



Advising the Congress on Medicare issues

Status Report on Medicare Accountable Care Organizations (ACOs)

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Outline

- 2016 program status
- 2015 results
- Conclusion
- Discussion

MSSP program growing

	2012	2013	2014	2015	2016
MSSP	114	220	333	392	433
Pioneer	32	23	20	12	9
Next Generation					18

Medicare Shared Savings Program, 2016

	Track 1	Track 2	Track 3
# of ACOs	411	6	16
Two-sided risk	No	Yes	Yes
Savings/loss %	50%	60%	75%
Attribution	Retrospective	Retrospective	Prospective
Minimum savings/loss rate	2-3.9%	1. 2-3.9% 2. 0.5-2% 3. None	1. 2-3.9% 2. 0.5-2% 3. None
Payment	Fee for service (FFS)	FFS	FFS

Pioneer and Next Generation Model Comparison

	Pioneer	Next Generation
Two-sided risk	Yes	Yes
Savings/loss %	60-75%	80-100%
Attribution	Prospective	Prospective
Benchmark	3 years	1 year
Minimum savings/loss rate	1-2.7%	None
Payment	<ol style="list-style-type: none">1. FFS2. Population-based payment (PBP)	<ol style="list-style-type: none">1. FFS2. PBP3. FFS + Infrastructure4. Partial capitation

2015 ACO quality results

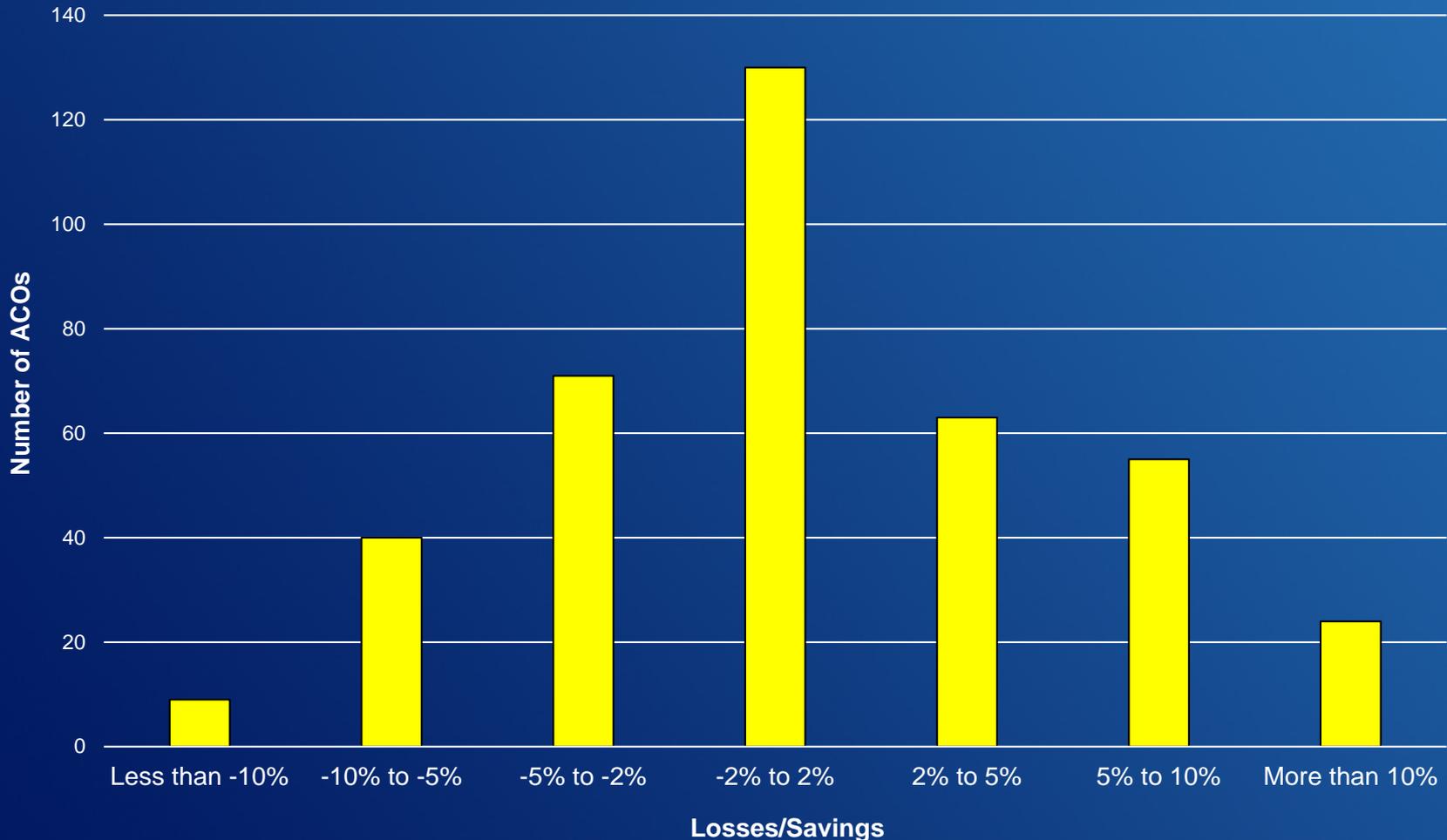
- CMS reports ACOs continue to score high on overall quality measures
 - Pioneer: 92% (76%-98%)
 - MSSP: 91% (17 below 80%)
 - Quality is improving each year
- Weak/no correlation between quality and savings
- Mostly process measures

2015 Financial results for Medicare ACOs

	Pioneer 2015 (12 ACOs)		MSSP 2015 (392 ACOs)	
	Millions of \$	%	Millions of \$	%
Benchmark	\$5,490	100.0	\$73,298	100.0
Actual spending	5,453	99.3	72,868	99.4
Savings	37	0.7	429	0.6
Paid to ACO	34	0.6	646	0.9
Returned to CMS	2	0.0	\$0	0.0
Net	+5	+0.1	-216	-0.3

Note: Savings = Benchmark – Actual
Source: CMS Data

Distribution of percentage savings and losses for MSSP ACOs in 2015



Distribution by geographic region and type (MSSP 2015)

ACO Type	South	Mid-West	North-East	West	Total
Hospital	55	59	47	25	186
Physician	107	29	37	32	205
Total	162	88	84	57	391

Note: Table does not include an ACO in Puerto Rico

Source: Harvard School of Public Health and MedPAC analysis of CMS data

Many report ACOs with certain characteristics more likely to exhibit savings

- ACOs in South > ACOs in Midwest, West, and Northeast
- Physician ACOs > Hospital ACOs
- Small ACOs > Large ACOs

Key variable: Relative service use

- Other analyses do not consider an area's historic relative service use—spending adjusted for prices and health status relative to the national average
- Relative service use
 - High correlation with ACO's savings
 - Correlated with other variables

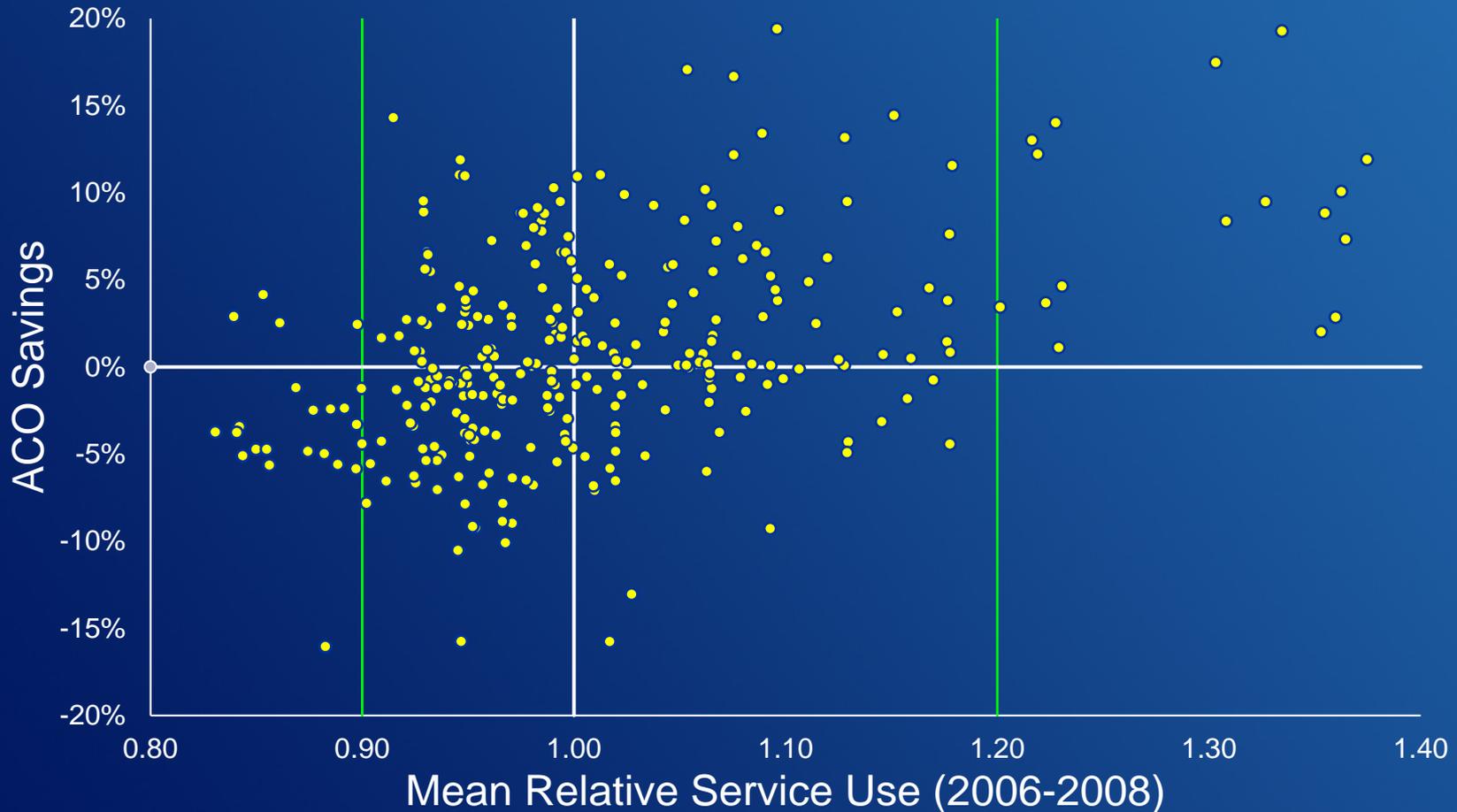
Service use dominant factor in predicting savings

Factor	Parameter estimate	Standard error	Statistical significance
Historical Service use relative to national average	.196	.033	p<.001
10,000+ beneficiaries	-.021	.007	p<.01
Southern ACO	.016	.007	p<.05
Primary care ACO*	-.000	.010	Not significant
Multispecialty practice ACO*	-.001	.007	Not significant

R²=.22 N= 300 MSSP ACOs that were formed from April 2012 to January 2014

*The omitted category is hospital-based ACOs. The historical service use refers to 2006 to 2008 service use.

Historical service use good predictor of ACO performance in 2015



White paper on Part D and ACOs

- Mutual incentive to control drug cost and improve health outcomes would be desirable, but:
 - Mismatch between beneficiaries in PDPs and ACOs
 - Risk sharing between Medicare and PDPs very different from risk sharing between Medicare and ACOs
- No straightforward approach to aligning incentives

Conclusion

- Findings
 - Univariate analysis: Physician ACOs, small ACOs, ACOs in South—all show greater savings
 - Multivariate analysis shows historical service use in market key determinant of savings
 - CMS reports high quality, but primarily process measures
- Assessing overall performance of ACO programs
 - Program perspective:
 - One-sided model—some ACOs save but Medicare may lose money
 - Second order effects may be important
 - ACO perspective: balance administrative costs and expected shared savings

Discussion

- MedPAC policy principles
 - Synchronize market benchmark across MA, FFS, and ACO
 - ACOs should move to two-sided risk models
 - ACOs should be large enough to measure reliably
- Possible issues:
 - Historical benchmark not sustainable—blend with regional average
 - Level playing field across MA, FFS and ACOs or favor two-sided ACOs in low-use markets
 - Some evidence of small ACOs' success, but more difficult to measure accurately and less likely to take two-sided risk
 - Could aggregate small ACOs to pool risk
 - Could limit risk to encourage two-sided and harmonize with APM 5% bonus