Status report on Medicare Accountable Care Organizations (ACOs)

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Overview

- Background on ACOs
- Status of ongoing and completed ACO programs
- 2016 quality and financial performance
- Potential issues when setting/rebasing benchmarks
- Policy issues
Medicare ACOs

- Groups of providers held accountable for the cost and quality of care for a group of beneficiaries—if successful, rewarded with shared savings
- Goal to improve quality and slow Medicare spending growth by rewarding efficient, high-quality providers
Three key concepts

- **Composition**: What providers are in the ACO?
  - Can vary; primary care clinicians, hospitals, specialists
  - Must meet minimum attribution requirement

- **Attribution**: How and when are beneficiaries attributed to the ACO?
  - Plurality of service use
  - Voluntary alignment
  - Prospective or retrospective

- **Benchmark**: How is an ACO’s financial performance judged?
  - Expected Part A & B spending
  - One-sided and two-sided risk arrangements
Medicare ACO models

- Permanent ACO models: Medicare Shared Savings Program (MSSP), Tracks 1-3
- CMS Innovation Center demonstrations:
  - Pioneer ACO demonstration (ended 2016)
  - Next Generation (NextGen) ACO demonstration
  - End-Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs)
  - Medicare ACO Track 1+
  - Vermont All-Payer ACO
Number of Medicare ACOs growing

Approximately 10.5 million beneficiaries attributed to ACOs in 2017

Source: CMS data.
ACO quality assessed predominantly on process measures

- ACOs have consistently high **overall** quality scores
- But in all ACO models, more than half of measures are process measures
- On population-based outcome and patient experience measures, ACOs maintain at least average results
  - MSSP ACOs: Slightly higher performance on readmissions measure compared to FFS
  - ESCOs: Patient experience similar to national average
ACO financial performance by ACO model, 2016

Source: CMS data.

Results preliminary and subject to change.
Two-sided models resulted in net savings to Medicare, 2016

Source: CMS data.

Results preliminary and subject to change.
Shared savings more likely for MSSP ACOs with higher historical service use

Note. Excludes 38 ACOs serving beneficiaries in multiple states that do not share a border (e.g., an ACO serving beneficiaries in both New York and California). Source: CMS data.

Results preliminary and subject to change.
ESCOs generated savings in 2016

Results preliminary and subject to change.

Source: CMS data.
Two-sided risk models generate more savings for Medicare

- ACO savings relative to CMS benchmarks
  - One-sided: MSSP Track 1 (-0.1%)  
  - Two-sided: MSSP Track 2 and 3 (0.7%), Pioneer (0.7%), NextGen (1.2%), ESCOs (1.7%)

- Other researchers find savings relative to comparison groups
  - McWilliams et al. (2015, 2016): MSSP savings 0.7%, Pioneer savings 1.2%
  - Office of Actuary (2015): MSSP savings 1.2%, Pioneer savings 2.1%

- All find ACOs at two-sided risk have savings greater than ACOs at one-sided risk
Potential issues when setting/rebasing benchmarks

- What policy goals should be incorporated into benchmarks?
  - Equity within a market (rewarding efficient vs. inefficient ACOs within a market)
  - Equity across markets (high-use markets vs. low-use markets)
  - Equity over time

- Should benchmarks factor in our finding that beneficiaries who move in and out of ACOs have different rates of spending growth?
Policy issues

- How should assessment of ACO quality be changed to be more consistent with MedPAC’s quality principles?
- How should benchmarks be set to correctly incentivize ACOs and keep them in the program long-term?
- How do we better encourage ACOs to take on two-sided risk?
- Should voluntary alignment be encouraged to stabilize attribution?