

# Benchmark incentives for accountable care organizations

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# Roadmap for today's presentation

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- Current accountable care organization (ACO) landscape
- How ACO benchmarks are set
- ACO benchmark challenges for the Commission to consider

# The Medicare shared savings program (MSSP)

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- Began in mid-2012 and (as the only permanent ACO program) is the largest ACO program
- In 2021, consists of 477 ACOs with 10.7 million assigned beneficiaries
- Evaluations show gross savings to Medicare likely exceeded “shared savings” payments to ACOs over the entire 2012-2016 period
- In 2019 and 2020, “shared savings” payments dramatically increased, making net savings unlikely

# NextGen and Direct Contracting

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- Have higher levels of risk and reward and prospective payments relative to MSSP
- The Next Generation ACO program (NextGen) is running from 2016-2021 and currently has 35 ACOs
- Evaluations show NextGen generated modest gross savings that were exceeded by shared savings payments
- NextGen will be succeeded by *Direct Contracting*, which began in April 2021 and offers options for full capitation and risk

# How Medicare sets ACO benchmarks

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- Shared savings and losses determined by comparing per capita Part A and B expenditures for beneficiaries assigned to an ACO with the ACO's benchmark
- Two major benchmark components:
  - Baseline spending—Expenditures for comparable beneficiaries who would have been eligible for ACO assignment during the baseline years
  - Performance year updates—The allowed growth in spending (using risk scores and trend factors) for an ACO between the baseline years and the performance year

# Baseline spending in ACO benchmarks

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- **MSSP:**
  - Three-year fixed baseline period (e.g., baseline period 2017-2019 for an agreement period that starts in 2020)
  - At the end of five-year agreement period, benchmarks are rebased (i.e., updated) using the three most recent years—regional spending incrementally blended with ACO historical spending
- **NextGen and Direct Contracting:**
  - Rolling baseline period with a one-year lag between the baseline period and performance year
  - Benchmarks annually rebased using multiple years (three years in Direct Contracting) —regional spending incrementally blended with ACO historical spending

# Performance year updates in ACO benchmarks

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- **MSSP:**
  - Baseline spending increased up to 3 percent for differences in an ACO's risk score
  - Spending trended forward retrospectively using a blend of regional and national spending growth rates
- **NextGen and Direct Contracting:**
  - Baseline spending adjusted up to (+/-) 3 percent for differences in an ACO's risk score
  - Spending trended forward prospectively (one year) by projected national spending for the assignable population

# Rebasing and trending can penalize ACOs that achieve gross savings

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- Ratcheting effect: ACO gross savings result in lower spending levels that become part of an ACO's baseline spending benchmark (when rebased) and trend factor (in MSSP)
- If ACOs consistently produce savings for Medicare and benchmark levels decline, ACOs would have to continuously find new efficiencies—putting long-term ACO participation at risk



# Current benchmark incentives are imbalanced

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- Ratcheting effect can reduce the incentives for ACO gross savings while keeping undesirable incentives for Medicare, such as:
  - Benchmarks reward increased coding-induced risk score growth—undermining risk adjustment
  - Rebasing has increasingly incorporated regional spending into benchmarks—rewarding ACOs that are already efficient relative to their region (without additional savings)

# Abundant benchmark policy changes have not fully balanced incentives

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- Recent examples of ACO benchmark policy changes:
  - Historical baseline spending to a regional blend
  - MSSP: National spending trends to blend of regional and national spending trends
  - MSSP: Rebasing every 3 years to rebasing after 5 years
  - NextGen/Direct Contracting: Fixed baseline to rolling baseline
  - MSSP: Stringent coding policies to some coding allowed
  - NextGen/Direct Contracting: Some coding to full coding adjustment
- Changes in policy have not removed the ratcheting effect and net savings are increasingly unlikely

# Alternatives that indirectly limit benchmark ratcheting

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- One alternative: Slowly blend in the rebased benchmark (e.g., in MSSP, full rebasing in year 10 of second agreement period)
- A second alternative: Rebase using a three-year lag between the baseline period and the first performance year in an agreement period
- However, these alternative only delay the effect of benchmark ratcheting

# Administrative trending as an alternative that directly limits ratcheting

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- Avoid rebasing and ratcheting by using an administratively set trend factor (based on GDP growth, discounted Medicare fee-for-service spending growth, or another metric)
- ACO gross savings could create an increasing “wedge” between benchmarks and reduced actual program spending
- If benchmarks do not surpass counterfactuals (i.e., spending in the absence of ACOs) both ACOs and the Medicare program may be able to share in the savings
- Could allow for greater predictability in benchmarks while aligning with policy goals

# Challenges of using administrative trending

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- Relies on reasonable approximation of projected program savings several years into the future
- Initial baseline spending susceptible to random variation in spending changes (particularly for small ACOs)
  - ACOs could be rewarded or penalized for one-time changes in spending policy, practices patterns (e.g., long-term care hospital closures, new medical technologies) or changes in beneficiary assignment
  - Potential selection bias: ACOs with a favorable benchmark would be more likely to stay in while those with unfavorable benchmarks may not participate or drop out altogether
- Coding intensity and selection incentives remain

# Conclusion

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- ACO gross savings are likely being surpassed by shared savings payments (i.e., ACO programs are not likely currently generating net program savings)
- Abundance of benchmark policies have not fully balanced incentives—especially the ratcheting down of benchmarks
- Current policy diminishes the long-term incentives for ACOs to achieve savings while rewarding ACOs for activities that do not improve care delivery (e.g., coding)

# Discussion

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- Do concerns about the long-term downward ratcheting effect necessitate a new method for updating benchmarks?
- Should the Commission develop ideas around setting administrative benchmark updates?
- How should ACO benchmarks be adjusted to account for changes in risk scores and coding intensity?
- Are there other alternatives to address benchmark challenges?