Improving Accountable Care Organization (ACO) beneficiary assignment

David Glass, Luis Serna, Jeff Stensland

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MEDPAC

Roadmap

① **ACO background**

② Concerns with TIN-level assignment

③ Concerns with retrospective assignment

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 over the benchmark the difference ("losses") is:
    - One-sided model losses absorbed by Medicare
    - Two-sided model losses shared between Medicare and the ACO

Medicare Shared Savings Program (MSSP)

- 518 ACOs, 10.9 million beneficiaries in 2019
- New rules went into effect in 2019
  - Two new tracks BASIC and ENHANCED
  - Faster movement toward two-sided risk
  - In 2019 most ACOs still in one-sided models

Did ACO models achieve 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 ACO model did not exist)
- MedPAC found (June 2019), 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 ACOs had higher spending growth than those who were not (health event leads to higher spending and more frequent change in assignment)
- Over all ACO models, studies estimate 1 to 2 percent savings; about 1 percent after shared savings payments

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Definitions

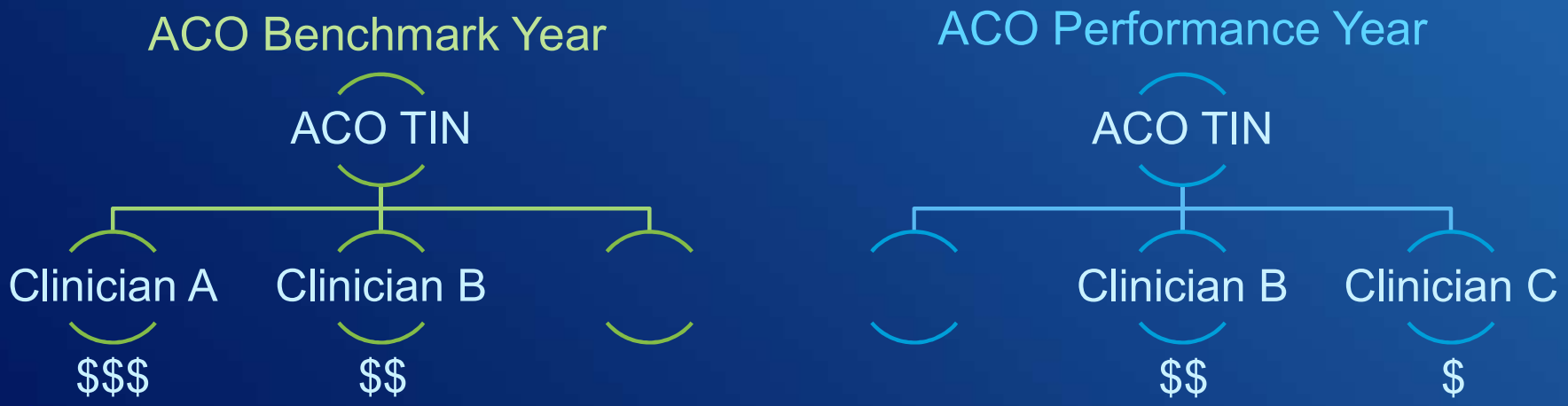
- NPI = National Provider Identifier
  - Each clinician has exactly one NPI
- TIN = Taxpayer Identification Number
  - TIN can range from single physician in a single office to a multi-state integrated delivery system with many NPIs
- MSSP ACO = a collection of one or more TINs
  - Beneficiaries are 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

- TINs used for benchmark and performance spending:
  - 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 combination of TIN and NPI to designate participating clinicians
  - Benchmarks correspondingly change when clinicians are removed from TINs
- TIN/NPI combination and TIN-level benchmarks have overlapping concerns
  - If NPIs are added to TINs, benchmarks do not change
  - If NPIs selectively bill expensive patients using a TIN outside the ACO, benchmarks do not change

Using NPI for ACO beneficiary assignment may reduce unwarranted shared savings

- NPI-level benchmarks would most accurately capture historical spending
- All changes in performance year clinicians correspond with changes in the clinicians used for historical spending
- A clinician who joins an ACO after having moved from a different market would need to have those claims removed from benchmarks
- A clinician's claims could only be used for assignment to a single ACO (can continue to treat any beneficiary)

Redefining ACOs on the basis of clinicians' NPIs

Options for defining ACOs

ACO Definition	Potential inaccuracies	Unintended incentives
Collection of TINs	Benchmark does not change if clinician (1) leaves TIN, (2) joins ACO through existing ACO TIN, or (3) selectively bills using a TIN outside of ACO	ACO could remove high-cost clinician and beneficiary or add low-cost clinician and receive unwarranted shared savings
Collection of TIN/NPI combinations	Benchmark does not change if clinician (1) joins TIN or (2) selectively bills to a different TIN	ACO could add low-cost clinician or bill for high-cost beneficiary through different TIN and receive unwarranted shared savings
Collection of NPIs (i.e., clinicians)	Benchmark could include claims from outside the ACO's service area, unless those claims were excluded	Physicians used for assignment would not be able to be participants in multiple ACOs

Source: Analysis of MSSP program rules for benchmark calculations.

Results preliminary; subject to change

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Advantages of prospective and retrospective assignment

- Advantages of retrospective assignment
  - ACO never responsible for the spending of patients its clinicians did not see during the performance year
- Advantages of prospective assignment
  - ACO never responsible for beneficiaries its clinicians have not previously seen
  - ACO knows beneficiaries with certainty at beginning of year
  - Ensures more accountability for decedents
  - Mitigates unwarranted shared savings from targeting low-spending patients at the end of the year (e.g., wellness visits)

Retrospective assignment may exacerbate spending differences after assignment changes

- In our June 2019 report, we found that MSSP beneficiaries who were retrospectively assigned:
  - Often gained assignment or lost assignment based on significant changes in health care use (e.g., hospitalization)
  - Had far higher spending when they gained assignment (joiners) or lost assignment (leavers) to an ACO relative to those who remained in the ACO (stayers)
- Are spending differences between stayers, leavers and joiners reduced under prospective assignment?

Prospective assignment reduces potential rewards for selection

MSSP Assignment	Number of beneficiaries (millions)			2017 Per-beneficiary spending		
	Assigned 2016-2017 (stayers)	Dropped in 2017 (leavers)	Added in 2017 (joiners)	Stayers	Leavers	Joiners
Retrospective	4.3	1.4	1.7	$10,795	$14,879	$13,014
Simulated Prospective	4.0	1.2	1.9	$11,684	$13,104	$11,924

Source: MedPAC analysis of CMS data on MSSP assignment and beneficiary spending.
Note: MSSP (Medicare Shared Savings Program). Data includes 364 Track 1 and Track 2 Accountable Care Organizations (ACOs) in 2016-2017. Beneficiaries only included who were eligible for assignment in both years. Patterns in improved spending parity persisted when examining (1) Track 3 ACOs or (2) risk score-standardized spending. Results are preliminary and subject to change.

Discussion

- Should prospective assignment be mandatory for MSSP?
- Should MSSP use the NPI instead of TINs to identify clinicians in ACOs?
- Other policy ideas related to assignment?