Status Report on Medicare Accountable Care Organizations (ACOs)

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MEDPAC

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	1. FFS 2. Population-based payment (PBP)	1. FFS 2. PBP 3. FFS + Infrastructure 4. 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

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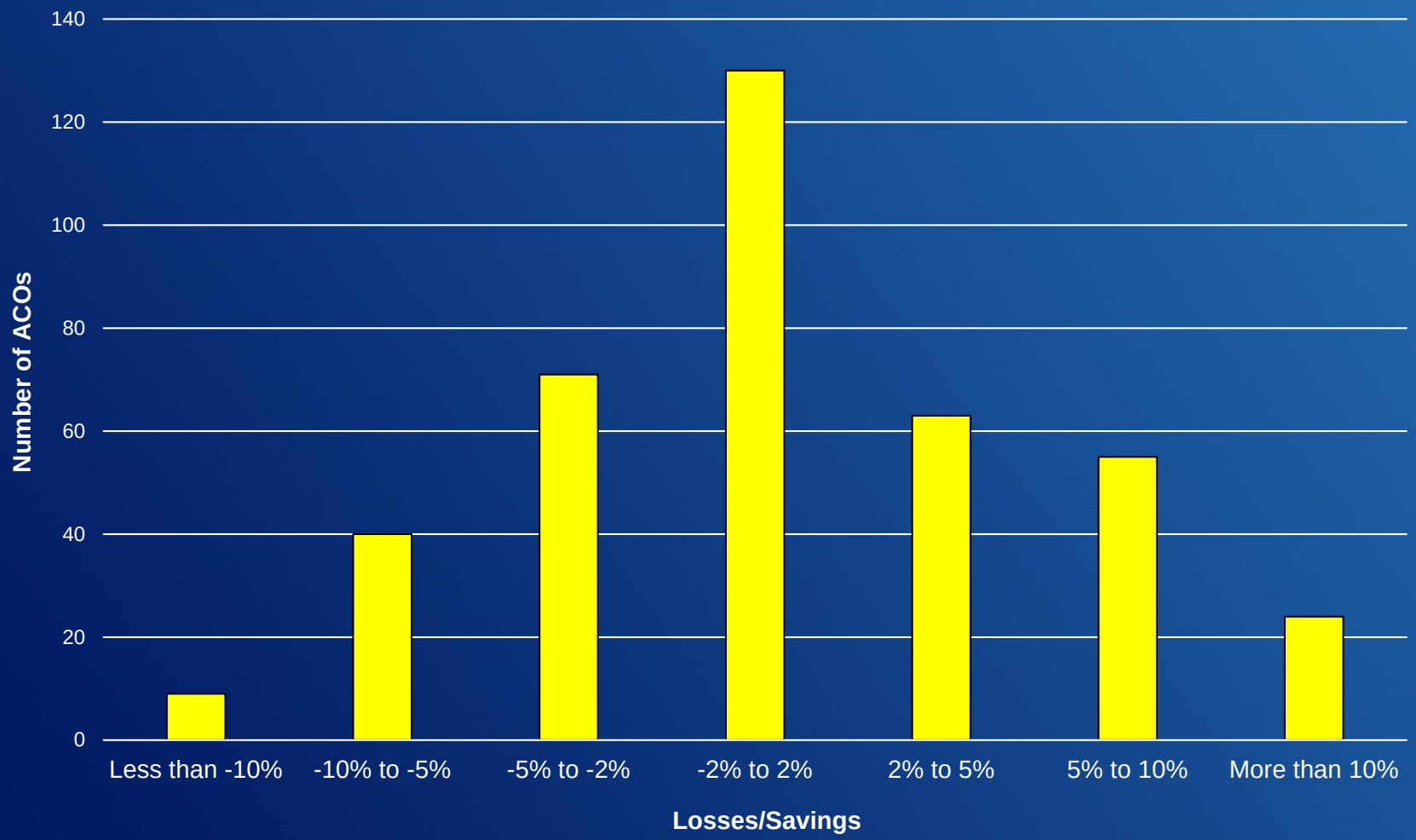
Distribution of percentage savings and losses for MSSP ACOs in 2015



MEDPAC Note: Savings percentage = (benchmark minus actual expenditures)/benchmark.
Source: CMS data

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

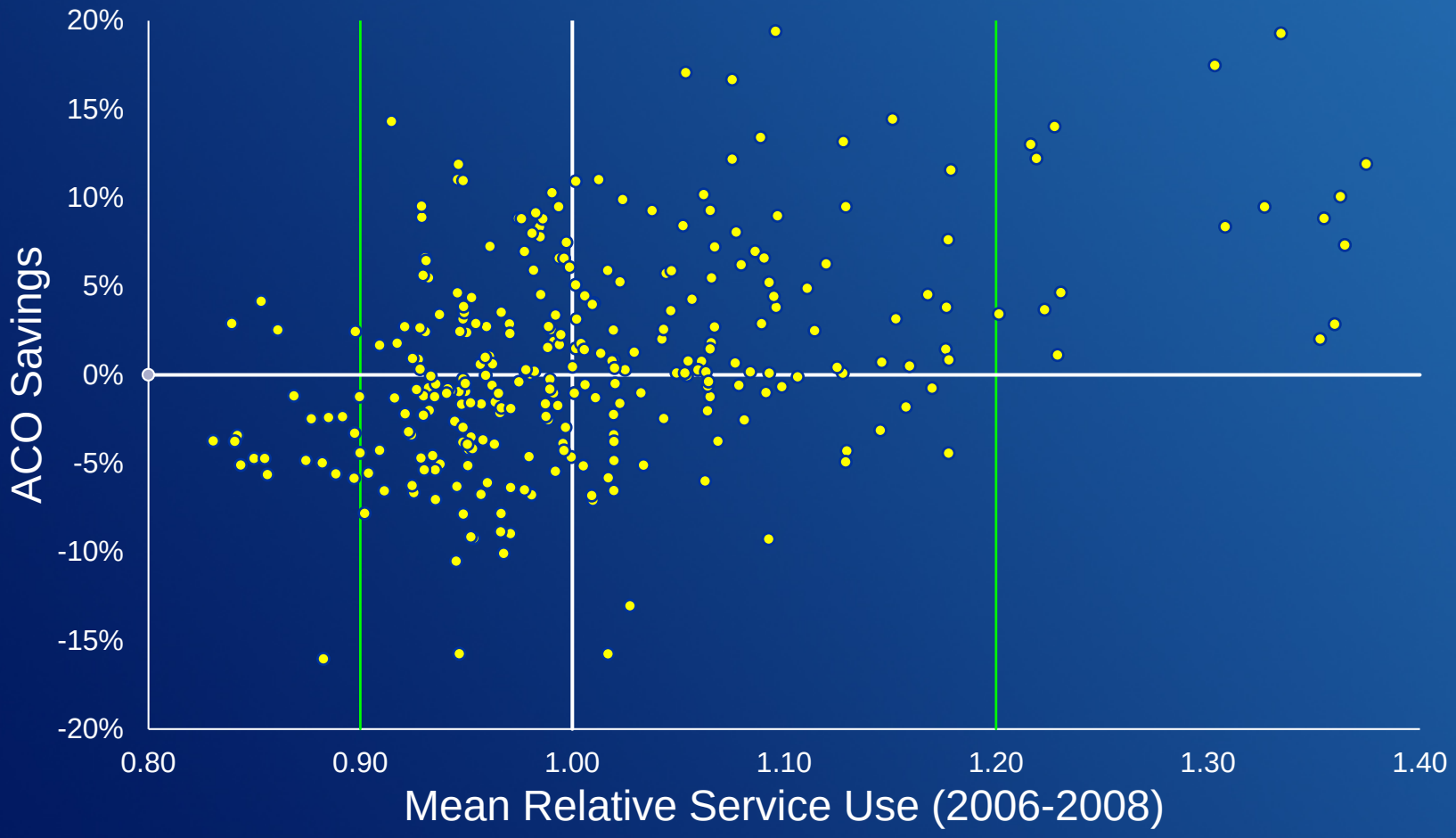
Service use dominant factor in predicting savings

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

R^2=.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.

Preliminary data subject to change

Historical service use good predictor of ACO performance in 2015



Preliminary data subject to change

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