual basis

Policy/technical issues for Medicaid ACOs

- Risk bearing & MSR threshold
 - May discourage participation
 - “Overpayments” may be reinvested into care improvements
- Cost outliers
 - MSSP truncates @ 99th percentile
 - What about “super-users”?
- Interaction w/MCOs
 - Part of care management ==> shared savings
 - Free-rider problems ==> adjustment of plan rates
- Medicaid-specific quality measures
 - Different patients (pregnancy outcomes, behavioral health)
 - Quality improvement vs. quality maintenance
 - Link to distribution of shared savings (all/nothing vs. sliding scale)

QUESTIONS?



Questions later: ddelia@ifh.rutgers.edu