Long-term issues confronting Medicare Accountable Care Organizations (ACOs)

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Overview

- Background on ACOs
- 2018 status
- ACO provisions in the Bipartisan Budget Act of 2018
- Issues for two-sided ACOs in the long term
- Discussion

Medicare ACOs

- Groups of providers held accountable for the cost and quality of care for a group of beneficiaries
- Goals of ACOs:
  - Improve provider accountability
  - Increase quality of care and patient experience
  - Lower costs
- If ACOs are successful, they are rewarded with shared savings

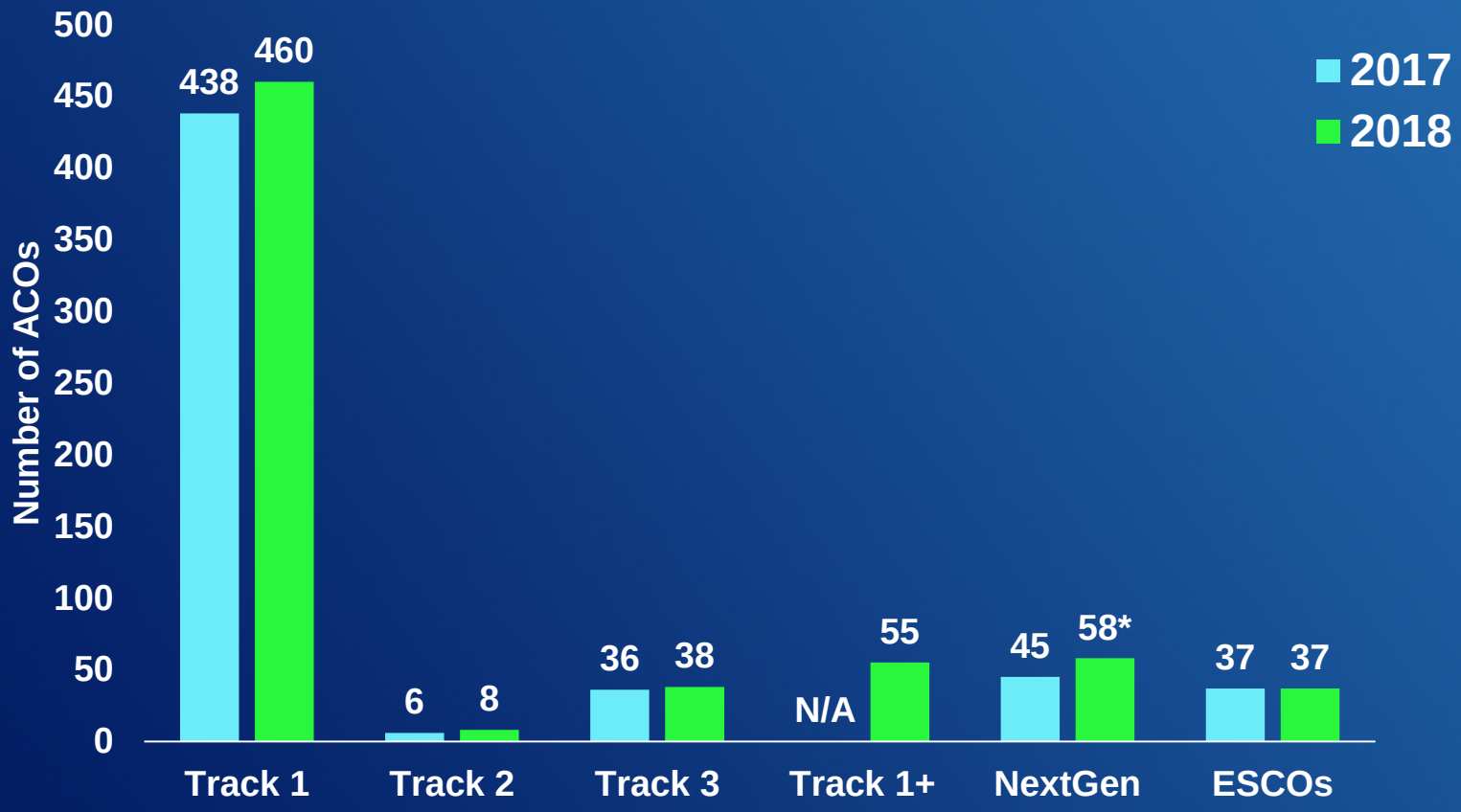
Key concepts for ACOs

- Composition: What providers are in the ACO?
  - Primary care clinicians, hospitals, specialty practices, etc.
- Attribution: How and when are beneficiaries attributed to the ACO?
  - Plurality of service use
  - Voluntary alignment
  - Prospective vs. retrospective
- Benchmark: How is an ACO's financial performance judged?
- Financial risk: Is ACO at one-sided or two-sided risk?

Medicare ACO demonstrations that began in 2018

- Track 1+ ACO Model
  - Prospective attribution
  - Asymmetric risk model
    - Up to 50% in shared savings; 30% in shared losses
    - Shared savings cap is higher than cap on shared losses
- Vermont All-Payer ACO Model
  - Brings Medicare, Medicaid and commercial insurers into one ACO (OneCare Vermont)
  - Goals: Attribute 90% of Medicare beneficiaries by 2022; slow per-capita expenditure growth
- Both models qualify as Advanced-Alternative Payment Models (A-APMs) for 2018

Number of Medicare ACOs, 2017 and 2018



Note: N/A = not applicable. ESCO = ESRD seamless care organization.
* There were 58 NextGen ACOs at the start of 2018, but reports indicate that 7 have left the program, leaving 51 ACOs. The ACO participating in the Vermont All-Payer Model is included in the NextGen count.
Source: CMS data.

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Data are preliminary and subject to change

ACO provisions in the Bipartisan Budget Act of 2018

- ***ACO beneficiary incentive program***: Allows ACOs to pay beneficiaries for primary care visits with ACO providers
- ***Telehealth:*** Two-sided risk ACOs with prospective attribution are given flexibility on where to originate telehealth services
- ***Voluntary Attribution:*** Beneficiaries can be attributed based on identification of primary clinician
- ***Expanded prospective attribution***: ACOs in Track 1 and 2 can now choose prospective attribution

Two-sided risk models generate more savings for Medicare

- CMS data show that, relative to CMS benchmarks, one-sided ACOs generate small losses and two-sided ACOs generate small savings
- Researchers find that, relative to comparison groups, one-sided ACOs generate small savings and two-sided ACOs slightly larger savings

Advanced-alternative payment models (A-APMs) and ACOs

- Participation in A-APMs helps qualify clinicians for five percent incentive bonus on physician fee schedule (PFS) revenue
- Only ACOs at two-sided risk can be A-APMs
- Two-sided risk ACO models best meet Commission principles for A-APMs
  - Meaningful level of risk
  - At risk for all Part A and Part B spending

Issues for two-sided ACO model sustainability over the long term

- MedPAC's A-APM incentive payment proposal
- Hospital-ACO interaction
- Asymmetric two-sided ACO models
- Role of specialists in ACOs
- ACOs in relation to MA plans

A-APM incentive payment

- Incentive: Five percent bonus payment on clinician's entire PFS revenue, 2019-2024
- Clinician must meet threshold for payments or patients derived from A-APMs
- Creates payment 'cliff' at threshold
  - No bonus below threshold
  - Five percent on *all* PFS payment if above threshold

MedPAC's proposal for distributing the A-APM incentive payment

- Eliminate threshold and pay five percent bonus payment only on PFS revenue derived from A-APMs
- Makes bonus more equitable and certain
- Simplifies program and reduces administrative costs
- May strengthen incentives to participate in two-sided ACOs

Hospitals and ACOs

- Potential conflict between incentives
  - Hospitals want to maintain/increase admissions
  - ACOs want to restrain spending
- Finding: Reducing post-acute care—not inpatient admissions—is the primary source of ACO savings
  - Much less variation in inpatient use relative to PAC use
  - ACO growth does not appear to have contributed to decline in hospital admissions

Should asymmetric models be continued?

- Some models are ‘tilted’ toward ACOs
  - Share of savings greater than share of losses
  - Cap on savings higher than cap on losses
- Potential to increase availability of two-sided ACOs
- Could cost the Medicare program
- Track 1+ is asymmetric and has attracted many ACOs in its first year
- Could monitor progress of Track 1+ to inform policy on ‘tilting’ toward ACOs

Specialist participation in two-sided ACOs

- Some are concerned specialists will not have a place in ACOs
  - Attribution focused on primary care
  - Specialists might increase costs
- We find specialists are participating
- If more efficient, specialists:
  - Could help control spending
  - Could get more referrals
  - Could share in savings
- Some models are specialty focused, e.g., ESCOs

Are ACOs only a transition step to Medicare Advantage plans?

- Concern: Eventually ACOs will want to be MA plans because that is the most efficient model
- MA plans require beneficiary enrollment and have higher administrative costs
- We found in some markets ACOs were the low-cost model
  - Lower administrative cost
  - If ACO dominant, may get benefits of limited network without 'lock-in'

Discussion

- Should the Commission recommend eliminating the threshold and moving to a proportional policy for the five percent A-APM bonus?
- Under what circumstances should asymmetric risk ACOs be continued?
- What other issues should staff consider for two-sided risk ACOs in the long term?