SHADOW BUNDLES ARE COMING SOON TO MSSP AND ACO REACH

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In February 2024, the Centers for Medicare & Medicaid Services (CMS) will start giving Medicare Shared Savings Program (MSSP) and Realizing Equity, Access, and Community Health (REACH) ACOs shadow bundle reporting on 29 inpatient, three outpatient, and two multi-setting episodes based on a modified version of the Bundled Payment for Care Improvements (BPCI) Advanced program. This paper gives a brief background of why CMS is doing this, and then a dive into what ACOs can do with the data.

What is a shadow bundle?

A shadow bundle is a summary of information intended to enable a review of specialist performance on procedural or condition specific care. More specifically, a shadow bundle is an episode constructed for an aligned or attributed ACO beneficiary that captures the average cost of a defined set of services over a defined period. These are simply calculations that CMS will be providing, and not a part of a specific bundle program.

Why is CMS doing this?

In 2021, CMS set a goal of getting 100% of Medicare and the vast majority of Medicaid beneficiaries in an accountable care organization (ACO) by 2030 and outlined their goals as part of their strategic refresh.[1] CMS believes engaging specialists will be a critical next step in their lofty goal. Providing shadow bundle data is a means for CMS to equip ACOs with better insights to manage specialty care.

Why is CMS focusing on specialty care?[2]

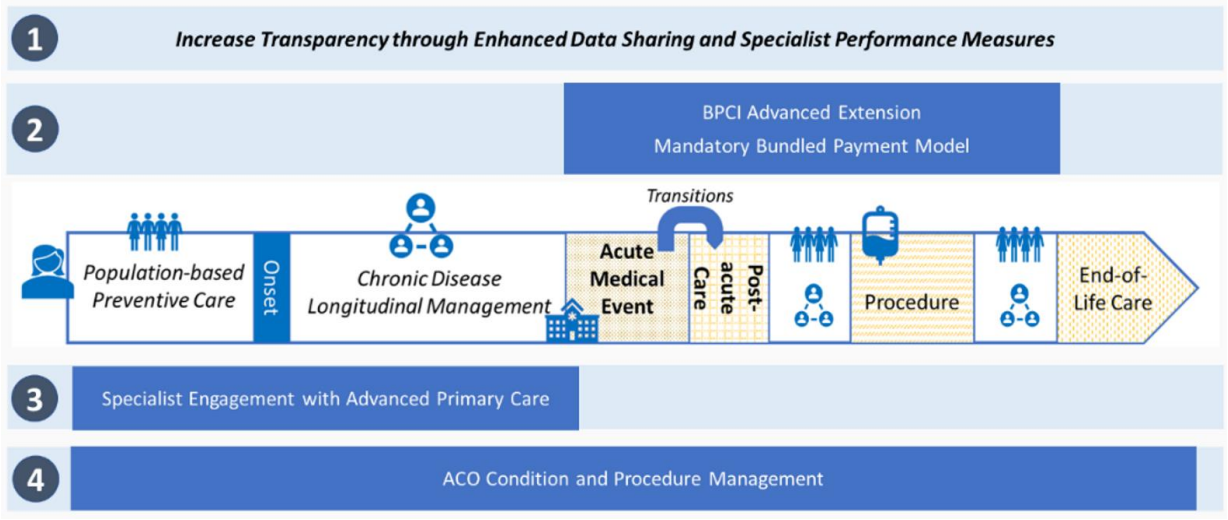
- Specialty care accounts for a large volume of healthcare expenditures in the United States
- Specialty care is a substantial source of variation in quality and outcomes
- CMS wants to provide ACOs a deeper view into specialist care performance
- CMS wants to support ACOs' ability to engage with specialists
- Data will promote ACOs to base referral decisions on specialist performance
- CMS wants to increase specialist participation in accountable care

Providing shadow bundles is the first step in advancing specialty value-based care. CMS has laid out its strategy (**Exhibit 1**). Giving ACOs access to the data is the first step, which will quickly (2-3 years)

[1] https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper).
[2] https://www.youtube.com/watch?v=XdHHmBT2qbA&t=123s)

be followed by mandatory bundled payment models[3] for specialists. All this in an effort to get to steps 3 and 4 where primary and specialist care will be "exceptionally coordinated".

Exhibit 1



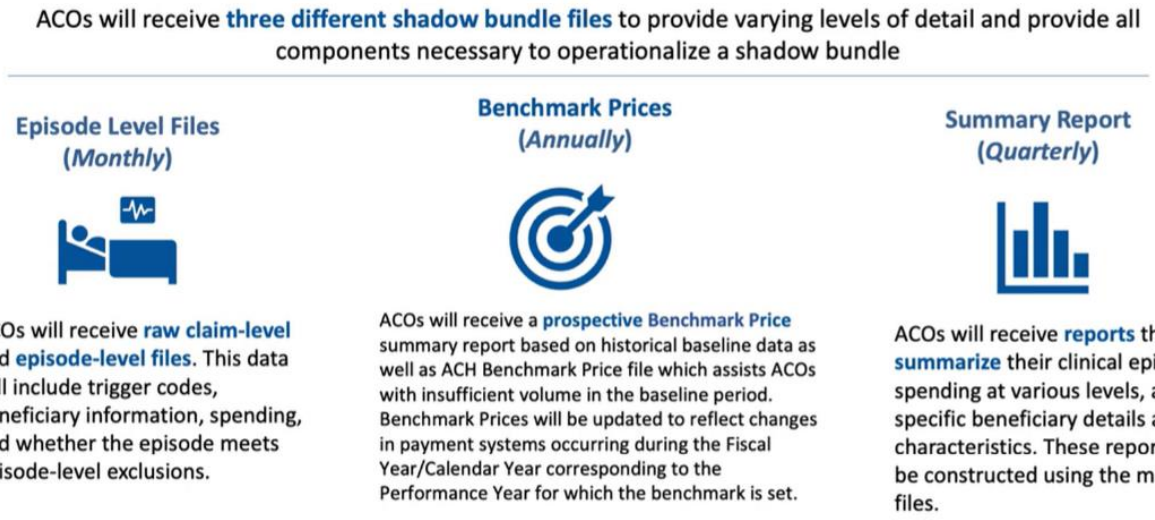
Other CMS Innovation Center (CMMI) programs are also building in requirements for specialty providers. The Making Care Primary (MCP) model requires Primary Care Physician (PCP) participants to establish Specialty Care Partners. Starting in Track 2, MCP will require participants to sign a Collaborative Care Arrangement (CCA) and develop a coordinating relationship with at least one Specialty Care Partner[4].

What data will ACOs get?

- Unique benchmark pricing for each clinical episode category
  - If the ACO generated 41 or more episodes for a category, they will get a unique ACO/ Acute Care Hospital (ACH) benchmark otherwise they will get an ACH level benchmark.
- Patient case mix (severity outside provider control)
- Persistent differences in patient care mix adjusted spending across peer groups
- Projected trend based on the peer group
- Data files (**Exhibit 2**)
  - Episode level files (monthly)- taking Claim and Claim Line Feed (CCLF) data, already received by the ACO, and reconstructing through an episode of care lens. It will show the episodes for their attributed beneficiaries for that month.
  - Benchmark price files (annual) - prospective benchmark price
  - Summary reports - quarterly (most turnkey)

[3] https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care
[4]https://www.cms.gov/priorities/innovation/mcp/faqs#:~:text=Making%20Care%20Primary%20(MCP)%20is,for%20cost%20and%20quality%20outcomes.)

Exhibit 2



How can ACOs use this information to start shifting risk to providers?

It is going to be hard for an ACO to develop risk-sharing arrangements for 34 conditions across two places of service. Even rolled up to CMS's eight Service Line Groups (SLGs), there are still many services. If there are three specialty practices in the region, that could be 24 different negotiations. If the ACO operates in multiple regions across multiple states, the numbers add up quickly.

For the specialist group or provider in an urban county, there could be five to ten or more ACOs participating, so they would have to negotiate with each ACO. This many-to-many relationship does not create efficiency. It would seem logical for CMS to manage specialty bundles directly, but there could be multiple issues hindering their ability to execute on it.

On top of that, CMS is not performing any reconciliation of the data or giving the final adjustments Patient Case Mix Adjustment (PCMA) or Peer Group Trend (PGT) that would be done in the BPCI advanced program. They are just giving a preliminary estimate.

All is not lost; these data still provide value if used correctly. Remember this is only step 1 in CMS's pathway. There is always a spectrum to transferring risk. On the lower end of that spectrum, there could be options for pay for reporting, pay for quality, or pay for performance without shifting any downside risk. These could be a good first step that gets the ball rolling for future arrangements. To do this ACOs need to identify areas of opportunity to start creating partnerships and start understanding current and potential future referral patterns.

Identifying Areas of Opportunity

How can ACOs engage the specialists/ACHs that could make the biggest impact? Map out the data into a two-by-two grid of volume vs. opportunity. What are the total dollars associated with the procedure and which procedures need the most improvement compared to the benchmark? Pick a few of the high volume / high opportunity procedures and dive deeper into the data.

Exhibit 3

Now that your ACO has identified the most impactful bundles, start thinking about how to use them.

- What are the relationships between the ACO's PCPs and these ACHs and specialists? Are they both a part of a clinically integrated network (CIN), have they been referring to each other for years, or is this a new relationship?
- What hospital affiliations do these specialists have? Is there a cost or quality difference in regions where there is more than one hospital?
- What is driving the higher costs; is it the ACH, post-acute, re-admissions? Break down each component of the bundle and compare it to the benchmark data. What is sticking out?
- Are there other specialist groups in the area that are outside the current referral patterns of the ACO? Your data only reveals your patterns, but what are other ACOs or FFS members doing in the region? Layering on external data can help fill in the missing pieces for specialty services in a particular region.

Answering some of these questions helps create a path forward to extracting value out of the shadow bundle reporting packages.

Understanding Current and Future Referral Patterns

PCP and hospital-based ACOs will be on different paths to achieving CMS’s four-step goal of creating financial incentives to actively manage specialty care.

Success is going to be viewed differently for ACOs based on the mix of specialists in their practice. For ACOs with formal relationships with specialists and ACHs, the strategy may be less complicated.

Consider the below example of three providers in the area:

Table 1 - ACOs Where Specialty Exists Within Practice

Specialist	In Service Area	Historical Referral	In Practice	Cost Per Episode
Specialist A	**Y**	**Y**	**Y**	$9,000
Specialist B	**Y**	**Y**	**N**	$11,000
Specialist C	**Y**	**N**	**N**	$8,000

For this ACO, there may not be proper incentives to develop a relationship with the lowest-cost specialist in the area. However, the ACO has an advantage since it already has a relationship with an affiliated specialist and both the PCP and specialist are financially aligned through the ACO. It may not be getting the lowest cost specialist/ACH, but the shadow bundle data could encourage the ACO to start new conversations with its affiliated specialists.

PCP-led ACOs that have fewer specialists in the practice will need to focus on developing relationships with a preferred set of specialists. Within the BPCI program, there are 34 different bundles, covering eight specialties and many sub-specialties. ACOs will need to identify a preferred specialist for bundles so that the administrative burden is not too excessive to compete in this program.

Consider a similar example listed below:

Table 2 - ACOs Where Specialty Does Not Exist Within Practice

Provider Specialist	In Service Area	Historical Referral	In Practice	Cost Per Episode Surgery
Specialist Provider A	**Y**	**Y**	**N**	$9,000
Specialist Provider B	**Y**	**Y**	**N**	$11,000
Specialist Provider C	**Y**	**N**	**N**	$8,000

In the first scenario, it was clear that the hospital based ACO would continue contracting with Provider A for the shadow bundle program. In the second scenario, Provider C is the lowest cost option, however, the ACO's beneficiaries have historically only seen Providers A & B. The ACO needs to identify Provider C through other means if they want to maximize their savings. Access to external data may be required to understand all potential referral patterns for each of the 34 shadow bundles. A tool like Wakely's Referring Benchmark Tool that can summarize all referral pathways along with potential costs can help ACOs maximize PCP / specialist relationships.

Once you have identified areas of improvement start slow.

Resources are limited, and ACOs must weigh new interventions with their current initiatives. ACOs can take a play out of CMS's book. When rolling out new programs or initiatives, they start with pay for reporting, then pay for performance, and then get to risk-sharing arrangements. Remember, releasing these data was only step 1 in CMS's plan to get specialists more involved in risk-based contracts.

Please contact Zach Davis at zach.davis@wakely.com with any questions or to follow up on any of the concepts presented here.

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

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