MILLIMAN ISSUE BRIEF

The exclusion of some nursing facility visits from MSSP assignment has potential unintended consequences

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A number of Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) experienced significant, unanticipated changes in their 2017 performance year historical benchmarks and performance expenditures—changes that were not consistent in direction or magnitude. We believe the exclusion of some nursing facility visits from MSSP assignment, effective in 2017, is the likely cause of the unanticipated changes. This technical brief describes the assignment change and its possible impact.

Overview of the assignment methodology change

Medicare Part A covers skilled nursing facility (SNF) stays that initiate after discharge from an acute inpatient hospital admission (Part A SNF stays).[1] During a Part A SNF stay, a beneficiary may have frequent evaluation and management (E&M) visits by a primary care provider who is not the beneficiary's "normal" community-based primary care provider. To address a concern that some beneficiaries with SNF stays were not being assigned to their community-based primary care provider and instead were being assigned to a nursing facility (NF) provider, Centers for Medicare and Medicaid Services (CMS) now excludes NF E&M visits (HCPCS 99304-99318) coded with place of service (POS) 31 as a qualifying claim type for beneficiary assignment.[2,3,4] We refer to this assignment methodology change as the "POS 31 exclusion." The POS 31 exclusion change started with the 2017 performance year and is also applied to the corresponding baseline years for all MSSP tracks. POS 31 should be coded when the E&M visit is provided in conjunction with a Part A SNF stay while POS 32 should be coded when the E&M visit is provided to a patient in a non-skilled NF stay or in a non-Medicare Part A covered SNF stay. NF E&M claims coded with POS 32 continue to qualify for beneficiary assignment.

Inconsistent POS coding practices may be causing unintended consequences

The typical ACO will lose and gain assigned NF beneficiaries due to the new POS 31 exclusion in both the baseline and performance years. NF beneficiaries can include beneficiaries who have post-acute short-term SNF stays as well as those who are long-term institutional NF residents. The beneficiary who would have been assigned to the ACO in the absence of the exclusion may continue to be assigned to the ACO, may be assigned to another ACO, or may become unassigned—depending on where the beneficiary received the plurality of the non-POS 31 primary care. If this loss and gain is consistent between the baseline and performance years, the POS 31 exclusion affects the baseline and performance years evenly.

The POS 31 exclusion only works as intended if POS codes correctly differentiate between Part A SNF and other NF patient services. Our analysis, however, shows that POS 31 and 32 codes are often misassigned. Given the high misassignment rates, we cannot be certain that the rate of misassignment is consistent between the benchmark and performance years. Misassignment of POS codes to NF E&M claims may occur if the physician's biller does not have access to the records necessary to determine whether the patient's NF stay, on the date of the E&M visit, was being paid for by Medicare Part A. While misassignment of POS codes for these E&M visits does not affect physician reimbursement, it now impacts ACO assignment.

We examined national Medicare data and found that 32% of POS 31 E&M claims do not have a corresponding Part A SNF claim and 49% of POS 32 claims do have a corresponding Part A SNF claim—this translates to an overall miscode rate of 36% (see Figure 1). Furthermore, the miscode rates vary, sometimes dramatically, by metropolitan statistical area. For example, in the

[1] Some MSSPs have a SNF waiver whereby Part A pays for some SNF stays without an acute inpatient hospital admission.

[2] Federal Register, Vol. 80, No. 220, November 16, 2015, Assignment of Beneficiaries Based on Certain Evaluation and Management Services in Skill Nursing Facilities, pp. 71271-71272.

[3] AMDA, CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals & Other Providers, November 7, 2015.

[4] Ninety-seven percent (97%) of Medicare NF E&M visits are POS 31 to 32 based on Milliman analysis.

Orlando, Florida, area, 76% of the claims coded to POS 32 should have been POS 31 (versus 49% nationally). Within the Medicare 5% sample, we find that some individual physicians code all of their claims to POS 31 or 32 regardless of whether the patient has a corresponding Part A SNF claim.

FIGURE 1: NURSING FACILITY E&M VISIT MISCODING

CORRECT CODE BASED ON SNF CLAIM (OR LACK THEREOF)	CODE APPEARING ON E&M CLAIM		
	POS 31	POS 32	TOTAL
NUMBER OF NF E&M VISITS			
POS 31	235,195	**55,052**	290,247
POS 32	**108,988**	58,419	167,407
TOTAL	344,183	113,471	457,654
DISTRIBUTION OF NF E&M VISITS			
POS 31	68%	**49%**	63%
POS 32	**32%**	51%	37%
TOTAL	100%	100%	100%

Blue denotes presumed incorrect coding.

Source: Milliman analysis of 2016 Medicare 5% sample. See *Methodology Details: Figure 1* at the end of this brief.

A few NF beneficiaries can have a significant impact

Because of their high expenditures, a net gain or loss of a few NF beneficiaries can have a significant impact on the ACO's per beneficiary per year (PBPY) expenditures. Figure 2 illustrates that adding 150 beneficiaries with four times the average PBPY expenditures to a 15,000-beneficiary ACO increases PBPY expenditures by 3%. Based on our observations, the impact for some ACOs has been far greater than the illustration below.

Risk adjustment provides limited protection for changes in this population during ACOs' agreement period

Risk adjustment has the potential to mitigate changes in beneficiary assignment between the baseline and performance years. However, the MSSP financial benchmark methodology caps risk adjustment factors for continuously assigned beneficiaries. CMS classifies a beneficiary as continuously assigned if, in the previous assignment period, the ACO had any primary care relationship, even if the beneficiary had just one visit and received the plurality of care elsewhere.[5] Therefore, if an ACO gains more (or loses fewer) NF beneficiaries for its performance year than for its benchmark years, risk adjustment will likely provide limited mitigation for high-expenditure NF beneficiaries. Furthermore, even if these members are newly assigned beneficiaries, meaning that they are not subject to the MSSP risk adjustment cap, the associated risk scores may not be adequate given that these beneficiaries tend to be particularly high cost beneficiaries.[6]

[5] MSSP risk adjustment factors are capped at the greater of 1.00 or aging for beneficiaries that CMS classifies as "continuously assigned." See Medicare Shared Savings Program, Shared Savings and Losses and Assignment Methodology, Specifications, April 2017, Version #5, Applicable Beginning Performance Year 2017, p. 40.

[6] This is based on our general understanding that, while helpful in adjusting for risk across populations, risk adjustment models oftentimes are less accurate when predicting individual high-cost beneficiaries.

[7] Medicare Shared Savings Program, Quarterly Aggregate Expenditure/Utilization Reports, All MSSP ACO PBPY Expenditures.

FIGURE 2: ILLUSTRATIVE BENCHMARK IMPACT OF NEW NURSING FACILITY BENEFICIARIES

BENCHMARK BENEFICIARIES	NUMBER OF BENEFICIARIES	EXPENDITURES PBPY*	TOTAL ANNUAL EXPENDITURES
NON-IMPACTED BENEFICIARIES	15,000	$10,000	$150,000,000
NET NEW NF BENEFICIARIES	150	$40,000	$6,000,000
TOTAL BENEFICIARIES	15,150	$10,297	$156,000,000
CHANGE DUE TO NEW NF BENEFICIARIES	1.0%	3.0%	4.0%

GENERAL RULE: FOR EVERY 1% BENEFICIARIES ADDED (OR SUBTRACTED) WITH EXPENDITURES N-TIMES THE ORIGINAL POPULATION, THE PBPY EXPENDITURE IMPACT WILL BE APPROXIMATELY [N-1]%. THIS EXAMPLE ADDS 1% MORE BENEFICIARIES WITH EXPENDITURES FOUR TIMES THE ORIGINAL POPULATION AND THE PBPY EXPENDITURE IMPACT IS 3%.

* Nationally, ACO expenditures are about $10,000 PBPY across all enrollment types[7] and, from the data that we have seen and developed, the NF beneficiaries whose assignments are shifted because of the POS 31 exclusion have expenditures of about $40,000 PBPY.

The methodology change may have significant financial implications on Medicare ACOs

The POS 31 exclusion may significantly affect ACOs due to the combination of inconsistent coding practices, high claims costs for NF beneficiaries, and limitations of risk adjustment for MSSP. If the impact of the POS 31 exclusion is proportional for an ACO's benchmark and performance years, the financial consequences are minimal within the current agreement period: the ACO's benchmark changes, perhaps significantly, but so does the ACO's performance year expenditures. However, a significant change in the average per beneficiary costs for the ACO will have an impact on its benchmark in future agreement periods where the regional benchmark adjustment applies.[8]

In the case that the impact of the POS 31 exclusion varies between the baseline and performance years, this could have a material impact on the financial performance of the ACO in its current agreement period. For example, if an ACO, for the purpose of reducing inpatient admissions, initiated increased visits to beneficiaries residing in NFs and coded the visits with the correct POS, it would have more long-term NF patients in its performance year. The high expenditures associated with these beneficiaries and MSSP risk adjustment cap would have an adverse impact on the ACO's performance year savings. Under the current MSSP programs, no adjustment is made for a change in the proportion of long-term institutionalized NF beneficiaries assigned to the ACO. Although separate benchmarks are calculated for end-stage renal disease (ESRD), dual, aged non-dual, and disabled populations within the ACO, there is no separate benchmark or adjustment made for a change in the ACO's long-term institutionalized NF population. An increase in the assignment of long-term institutionalized NF beneficiaries to the baseline years without a corresponding increase to the performance years, and vice versa, can have significant financial consequences for the ACO.

CMS stated that some ACOs would lose more assigned beneficiaries than others.[9,10] As we discussed in this brief, ACOs will likely be losing and gaining beneficiaries due to the POS 31 exclusion change. The net impact may be uneven across baseline and performance years, resulting in unintended financial consequences for ACOs. Limitations of the Claim and Claim Line Feeds (CCLFs) and other data provided by CMS prevent ACOs from quantifying the full financial impact. Despite these limitations, we encourage ACOs to explore any abnormal changes in assigned beneficiaries and utilization patterns to assess the potential impact of this change.

Methodology Details: Figure 1

Using the 2016 Medicare 5% sample and limiting our analysis to fee-for-service beneficiaries with both Part A and Part B coverage for the month of service, we examined NF E&M claims (HCPCS codes 99304-99318) coded with POS 31 and 32 and looked for Part A SNF claims corresponding to the E&M dates of service. If POS is coded correctly:

1. Each POS 31 NF E&M claim will have a date of service within the dates of service of a Part A SNF claim (a corresponding Part A SNF claim)
2. No POS 32 NF E&M claim will have a date of service within the dates of service of a Part A SNF claim (no corresponding Part A SNF claim).

[8] The regional benchmarks are not expected to change significantly. As such, any ACOs that have an increase in average per beneficiary costs will have a less favorable regional benchmark adjustment.

[9] Federal Register, Vol. 80, No. 220, November 16, 2015, Assignment of Beneficiaries Based on Certain Evaluation and Management Services in Skill Nursing Facilities, pp. 71271-71272.

[10] CMS did not seem to anticipate that some ACOs would gain beneficiaries.

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