NAACOS Summary of the ACO Chapter in the June 2019 MedPAC Report

Background and NAACOS's reaction: The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency that advises Congress on issues affecting Medicare, primarily payments to private health plans participating in Medicare and payments to providers in the traditional fee-for-service program. The 17-member commission meets monthly between September and April and publishes two reports a year; March and June. MedPAC's June report devotes an entire chapter to ACOs and assess the performance to date of the Medicare Shared Savings Program (MSSP). The full report is available here and the ACO chapter here. MedPAC also devoted a chapter to ACOs in its June 2018 report, which NAACOS summarized here.

NAACOS continues to be pleased with MedPAC's work to support to prolonged success of ACOs. We are particularly appreciative of MedPAC's findings that the MSSP has lowered Medicare spending by 1 percent to 2 percent from 2012 to 2016. This represents a substantial amount of savings to the federal government and is further proof of the benefits ACOs bring patients and Medicare. NAACOS issued a press release on the report, highlighting need for Congress and the Centers for Medicare & Medicaid Services (CMS) to work to ensure the long-term viability of Medicare ACOs and enact positive changes to increase participation to help grow savings and improve quality.

Spending Effect of MSSP

As MedPAC stated in its 2018 report and NAACOS argued in the past, the 2019 report acknowledges that comparing ACO performance to their established benchmarks cannot be taken as an estimate of ACO savings. Instead, the impact on Medicare spending requires use of a "counterfactual," or analysis of Medicare spending in the absence of ACOs. MedPAC conducted such an analysis using an intent-to-treat approach for the 2019 report. Using this approach, MedPAC found Medicare spending growth was 1 to 2 percent lower than it would have been without the MSSP from 2012 to 2016. Savings were somewhat larger for physician-only ACOs compared to ACOs with hospitals. MedPAC's findings do not account for shared savings payments.

However, MedPAC found that how treatment and comparison groups are defined can affect the magnitude and validity of estimated savings. Specifically, the commission's report noted that beneficiaries who switched into and out of ACOs – which it calls "switchers" – tend to have high spending. The intent-to-treat approach MedPAC used mitigates the effect of beneficiary switching and moving of physicians into and out of ACOs.

The 'Switcher' Effect

Since switchers tend to have high spending due to changes in health status, defining study groups in a counterfactual analysis as either patients ever assigned to ACOs or never assigned to ACOs would result in lower estimated ACO savings. Conversely, examining ACO composition during just 2016 would place switchers in a comparison group (since high-cost patients and providers might have dropped out of the program by 2016), inflating the effects of ACOs' efforts on reducing Medicare spending. Therefore, MedPAC spent a great deal of time and effort to determine the best analytic approach.

The commission zeroed in on the 2.8 million beneficiaries who were ever assigned to ACOs at any time from 2013 to 2016. Their spending was compared to 3.8 million beneficiaries who were never assigned to an ACO from 2013 to 2016 but lived in the same market as the ACO cohort. Both groups needed to be fee-for-service patients for the entire period and had at least evaluation and management (E&M) visit each year to be eligible for MSSP assignment. Control groups were compared to treatment groups using market-level propensity scores.

The MedPAC report noted several findings in Table 6-7, which is displayed below:

- Beneficiaries who stayed assigned to the same ACO from 2013 to 2016 had dramatically lower growth compared to their market's average.
- Beneficiaries who were first assigned to an ACO in 2016 or dropped from an ACO in 2016 after being assigned to one from 2013 to 2015 had dramatically higher spending growth relative to their market's average.
- Beneficiaries who were never assigned to an ACO from 2013 to 2016 had slightly lower spending growth compared to their market's average, but still far lower than for continuously assigned ACO patients.

Changes in Beneficiaries' Spending Growth and Assignment are Related

Beneficiaries' ACO assignment	Percentage point difference in spending growth relative to the market average, 2012–2016	Number of beneficiaries in category
Assigned to same ACO in 2013, 2014, 2015, and 2016	–10.0	408,292
Assigned to same ACO from 2013 to 2015, but dropped in 2016	13.8	149,427
Switched from one ACO to another ACO during 2013, 2014, or 2015	1.2	1,777,369
First ACO assignment in 2016 to an ACO that was newly formed in 2016	2.1	183,615
First ACO assignment in 2016 to an existing ACO (started before 2016)	16.0	281,300
Never assigned to an ACO (2013–2016)	–1.3	3,838,089

Source: MedPAC analysis of beneficiary-level spending data from the CMS Chronic Conditions Data Warehouse; Table 6-7 of June Report to Congress.

Explanation of Findings

The MedPAC report states the most obvious reason for differences in spending among the four cohorts is change in beneficiary health status. If a patient falls ill, their pattern of visiting doctors would likely change. This could mean their being assigned to an ACO and then falling out of assignment, or vice versa, when use of services from ACO clinicians increases or wanes.

The commission points to a few possible causes for why continuously assigned ACO beneficiaries showed a 10-percentage point lower spending growth rate. First, these patients experienced no major change in health status, and therefore continued to see the same clinicians. Second, high-cost ACO were likely to leave the program, making it impossible to maintain assignment through 2016. Third, beneficiaries received

better coordinated care. But MedPAC dismisses this reason, pointing to the high spending growth for beneficiaries who switch out of ACOs in 2016.

In further research in the area, MedPAC explained switching ACO assignment can be correlated to new hospitalizations, new home health use, a higher frequency of E&M visits in skilled nursing facilities, and new assignment to a specialist. Table 6-9 of the chapter highlights why patients changed ACO assignment over the studied timeframe. For example, explanations could be annual changes in ACO participation, clinicians moving into and out of ACO participant practices, or ACOs seeking out patients with lower spending.

Use of Annual Wellness Visits

The MedPAC report, however, notes small changes in patient assignment could be the difference between ACOs achieving shared savings or having to pay shared losses. Because of that, the commission explored how the use of annual wellness visits can help healthier patients be assigned to ACOs using retrospective assignment.

MedPAC states that, because ACOs have access to the claims data of provisionally assigned patients, ACOs are aware of what patients are healthier and lower cost and therefore would benefit them to be assigned to their ACO if they had an annual wellness visit with an ACO participant. The commission points to data showing annual wellness visits were more likely to occur in the last quarter of the year (32 percent for ACO patients versus 25 percent for non-ACO patients) as evidence that ACOs could be using the visits to achieve favorable patient attribution.

ACOs use wellness visits at greater rates than the rest of fee-for-service Medicare. In 2016, 33 percent of ACO-assigned beneficiaries received an annual wellness visit compared to 18 percent of non-ACO patients. Physician-led ACOs conducted wellness visits at a higher rate.

NAACOS notes that annual wellness visits provide an opportunity to engage beneficiaries, identify gaps in patient care, and address those gaps.

Implications of Assignment Method

MedPAC suggests wider use, perhaps mandatory use, of prospective attribution to protect Medicare from ACOs seeking favorable patient selection through annual wellness visits. Under prospective assignment, beneficiaries are aligned to an ACO because of their history of primary care visits from three to 15 months prior. Once a beneficiary is prospectively assigned to an ACO, they will not be eligible for assignment to a different ACO, even if they obtain a plurality of primary care services from another clinician.

With prospective assignment, ACOs can still use wellness visits to identify gaps in care and address those gaps. Prospective assignment also protects ACOs from the potential of patients who become ill during the year, starts seeing a new set of doctors and becomes assigned to the ACO for the entire year, despite receiving only some care during the course of the performance period.

Conclusion and Next Steps

Unlike in some other chapters of its annual reports, including last year's ACO chapter, MedPAC does not make any definitive policy recommendations in its 2019 chapter on ACOs. For example, the commission didn't make statements about the need for changes in MSSP assignment methodology or risk adjustment. Outside of calling for wider use of prospective attribution for reasons outlined above, the report merely summarizes the commission's work to study and understand MSSP performance to date. MedPAC does, however, note that policymakers should be aware of ACOs' favorable or unfavorable selection of patients.