Examining different accountable care organization payment models

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Two new studies published online by *JAMA Internal Medicine* take a look at different accountable care organization (ACO) payment models.

The first study by J. Michael McWilliams, M.D., Ph.D., of Harvard Medical School, Boston, and coauthors used a sample of fee-for-service Medicare claims to examine changes in postacute care spending and the use of postacute care associated with provider participation as ACOs in the Medicare Shared Savings Program. The 20 percent sample of beneficiaries included more than 8.3 million hospital admissions and more than 1.5 million stays in skilled nursing facilities (SNFs).

Excessive use of postacute SNF care is thought to be a major source of wasteful spending and a target for health care professionals who participate in new payment models, such as Medicare ACO programs.

The authors report that entrance into the Medicare Shared Savings Program (MSSP) in 2012 for ACOs was associated with a 9 percent differential reduction in postacute spending by 2014 - driven by reductions in discharges to facilities, length of facility stays and acute inpatient care. Reductions were smaller for later program entrants and similar for ACOs with and without financial ties to hospitals, according to the article.

The study's limitations include that the MSSP is a voluntary program and ACOs likely differ from providers who don't participate.

"Participation in the MSSP has been associated with significant reductions in postacute care spending without ostensible changes in quality, suggesting gains in the value of health care. Postacute care spending reductions were more consistent with efforts by clinicians working within hospitals and SNFs to influence care for ACO patients than with hospital-wide initiatives by ACOs or use of preferred SNFs. Understanding such early successes can support regulatory policy that enhances rather than inhibits the effectiveness of payment and delivery system reform," the article concludes.

A second study by K. John McConnell, Ph.D., of the Oregon Health & Science University, Portland, examined early performance in Medicaid ACOs in Oregon and Colorado.

With a $1.9 billion investment from the federal government, Oregon started to transform Medicaid in 2012 by moving enrollees into 16 Coordinated Care Organizations so care was managed within a global budget. In 2011, Colorado began its Medicaid Accountable Care Collaborative by creating seven regional care collaborative organizations that were funded to coordinate care and connect Medicaid enrollees with community services, according to the article.

The authors report standardized expenditures, which have common codes across states, for selected services decreased in both states from 2010 to 2014 with no difference between the states. The Oregon model also was associated with improvements in some utilization, access and quality measures.

The study notes important limitations, including that the analysis did not include prescription drug expenditures, which is a growing portion of Medicaid spending.

"These results should be considered in the context of overall promising

trends in both states. Continued evaluation of Medicaid reforms and payment models can inform the most effective approaches to improving and sustaining the value of this growing public program," the article concludes.

More information: *JAMA Internal Medicine*, jamanetwork.com/journals/jamai … ainternmed.2016.9115

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