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The Impact of Changes in Centers for Medicare & Medicaid Services Payment Programs on Risk Scores

Abdelomonaem Abunnur[1], Thomas Shaw, Ph.D, MBA[2]

[1]MHA, School of Health Sciences,
Southern Illinois University Carbondale
Carbondale, Illinois
[2]Health Administration, School of Health Sciences
Southern Illinois University Carbondale
Carbondale, Illinois

Abstract*: This paper discusses the various payment methods that the U.S. Centers for Medicare & Medicaid Services (CMS) has introduced to reimburse health providers. Quality and costs control are the main goals of the alternative payment program. Fee for Services (FFS) was the traditional method; however, it has many criticisms due to focusing only on the volume of services. Alternative programs aim to promote integrated health care based on provider agreements to share risk. CMS used risk-adjustment methods to determine risk scores that enhance the accuracy and fairness of these payments. In 2021, under the Biden-Harris administration, CMS launched an alternative model. The new model is called the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. The introduction of this model responds to criticism about the fairness of the previous model, the Global and Professional Direct Contracting (GPDC). The new model aims to include more underserved populations in the healthcare system who may involve high risks that increase risk scores above CMS benchmarks.*

Keywords— Healthcare payment, CMS, providers, care, Medicare, and Medicaid services

Introduction

The U.S. Centers for Medicare & Medicaid Services (CMS) has introduced many payment programs in order to control and reduce healthcare expenditures and improve quality (Chernew, *et al.*, 2020). The establishment of Medicare and Medicaid programs in 1965 was combined with the introduction of the Fee-For-Service (FFS) that reimburses health providers based on their services separately. However, this program faced many criticisms because it incentivized providers to focus on delivering more volume and quantity of care rather than improving the quality of care by discouraging the utilization of integrated care (Feldman, 2015; Chernew, *et al.*, 2020). As a result, alternative programs were introduced to enhance the reimbursement system's efficiency, including value-based payments such as bundled payment or episode-based payment models, patient-centered medical homes, and Accountable Care Organizations (ACOs) (Abbey, 2009; Peck, *et al.*, 2019). In addition, CMS introduced the Medicare Shared Savings Program (MSSP) to create opportunities for physicians and health organizations to coordinate to provide more integrated care (Feldman, 2015). The Accountable Care Organization (ACO) uses a payment method that integrates the utilization of risk-sharing to promote providers' engagement in population health management. In addition, the CMS Innovation Center set a targeted per capita expenditure level as a benchmark based on the average of actual CMS expenditures on groups in prior years (Centers for Medicare & Medicaid Services, 2018). Thus, health organizations will share savings if their spending is less than the benchmark while incurring losses and risks from overspending.

Risk adjustment accounts for expected expenditures based on patients' diagnoses, and behaviors are utilized to achieve fair payments. For example, capitation payments consider an individual's previous and current health conditions to determine the financial arrangements that ensure payment accuracy and fairness (Brown *et al.*, 2014). Therefore, payments must reflect the actual health status of the population being served, especially for patients with higher needs who are usually associated with higher costs; otherwise, the plan may tend to avoid beneficiaries with these conditions (Markovitz et al., 2019). Risk scores adjusted for health conditions for individuals are calculated using specific formula accounting for more than 70 disease conditions instead of the average cost of FFS enrollees (Brown *et al.*, 2014). This calculation limits providers' incentives to enroll low-cost individuals on all dimensions (Brown *et al.*, 2014). However, the score can be affected by changing the dimensions of the formula. For example, increasing the underserved population could increase the risk scores more in low-quality contracts already enrolling high-risk individuals in the baseline (Center for Medicare and Medicaid Innovation, 2022).

Fee-For-Service (FFS)

The traditional FFS pays providers separately based on patient services, and the federal or state budget bears the risk of unanticipated healthcare costs (Hayford & Burns, 2018). CMS has assigned risk scores of around 1.0 as a benchmark based on historical spending data. Higher scores indicate unexpected healthcare costs, and lower scores mean lower expected costs. In this program, healthcare providers do not share risks with their payers if expected costs exceeded the standard.

CMS has introduced several alternative payment models to promote integrated care and risk-sharing while

reducing unnecessary medical expenditures. In these programs, providers participate in risk-sharing and bear a portion of the risks in order to receive their reimbursements. In addition, healthcare organizations have set specific goals, including improving quality, improving the population's health, and reducing costs (Center for Medicare and Medicaid Innovation, 2022; Kessell, *et al.*, 2015).

Accountable Care Organizations (ACOs)

ACOs represent groups of doctors and hospitals who voluntarily share the responsibility to provide coordinated, high-quality care while avoiding unnecessary costs. The Accountable Care Organizations (ACOs) were established by the Center for Medicare and Medicaid Innovation (CMMI) as shared savings programs as one of the value-based payment models that incentivize and reward providers to deliver integrated care that lowers healthcare costs (Kaufman, *et al.*, 2017; Feldman, 2015; Peck, *et al.*, 2019). Capitation payment methods are used in this system to substitute FFS payment programs. Insurance plans receive a flat risk-adjusted payment from Medicare and Medicaid to reimburse contracted providers. Thus, the insurance plans will bear any healthcare costs that exceed the received payments. The Medicare program established a risk-adjustment mechanism to set expected payments and determine a risk score. This score is calculated for each enrollee using the risk adjustment based on the CMS Hierarchical Condition Category (CMS-HCC) model. It aims to reduce the insurer's incentives to enroll lower-risk beneficiaries only to generate a surplus by incurring costs less than the Medicare capital payments. In addition, CMS's risk adjustment aims to enhance payment accuracy, incentivizing healthcare organizations to manage complex cases that involve high costs, such as patients with chronic diseases.

Hayford and Burns (2018) found that implementing a Medicare Advantage (MA) risk adjustment for patients assigned to medical care benefits led to an increase in the risk score by 1.2% increase per year (from 5% in 2009 to 8% in 2012) increasing providers' incentives to participate in risk-sharing. Kaufman, *et al*., (2017) found consistent associations between ACOs implementation and reduced use of inpatient services and emergency department visits. The authors also illustrated that ACOs programs focus on providing preventive care and unique treatments for patients with chronic diseases. Coordinated care assisted ACOs in shifting healthcare to low-cost settings for complex cases by promoting preventive care and disease management. It aims to assist patients, especially those with chronic diseases, in managing self-care and determining their expected behaviors based on social determinants of health (Hefner, *et al.*, 2016). Medicare's ACOs are a combination of essential elements that lower per-patient expenditures below a targeted amount of ACO programs by transferring some degree of risk to a provider group (Kaufman, *et al.*, 2017). However, ACOs are inherently heterogeneous in risk and may be influenced by many social and economic factors affecting health systems and the credibility of measures. (Patel, *et al.*, 2015). In addition, there is a concern about the impact of ACO contribution on downside risks and providing financial support to those who fail to achieve their financial goals (Peck, *et al.*, 2019).

The Medicare Shared Savings Program (MSSP) contracts

This program aims to enhance accountability by establishing incentives for ACOs to reduce Medicare Parts A and B expenses for their assigned patient groups (McWilliams, *et al.*, 2020; Feldman, 2015). The MSSPs ACOs must meet specific qualifications, such as having at least five thousand Medicare FFS designated patients and offering the ability to cut their expenses below the CMS standard for savings participation (Kessell, *et al.*, 2015; Roeder, 2018).

Based on this model, providers accept risk by accepting high-risk populations for an opportunity to participate in savings if their costs are lowered below the CMS benchmark. MSSP uses two payment methods; the first is a one-sided model in which ACOs share only the upside savings (providers share in the savings and not the risk of loss). The second method is to share two-sided savings, upside savings, and downside losses (providers share in the savings and potential losses), with high risks and higher rewards (Kessell, *et al.*, 2015). In addition, MSSP contracts are used in both public and private sectors to achieve savings on risk-sharing contracts by reducing service costs. ACOs that accept contracts with higher baseline risks are significantly more likely to generate savings than groups that only take lower-cost contracts (Berkson, *et al.*, 2018). Therefore, these savings contracts encourage ACOs to choose high-risk contracts while avoiding choosing plans that include low-risk patients (McWilliams, *et al.*, 2020). These risk scores for the selected population must be lower than the CMS criteria for group participation in cost savings (Feldman, 2015).

However, the CMS standard does not change to reflect upward or downward trends in risk scores. Therefore, the CMS's failure to adjust beneficiary risk may encourage many ACOs to avoid high-risk recipients (Markovitz, 2019).

The Medicare Primary Care First Value-Based Payment Model

CMS launched this program in 2019 and aimed to increase patient's access to healthcare services, especially for procedures related to complex chronic conditions. The program is a five-year voluntary payment option focusing on quality care by stimulating positive patient performance and prioritizing enhanced physician-patient care for patients with complex chronic needs (Center for Medicare and Medicaid Innovation, 2021). Medicare payments based on this program are designed to motivate primary care providers to accept cases with financial risks in exchange for reduced administrative burdens that lower health care costs.

This model structures its payment methods based on how participating practices deliver care. First, for standard preceding procedures that focuses on advanced primary care practices, the method assumes that healthcare providers will

accept some financial risk in exchange for greater flexibility with lower administrative burden and performance-based payments (Center for Medicare and Medicaid Innovation, 2021). The second method will provide payments that are higher than fee-for-service methods for providers who deliver care for high-need populations to provide palliative or hospice care services to seriously ill patients. This model includes about 10% downside risk in which providers share in the savings and potential losses (Peck, *et al.*, 2019).

Under the Primary Care First model, payment will be made available to providers through two payment structures: The Total Primary Care Payment (TPCP) Promotes Flexibility in Care Delivery and Performance-Based Payment Adjustment (PBA). The TPCP aims to promote flexibility in care delivery by providing hybrid payment, a professional population-based payment (PBP) and the flat primary care visit fee, that incentivizes advanced primary care while compensating practices with higher-risk patients (Center for Medicare & Medicaid Innovation, 2021). The PBA, an adjustment to the TPCP, is designed to incentivize quality improvement and cost reduction by reducing preventable hospitalizations. (Center for Medicare & Medicaid Innovation, 2021). In addition, evaluation and monitoring will be performed, focusing on improper payments of care settings (Center for Medicare & Medicaid Innovation, 2021).

Direct Contracting Entity

Direct contracting is a voluntary, population-based payment approach designed to promote the use of risk-sharing arrangements in the practice of medical care and to enable beneficiaries' engagement in their care systems. It also seeks to reduce administrative burdens and effectively enhance providers to meet healthcare requirements. Based on direct contracting, Medicare contracts directly with clinicians to provide health care services that allow providers to meet patients' health needs (Liao & Navathe, 2020). In direct contracting, reimbursement is based on the capitation method. In addition, it employs a benchmark score based on historical spending data with the adjustment for regional conditions adapted by the Medicare Advantage program (Liao & Navathe, 2020). This model has multiple sharing options and various scores of risk-sharing. As a result, providers and organizations can choose between several selection options (Liao & Navathe, 2020). One of the primary advantages of direct contracting to providers is that they can directly benefit from improving the efficiency and effectiveness of care; unlike the traditional managed care model where insurers primarily benefit from efficiencies.

Direct contracting incentivizes managed care organizations to better coordinate care of individuals dually eligible for Medicare and Medicaid (Liao & Navathe, 2020). In addition, since providers are more likely to see their relationships with patients as long-term, they might be more willing to incur costs to reduce illness in the long run. Direct contracting includes three types of risk arrangements (Centers for Medicare & Medicaid Innovation, 2020):

- The standard direct contracting entity offers contracts for entities with remarkable historical experience under previous systems, Medicare FFS.

- New entrant risk arrangements offer contracts for entities with limited experience delivering care under the FFS payment system.

- High-Need Risk contracts offer contracts for patients with complex conditions. It also focuses on individuals eligible for services under both Medicare and Medicaid, such as critically ill populations. These contracts are planned to encourage health organizations to carry both sides of risk (Center for Medicare & Medicaid Innovation, 2020). These contracts offer two risk options: the professional, a lower-risk option with a 50% shared savings or shared losses option and a global option with a 100% shared savings or shared losses (Center for Medicare & Medicaid Innovation, 2020). In addition, the Direct Contracting Model uses the CMS-Hierarchical Condition Categories (HCC) approach for setting the risk adjustment for aged and disabled Medicare beneficiaries (Center for Medicare & Medicaid Innovation, 2020). Finally, risk adjustment in these contracts is combined with the asymmetric 3% cap to limit risk score growth (Kildow, *et al.*, 2022).

Global and Professional Direct Contracting (GPDC) Model

GPDC is a voluntary method designed to encourage patients to engage in the health care system, and it has two goals: replacing Medicare Fee-For-Service payment with risk-sharing arrangements (CMS.gov, 2022). GPDC offers either total or partial capitation payments to encourage providers to shift away from traditional FFS payments. In addition, the GPDC model aims to expand provider participation in integrated care systems that encourage recipients to engage in voluntary health care. Finally, the GPDC model also seeks to effectively reduce the administrative burden by enforcing a system that meets healthcare needs through simple procedures to measure quality. Thus, the model emphasizes voluntary alignment and beneficiary empowerment to create robust patient and provider relationships. There are two voluntary risk-sharing options under the GPDC model as described by CMS are:

- The professional option proposes a lower risk-sharing contract with 50% shared savings or shared losses. In this option, providers will be responsible for 50% of the savings or losses if the costs exceed the benchmark, while the CMS is responsible for the remaining 50%. In addition, the risk-sharing structure chosen by the Direct Contracting participant determines the kind of capitation payments. For example, for contracts with 50% shared savings or shared losses, the Centers for Medicare and Medicaid offers only one type of payment to participants, Primary Care Capitation (PCC) (Centers for Medicare & Medicaid Services, 2019).

- The global option is designed for a higher risk-sharing arrangement with 100% shared savings or shared losses. The CMS offers two payment options: Primary Care Capitation (PCC) or Total Care Capitation (TCC). The Care capitation payment amount will reflect the estimated total cost of care for services provided by the Participant and Preferred Providers while PCC payment amount will be equal to 7% of the DCE's prospective benchmark (Centers for Medicare & Medicaid Services, 2019).

  In addition, coding intensity factors (CIF) and a risk coding growth ceiling are used to limit the growth of risk scores relative to the baseline period (Centers for Medicare & Medicaid Services, 2019). CMS assumes that financial risks will encourage global ACOs to use this benefit enhancement effectively, considering their financial responsibility while maximizing beneficiary care.

The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model.

Due to criticisms that the Global and Professional Direct Contracting (GPDC) model was encountering, the Centers for Medicare and Medicaid Services redesigned the ACO REACH management model to be implemented over a six-year performance period (CMS.gov, 2022). The model concentrates on healthcare equity, encouraging financial incentives, emphasizing patient preferences, and monitoring procedures that ensure fairness in beneficiaries' accessibility to healthcare care (CMS.gov, 2022). In addition, the model was introduced to address stakeholders' considerations and provide more transparency about the features of calculating the risk benchmark based on the GPDC model. Centers for Medicare & Medicaid Services set three objectives for this model:

- Improving the quality and coordination of care.
- Creating systems for linking providers with beneficiaries.
- Increasing insurance range to include underserved beneficiaries.

ACO REACH application uses capitation payment mechanisms with other advanced payment options to reimburse providers based on risk-sharing choices. Like the GPDC model, professional and global options are two risk-sharing options. In addition, this model offers three types of ACOs:

1. Standard ACOs include organizations that have previous experiences under FFS systems with Medicare patients, including dual-eligible Medicare beneficiaries, who are aligned with an ACO through voluntary or claims-based matching. For example, these organizations may have previously participated in another CMS-shared savings program. As a result, clinicians participating in these organizations would have substantial experience serving traditional Medicare beneficiaries. A risk score will be calculated using the CMS-Hierarchical Condition Categories (HCC) risk adjustment model for each beneficiary aligned to a Standard ACO via voluntary alignment (CMS.gov, 2022).

2. New Entrant: ACOs serve entities that have not provided FFS services and wish to join a risk based TCC model that relies primarily on voluntary alignment. These beneficiaries will have a risk score calculated using the new enrollees' risk adjustment model that accounts for the beneficiary's demographic factors (CMS.gov, 2022). In addition, a risk score will be calculated using the CMS HCC model that considers risk scores for each beneficiary designated as a new entrant ACO. The standard and new entrant Direct Contracting Entities (DCEs) are not responsible for the initial reporting of diagnostic risk scores for the CMS-HCC prospective risk adjustment model (CMS.gov, 2022).

3. High Needs Populations: ACOs serve Medicare patients with complex conditions or are eligible for Medicare and Medicaid plans. These dual beneficiaries include patients with chronic or other serious illnesses with a risk score of 3.0 or more significant for the Aged & Disabled (A&D) or a risk score of 0.35 or greater for End-Stage Renal Disease (ESRD). CMS uses the Centers for Medicare & Medicaid Innovation-Hierarchical Condition Categories (CMMI-HCC) concurrent risk adjustment model to calculate risk scores for populations with high needs. This method is more accurate for forecasting the higher costs incurred during the performance year and provides a more stable financial position. In addition, the model uses demographics and diagnoses from the year of performance to forecast expenditures in the same year.

Centers for Medicare & Medicaid Services uses the CMS-HCC model for risk adjustment in standard ACOs and new entrant ACOs to predict healthcare expenditures at the group level instead of individual levels. Thus, health expenditures are expected to be less accurate for a particular beneficiary than for groups. In addition, beneficiary risk scores will use diagnoses reported before predicting costs during the Performance Year (PY). This model is different from the GPDC model in several ways:

1. All participants must focus on health equity and participate in plans for underserved communities that reduce health inequalities.

2. Emphasize the importance of provider-led organizations in which participating providers or agents must control the majority of each ACO's governing duties with voting rights compared to GPDC (CMS.gov, 2022).

3. Enforce screening protocols for applicants and closely monitor participants to ensure compliance with the protection of beneficiaries. In addition, measures to

enhance transparency and data sharing on the quality of participant care and financial performance, more robust safeguards against inappropriate coding, and growth in risk (CMS.gov, 2022).

4. Adopt performance systems to mitigate any degree of potential inappropriate risks (CMS.gov, 2022).

Conclusion

The analysis of the above methods showed that payment method changes involve different risk levels that need to be adjusted based on their population's conditions. High-risk scores indicate a costly contract and have high chances for high margin profits or significant losses. The Fee for Service system encounters accountability issues in which providers focus on volume and quantity, not outcome. In addition, participants do not share risks with their payers if expected costs exceed the standard. The Medicare Shared Savings Program (MSSP) is structured to enable Accountable Care Organizations (ACOs) to share risk and savings with Medicare. Risk score establishment depends on the degree and costs of using ACOs and the risk adjustment model used. The new ACO REACH Model differs from GPDC in many ways, including increased provider governance, Participant Providers control, a heightened focus on health equity, improvements to risk adjustment, lower discounts, and others.

Limitations

Despite the above results, the analysis may have a potential limitation, including (a) time constraints where the study was prepared in eight weeks. In addition, the ACO REACH model is a new model designed to improve the efficiency of payment systems. Therefore, there are limited resources in the literature on the effectiveness or drawbacks of this model. Related resources were gathered from PubMed (including MEDLINE), the EBSCOhost database, and CINHAL to minimize the impact of the above limitations.

References

Abbey, D. C. (2009). Health Care Payment Systems. New York: An introduction. *CRC Press*.10.1201/b10253

Brown, Jason, Mark Duggan, Ilyana Kuziemko, and William Woolston. 2014. "How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program." A.E.R. 104 (10): 3335–64.

Center for Medicare & Medicaid Innovation (2018). Medicare Shared Savings Program, Medicare Shared Savings Program, Shared Savings and Losses and Assignment Methodology. Specifications. *Version* #6. https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-1

Center for Medicare & Medicaid Innovation (2019). Direct Contracting: Professional and Global. Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/direct-contracting-professional-and-global

Center for Medicare & Medicaid Innovation (2020). Direct Contracting (Professional and Global) Frequently Asked Questions Version 3 Date: October 2020

Center for Medicare & Medicaid Innovation (2021). Primary Care First Model Options | CMS Innovation Center, Mar 16, 2021 https://innovation.cms.gov/innovation-models/primary-care-first-model-options

Center for Medicare & Medicaid Innovation (2022). The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. https://innovation.cms.gov/innovation-models/aco-reach

Chernew, M. E., Conway, P. H., & Frakt, A. B. (2020). Transforming Medicare's Payment Systems: Progress Shaped By The ACA. *Health Affair*s, 39(3), 413–420. https://doi-org.proxy.lib.siu.edu/10.1377/hlthaff.2019.01410

Feldman R. (2015). The economics of provider payment reform: are accountable care organizations the answer? *J Health Polit Policy Law*. 40(4): 745–760

Hayford, Tamara Beth, and Alice Levy Burns. 2018. "Medicare Advantage Enrollment and Beneficiary Risk Scores: Difference-in-Differences Analyses Show Increases for All Enrollees on Account of Market-Wide Changes." *Inquiry 55* (Jan-Dec): 0046958018788640.

Hefner, JL, Hilligoss, B, Sieck, C, Walker, DM, Sova, L, Song, P, McAlearney, AS. 2016. "Meaningful Engagement of ACOs with Communities: The New Population Health Management." *Medical Care*. 54(11):970-976.

Kaufman, B. G., Spivack, B. S., Stearns, S. C., Song, P. H., & O'Brien, E. C. (2019). Impact of accountable care organizations on utilization, care, and outcomes: A systematic review. *Medical Care Research and Review*, 76, 255-290. doi:10.1177/1077558717745916.

Kessell E, Pegany V, Keolanui B, Fulton BD, Scheffler RM, Shortell SM. Review of Medicare, Medicaid, and commercial quality of care measures: considerations for assessing accountable care organizations. *J Health Polit Policy Law*. 2015; 40 (4): 761 – 96.

Kildow J, Gusland C, Kramer M. J., and L C.. (2022). Evaluating the financial cost of the asymmetry in the MSSP risk score growth cap. Jessica Kildow, Cory Gusland, Matthew J. Kramer, and Caroline Li, *Milliman White Papers.*

Liao JM and Navathe AS: Direct Contracting in Medicare: Opportunity and Risk for Surgeons. Annals of Surgery. October 9, 2019 - *Volume Publish Ahead of Print-Issue* doi: 10.1097/SLA.0000000000003620.

Markovitz AA, Hollingsworth JM, Ayanian JZ, Norton EC, Moloci NM, Yan PL, et al. Risk adjustment in Medicare ACO program deters coding increases but may lead ACOs to drop high-risk beneficiaries. *Health Aff (Millwood).* 2019; 38:253-61.

McWilliams, JM, Hatfield LA, Landon BE, et al. Savings or selection? Initial spending reductions in the Medicare shared savings program and considerations for reform. *Milbank* Q. 2020; 98:847-907.

Patel, K. K., Cigarroa, J. E., Nadel, J. J., Cohen, D. C., & Stecker, E. (2015). Accountable Car Organizations: Ensuring Focus on Cardiovascular Health. *Circulation*, 132(7), 603-610.

Peck, K. A., Usadi, B., Mainor, A. J., Fisher, E. S., & Colla, C. H. (2019). ACO Contracts With Downside Financial Risk Growing, But Still In The Minority. *Health Affairs*, 38(7), 1201–1206. https://doi-org.proxy.lib.siu.edu/10.1377/hlthaff.2018.05386.

Roeder K H. A Check-Up on ACO Compliance Programs. Suggested Areas for Focused Compliance Program Risk Assessments and Follow-Up Steps for MSSP ACOs, *Journal of Health Care Compliance* — July–August 2018