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What We Are Reading

Synopses of recent studies in health services research
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Variation in Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking

Take Away Points

- Medicare spending levels vary widely in the differences between ACOs and local non-ACO providers after standard case-mix adjustment.
- CMS's movement away from providing incentives based on a historical benchmark of past performance (do better than your own past) to a regional benchmark (do better than your neighbor) may inadvertently cause ACOs that still have high spending to leave the program.
- The authors proposed that this transition for reimbursement should be done gradually and thoughtfully to avoid the unintended consequences.
- Use of health characteristics data from CAHPS surveys could enhance risk adjustment and help mitigate unreasonable incentives for patient selection and upcoding, thus limiting potential negative impacts of new ACO benchmark methodologies.

Source

Rose S, Zaslavsky AM, and McWilliams JM. (2016). Variation in Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking. *Health Affairs*. http://content.healthaffairs.org/content/35/3/440.short

The Issue

Medicare accountable care organizations (ACOs) programs exemplify federal efforts to transition from paying providers by fee-for-service to alternative models intended to reward more efficient and quality care. The Centers for Medicare and Medicaid Services (CMS) sets a financial benchmark (or spending target) for each ACO. Providers' share in savings achieved compared to a projected benchmark, if they also meet required quality metrics for their patient population.

CMS current rule on setting the benchmark for ACOs in Medicare Shared Savings Program (MSSP):		
Benchmark (based on historical spending levels):	**Reimbursement**	**Potential Unintended Consequences**
Initial 3-year contact • Set at the average level of Medicare spending for patients served by the ACO during its preceding 3-year baseline period • Updated each contact year based upon national fee-for-service Medicare spending growth since the baseline period 3-year period "Rebase" • Most recent 3-year period serves as the basis for resetting ("rebasing") its benchmark for its next 3-year contract period	If an ACO keeps spending for an attributed population of Medicare patients sufficiently below its benchmark, it shares in the savings with Medicare, with the proportion of savings received by the ACO determined by how well it performed on a set of quality measures.	• Decreases incentives for ACOs to reduce spending • Penalizes ACOs with lower benchmarks (instead of rewarding) in the next contract period

The process by which CMS set the ACO benchmark policy evolved over time and is critically important to the viability of CMS's voluntary ACO programs. Benchmarks must offer sufficient incentive to encourage participation, improve quality, and generate savings (and corresponding rewards for providers), while also achieiving fiscal goals and minizing unintended consequences, such as penalizing ACOs for treating sicker patients.

Addressing concerns that current benchmarking methodology disproportionately rewards ACOs that are more inefficient at baseline and does not reward ACOs for maintaining spending levels below a benchmark, CMS proposed changes to the benchmark methodology, which include:

- Transitioning benchmarks closer to the level of risk-adjusted fee-for-service spending in a provider's geographical area instead of past history. By blending an ACO's rebased historical average spending after its intial contract period with the average risk-adjusted spending in its region, the ACO will be increasingly compared to its regional competitors over successive contract periods.
- Weakening the link between an ACO's benchmark and its prior savings will strengthen incentives for participating providers to generate savings due to the fact that regional spending is determined by all providers in an area.

Major challenges with CMS' proposed measures, which aim to converge benchmarks between ACOs with baseline spending above versus below local average fee-for-service spending, include:

1) Excessively rapid convergence could cause ACOs with higher baseline spending to leave the program as benchmarks fall below their reach, especially for the ones participating in two-sided risk contracts. Rapid convergence could also discourge ACOs with high spending from entering two-sided risk contracts.
2) Substantial convergence could lead to particularly generous benchmarks for ACOs with low baseline spending. Such benchmarks could reward already efficient ACOs for just maintaining the status quo, thereby partially or fully offsetting any savings to Medicare from the ACO programs
3) Methodologies that move away from using traditional, historical ACO spending rates must rely more heavily on risk adjustment to ensure that ACOs are not unfairly penalized for higher spending due to having sicker beneficiaries. The risk adjustment must be adequate so ACOs are not incentivized to attract healthier patients, rather than push to become more efficient.
4) ACOs have incentives to code more intensively (or "upcode") as a means to increase their spending benchmarks.

The purpose of this study was to analyze Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Medicare claims data to estimate differences between each ACO's spending and the spending of other, non-ACO providers in a geographic area, after standard case-mix adjustment.

Study Methods and Design

Data was gathered from the CAHPS survey of fee-for-service Medicare beneficiaries and the survey participants' linked Medicare claims from 2011 to 2012. Analyses included examining the amount of variation across ACOs, in the difference between an ACO spending level and local average spending for beneficiaries not attributed to an ACO, adjusting for beneficiaries' demographic characteristics and

Hierarchial Condition Category (HCC- predicts annual spending based on diagnosis codes in the prior year of claims) model score. Researchers also assessed the impact of health characteristics measured in the CAHPS survey on the variation of ACO spending deviations.

The primary outcome variable was total Medicare spending in the concurrent (survey) year.

Key Findings and Limitations

- Analysis of 2011-2012 CAHPS survey participants and their linked Medicare claims revealed differences in Medicare spending between ACOs and local non-ACO providers varied greatly. Even after adjustment for patient characteristics gathered from claims and CAHPS survey data, ACO spending deviations from local averages exhibited a spread of $858 per beneficiary from the 10th ($449 less) to 90th ($409 more) percentiles of ACOs (nearly 10% of mean per beneficiary spending).

"Measures to equilibrate benchmarks between ACOs with high and low baseline spending [including a transition to regional benchmarks] should be implemented gradually."

- These findings suggest a need for caution as CMS considers a policy proposal to transition benchmarks based on regional fee-for-service spending instead of solely based on organizations' past history.
- Risk adjustment with survey measures from CAHPS meaningfully reduced the variation in ACO spending deviations by 10%, and may be an important risk-adjustment approach. Survey measures of patient health may be useful for limiting ACO gains from upcoding (when a provider submits codes for diagnoses or procedures in order to increase risk-adjusted benchmarks) and mitigating the potential unintended consequences of new benchmarking methodologies for ACOs serving sicker patients. Self-reported health status on surveys helps validate the true status of patients in an ACO.
- **Limitations**: The sample was limited to CAHPS survey respondents which limited the precision of the estimates of variation. Nonresponse to the CAHPS survey (response rate of 52.9%) led to lower mean spending in the CAHPS sample which likely led to underestimate ACO variation in spending deviations. It was impossible to determine the extent to which variation in ACO spending deviations reflected variation in efficiency versus variation in other unmeasured patient characteristics, relative to local non-ACO providers.

Final Thoughts

- Many in the health care policy field believe 2016 will be a pivotal year as policies are set regarding Medicare reimbursement.
- CMS is attempting to succeed at a difficult balancing act in efforts to set ACO benchmarks that reward continuous improvement as well as attainment of financial goals.