Status report on Medicare Accountable Care Organizations (ACOs)

David Glass, Sydney McClendon, and Jeff Stensland

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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

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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

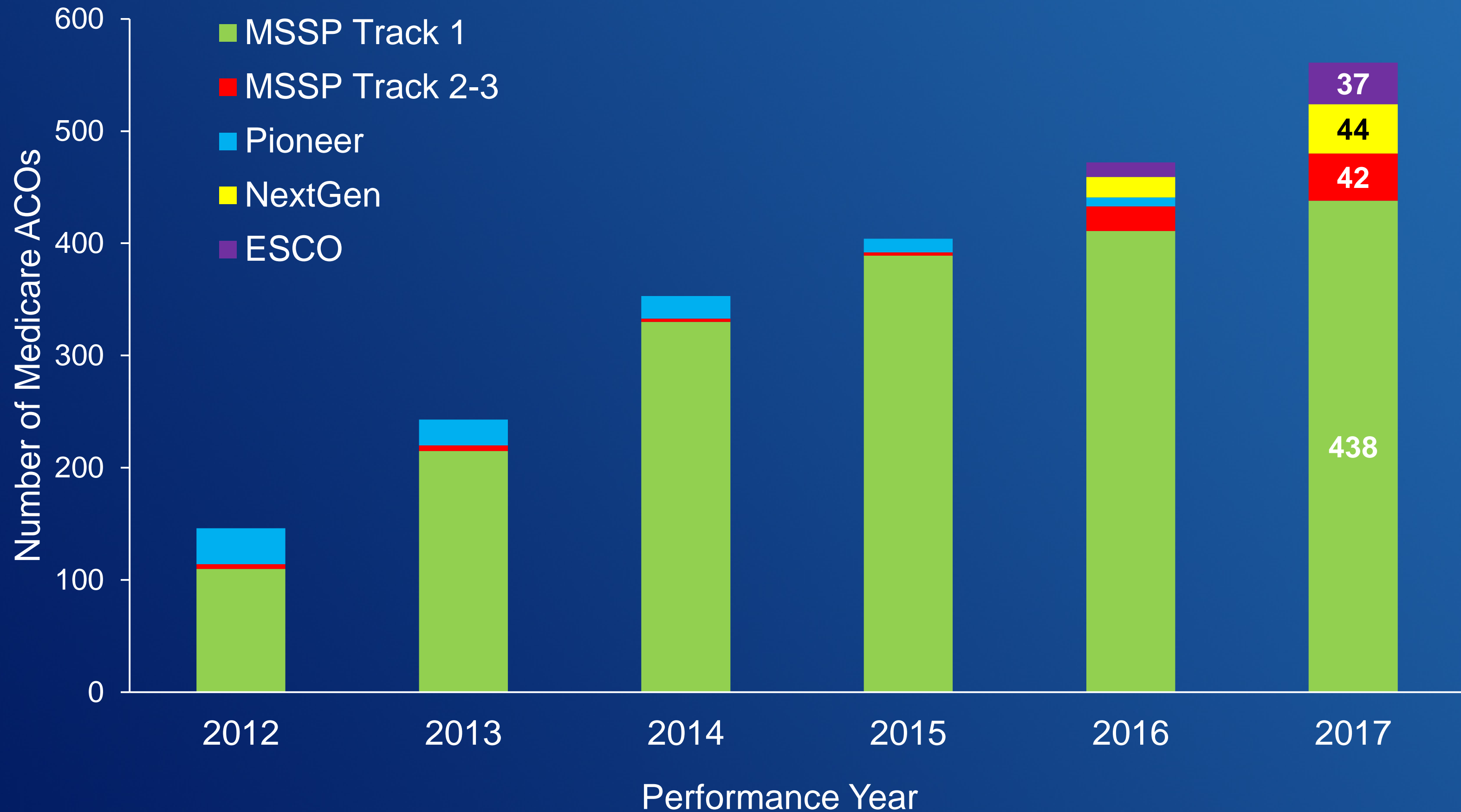
Three key concepts

- 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

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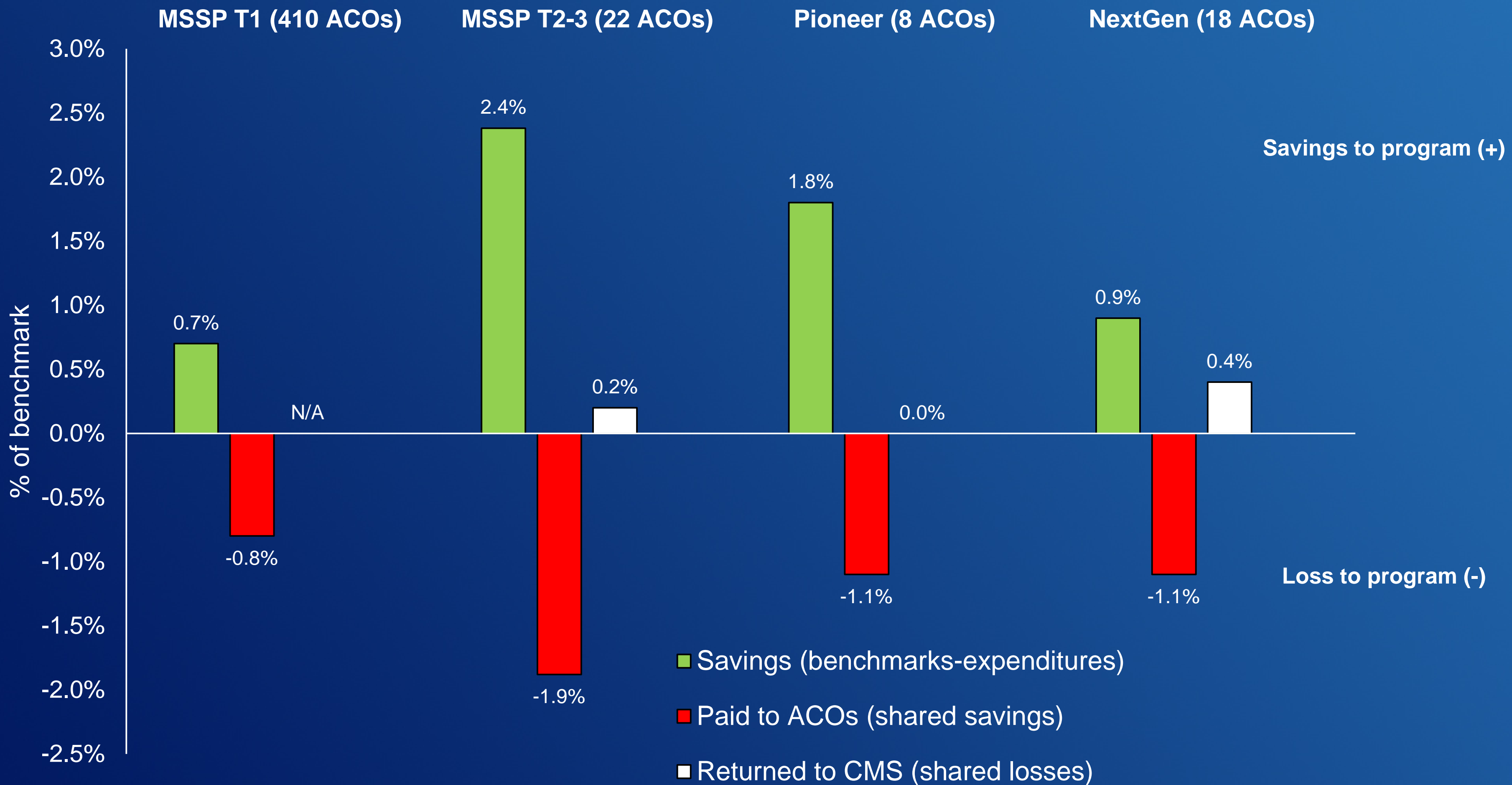
Source: CMS data.

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

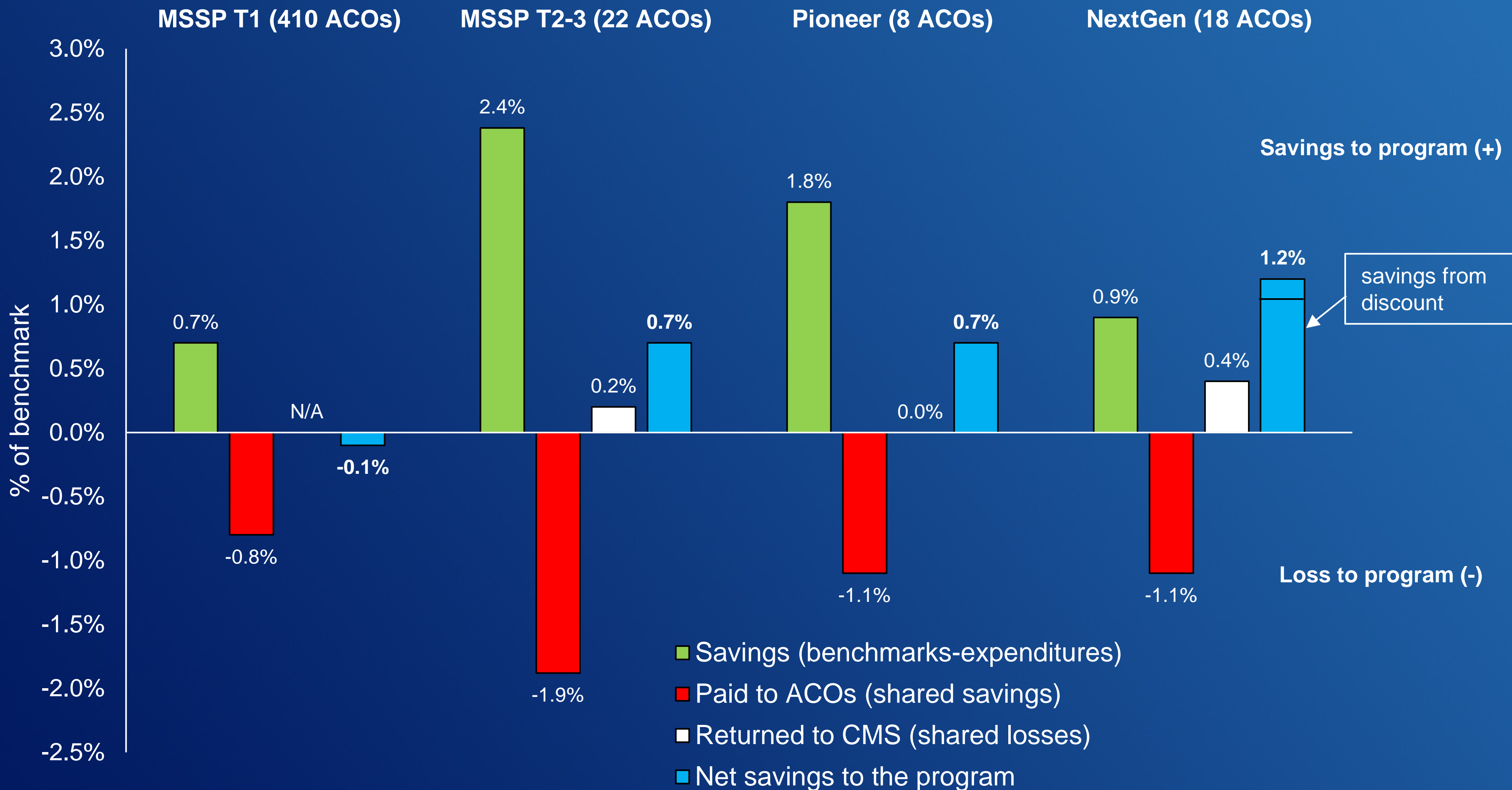
ACO financial performance by ACO model, 2016



Source: CMS data.

Results preliminary and subject to change.

Two-sided models resulted in net savings to Medicare, 2016



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Source: CMS data.

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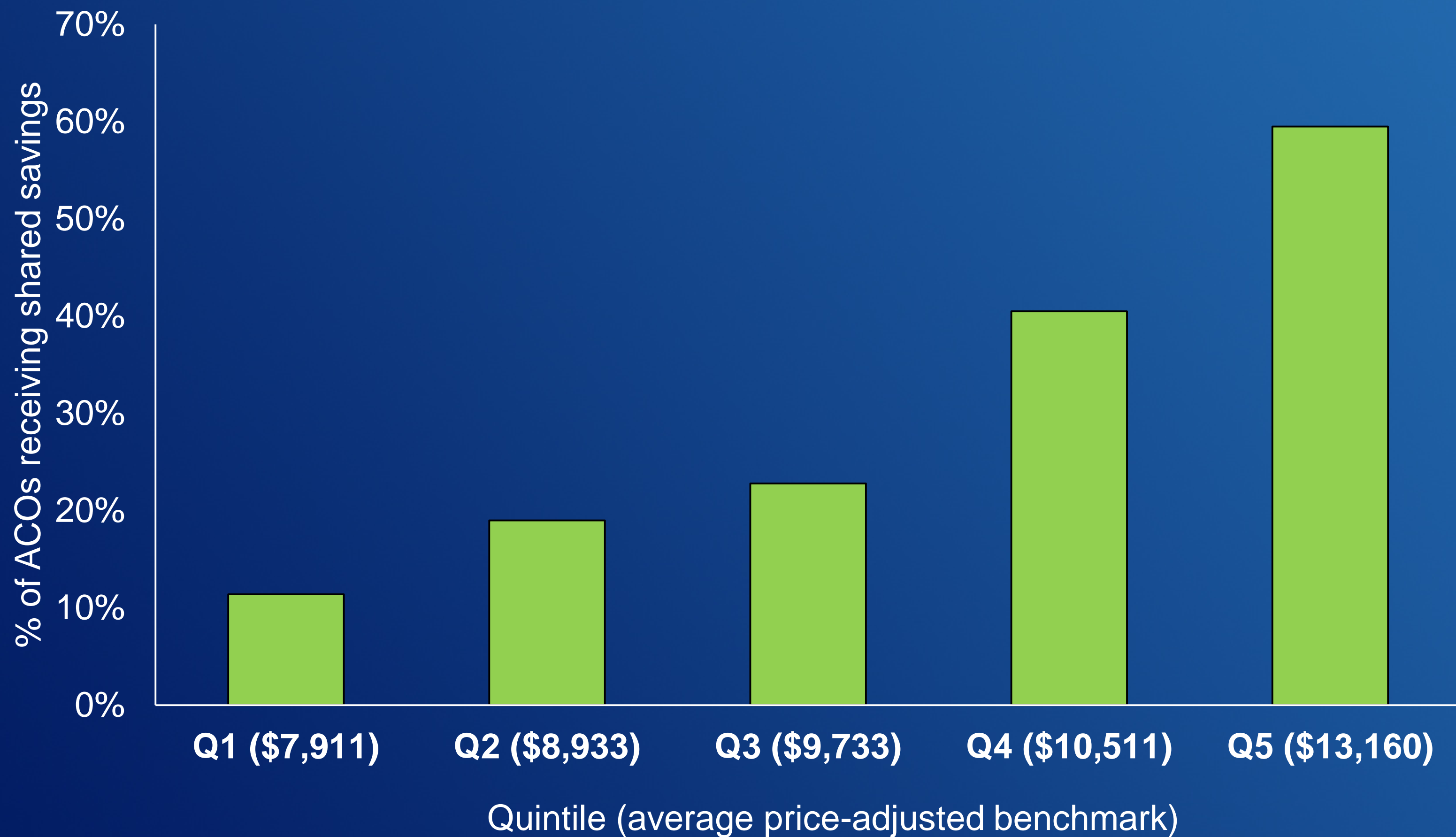
Shared savings more likely for MSSP ACOs with higher historical service use



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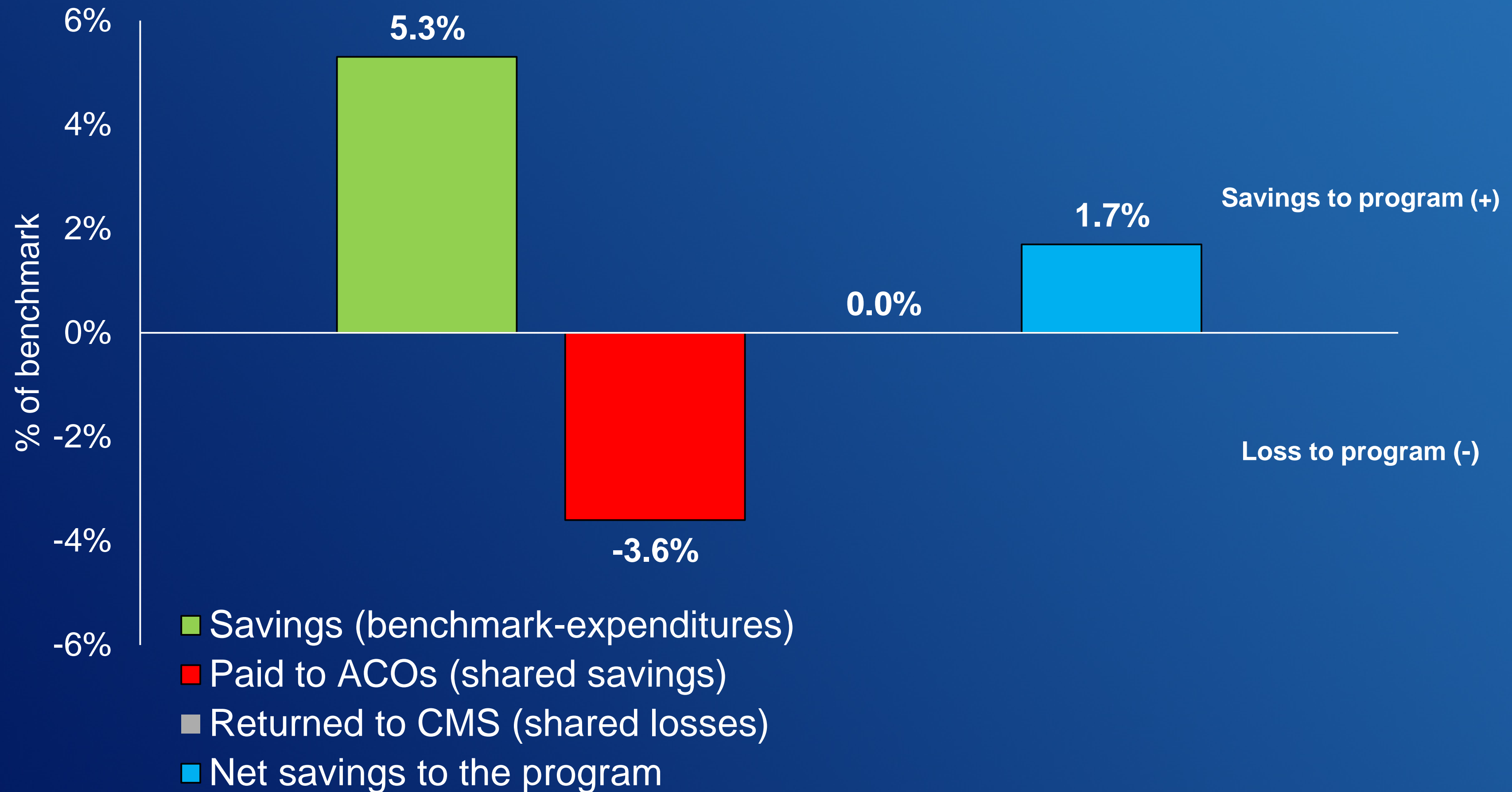
Note. Excludes 38 ACOs serving beneficiaries in multiple states that do not share a border (e.g., an ACO serving beneficiaries in both New York and California).
Source: CMS data.

Results preliminary and subject to change.

ESCOs generated savings in 2016



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Source: CMS data.

Results preliminary and subject to change.

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?

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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?