

CHAPTER

8

**Medicare accountable care
organization models:
Recent performance and
long-term issues**

Medicare accountable care organization models: Recent performance and long-term issues

Chapter summary

Medicare accountable care organizations (ACOs) were created to help moderate the growth in Medicare spending and improve quality of care for beneficiaries by giving providers greater responsibility for costs and quality. In reviewing current Medicare ACO models, we found that some models—predominantly those at risk for both savings and losses (two-sided risk)—have produced small savings relative to their benchmarks set by CMS, and all have maintained or improved quality. Spending relative to benchmarks is important because it determines which ACOs will receive “shared savings” bonuses. However, some have raised the point that benchmarks are not necessarily the best measure of what spending would have been in the absence of the ACO and thus may not be a good measure of true program savings. From our review of the literature on this question, we conclude that ACOs may have saved Medicare from 1 percent to 2 percent more than indicated by their performance relative to benchmarks and that two-sided ACO models appear to save more than one-sided ACO models.

In light of evidence regarding two-sided ACOs and savings, we identified issues that need to be resolved if two-sided ACOs are going to be part of the Medicare program in the long term:

- ***Are hospitals a viable participant in ACOs?*** Hospitals could be important participants in ACOs, especially given their ability to supply the capital needed to take on two-sided risk. But, while ACOs may want to constrain

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- ACO quality and financial performance relative to CMS-designed benchmarks
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unnecessary service use (e.g., unnecessary hospital admissions) to generate savings, hospitals may have conflicting incentives to admit patients to increase their fee-for-service (FFS) revenue. We find that hospitals may still want to participate in ACOs despite the apparent conflict in incentives around inpatient hospital care primarily because most ACO savings to date stem from reductions in the use of post-acute care and not from reductions in inpatient care.

- ***Should asymmetric models be continued?*** Asymmetric models—models with greater opportunities for savings than losses—could be one strategy to help ACOs transition to two-sided risk. For example, the new Track 1+ ACO model has two asymmetries. First, the shared savings rate is 50 percent (i.e., if actual spending is less than expected spending (the benchmark), then ACOs get half of the savings and Medicare keeps the other half), while the shared loss rate is 30 percent. Second, the loss cap is lower than the savings cap. Because potential gains to ACOs are greater than potential losses, this asymmetric relationship could result in a cost for the Medicare program. Currently, CMS’s Track 1+ model is a demonstration, and savings are not required under CMS’s demonstration and waiver authority. If Track 1+ were incorporated into permanent Medicare law, the costs may need to be offset if performance is essentially random. If it is demonstrated that ACOs are modifying their behavior from what they would have done if not in ACOs and are reducing spending, then this issue will not arise. The Commission will continue to monitor the Track 1+ model to determine whether aspects of it should be extended to other ACO models to encourage uptake of two-sided risk.
- ***How should benchmarks be set initially and then rebased for subsequent agreement periods?*** The basic ACO model essentially sets benchmarks as a function of historical spending for beneficiaries who would have been attributed to the ACO in the past. If ACOs reduce the level of spending or keep spending growth below the trend in FFS spending, they share in savings. If the same approach were taken in subsequent agreement periods, then ACOs would have to continuously improve over their own past performance to achieve savings, which could create diminishing returns for consistently successful ACOs and potentially discourage long-term participation. In some models, benchmarks are now being rebased using a blend of regional and historical spending. There are additional concerns related to the current benchmark methodology (e.g., the impact of beneficiaries moving in and out of the ACO), and we discuss several approaches to address these issues.

- ***Should the 5 percent bonus for clinicians in advanced alternative payment models (A-APMs) be distributed differently to encourage A-APM participation?*** Under current law, clinicians receive a 5 percent bonus on all of their physician fee schedule (PFS) payments if they exceed an annual threshold level for payments or patients in A-APMs. (One-sided ACOs do not qualify as A-APMs, and thus clinicians in them do not receive the bonus.) This A-APM provision could discourage clinicians from participating in ACOs because they would be uncertain about whether they would exceed the threshold. Moving to a system in which clinicians receive a 5 percent bonus with certainty on their share of PFS payments derived from an A-APM could make the incentive more equitable and encourage participation in two-sided ACOs.
- ***What will be the relationship between specialists and two-sided ACOs?*** Currently, a substantial number of specialists are on the participation lists of ACOs. ACOs may want to include specialists as a way to coordinate the care of their beneficiaries more effectively, and specialists may be incentivized to join ACOs to receive referrals and potentially share in savings. Moving forward, specialty-focused ACO models may also be an option for increasing specialist participation.
- ***Are two-sided ACOs a long-term option in the Medicare program?*** Some maintain that ACOs are one way for providers to take greater accountability for a group of patients and then transition toward taking full accountability as a Medicare Advantage (MA) plan. If ACOs are regarded only as a transition step toward becoming an MA plan, then it may discourage participation in the ACO model. We have found in previous work that ACOs can be the low-cost option in some areas of the country, and their advantage of lower administrative costs could keep them as a long-term option, if benchmarks are set equitably.

Given the early success and popularity of the ACO model, the above issues should be considered if Medicare's ACOs are to continue in the long term. ■

Introduction

The Commission has long maintained that Medicare should encourage clinicians to improve the quality of care, overall health, and costs of care for a population of patients. In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Congress provided an incentive for clinicians to join advanced alternative payment models (A-APMs), which were predicated on putting an entity responsible for meeting quality goals for a defined patient population at financial risk for Medicare spending. In response, the Medicare program deemed certain models to be A-APMs, created several A-APMs, and is currently developing new ones. The Commission has developed principles for A-APMs and commented on which A-APMs best meet those principles (Medicare Payment Advisory Commission 2016a). In general, accountable care organization (ACO) models at two-sided risk—that is, at risk for losses if spending exceeds benchmarks and sharing savings if spending is lower than benchmarks—seem to be the models that best meet the Commission’s principles because they encourage clinicians to be responsible for the quality and cost of care for a defined population of Medicare beneficiaries.

The Commission has determined that the balance of incentives in MACRA between clinicians in A-APMs and those not in A-APMs needs to be rethought. We recommended in our March 2018 report to the Congress that the current Merit-based Incentive Payment System (MIPS)—which pertains to all fee-for-service (FFS) clinicians not in A-APMs unless excluded—be eliminated and replaced with a voluntary value program that would encourage clinicians to elect to be measured for cost and quality purposes as a voluntary group (Medicare Payment Advisory Commission 2018). This recommendation was intended, in part, to prepare clinicians to eventually move to A-APMs.

If it is important for clinicians to move to A-APMs, and if two-sided-risk ACOs are the model most in keeping with the Commission’s principles for A-APMs, then it is important to understand performance on cost and quality and what issues need to be resolved for two-sided ACOs to be a long-term part of the Medicare program.

Background on ACOs

Medicare ACOs began in 2012 and have grown rapidly since then to care for about one-third of Medicare FFS beneficiaries. In Medicare, ACOs are groups of health care providers that have agreed to be held accountable for the cost (that is, spending in Medicare Part A and Part B) and quality of care for a defined group of Medicare beneficiaries. Generally, the goals of ACOs are to lower costs, increase quality of care and patient experience, and improve provider accountability for the cost and quality of care provided to their patients. Theoretically, ACOs could generate savings by substituting lower cost services for higher cost services (e.g., substituting outpatient services for inpatient services) or reducing low- or no-value services. If ACOs achieve their goals, they are rewarded with shared savings.

There are three main concepts in ACO programs:

- **Attribution**—Beneficiaries are primarily attributed to ACOs based on their use of services.¹ Prospective attribution occurs when beneficiaries are assigned to an ACO at the start of the performance year (based on their prior year usage); retrospective attribution occurs when a beneficiary is attributed at the end of the year (based on their current year usage). Unlike Medicare Advantage (MA) plans, beneficiaries attributed to ACOs can use whatever providers they choose.
- **Composition of the ACO**—An ACO’s providers do not have to provide all services for a beneficiary, although they are responsible for total Part A and Part B spending. The essential requirement is that the providers as a group have enough beneficiaries attributed to them to meet the minimum requirement for their model. ACOs can be clinician-only or can include providers such as hospitals and skilled nursing facilities (SNFs).
- **Benchmarks**—The goals of ACOs are assessed using a set of quality measures (see online Appendix 8-A, available at <http://www.medpac.gov>, for the list of measures) and spending benchmarks. The spending benchmark is an estimate of Part A and Part B spending for an ACO’s beneficiaries in a given year. If spending for an ACO’s beneficiaries—including health care services provided outside the ACO—is below the benchmark, then the ACO is eligible to earn

**TABLE
8-1**

Characteristics of the MSSP ACO tracks

	Attribution	Risk arrangement	Maximum shared savings or loss rate ^a	Cap on earned: ^b	
				Savings	Losses
Track 1	Retrospective ^c	One sided	50%	10%	0%
Track 2	Retrospective ^c	Two sided	60%	15%	10%
Track 3	Prospective	Two sided	75%	20%	15%

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).

^aThe actual shared savings/loss rate could change depending on the ACO's quality score (e.g., an ACO that scores poorly on quality would receive a smaller shared savings amount than if it had earned a high quality score).

^bThe amount an ACO can share in savings (or repay in shared losses) is capped as a percentage of the benchmark.

^cThese tracks have preliminary prospective attribution and then retrospective attribution for final reconciliation.

Source: Centers for Medicare & Medicaid Services 2017c.

a “shared savings” payment. If spending is above the benchmark, then the ACO may be financially liable for shared losses. One-sided-risk arrangements are those in which ACOs can earn shared savings but are not responsible for losses; two-sided-risk arrangements are those in which ACOs can earn savings and are responsible for shared losses. The amount of shared savings an ACO is eligible to earn varies by program.

Overview of Medicare’s ACO programs

The first Medicare ACOs began at the start of 2012 as part of the Pioneer ACO Model, which was a demonstration that ended in 2016. Midway through 2012, the first cohort of ACOs belonging to the Medicare Shared Savings Program (MSSP)—a permanent ACO program created by the Congress—began. Medicare’s ACO programs have grown quickly since their beginning in 2012, both through additional demonstrations and expansion of the MSSP. With the passage of MACRA in 2015, the Congress created stronger incentives for providers to move into A-APMs and, therefore, ACOs. The Commission has been supportive of ACOs since the beginning, especially two-sided risk ACOs that best fit our A-APM principles.

Medicare currently has three ACO programs that have been in operation since 2016 (or earlier), including the MSSP, the Next Generation (NextGen) ACO model, and the ESRD (End-Stage Renal Disease) Seamless Care Organizations (ESCOs). At the start of 2018, CMS introduced two new ACO models: the Track 1+ ACO Model and the Vermont All-Payer ACO Model.

Medicare Shared Savings Program

The MSSP was established in the Patient Protection and Affordable Care Act of 2010 (PPACA) and is a permanent part of the Medicare program. It currently consists of three ACO tracks: Track 1, Track 2, and Track 3. Table 8-1 summarizes the main differences between each ACO track.

MSSP ACOs are allowed to participate as a Track 1 ACO—which is a one-sided track—for only two three-year agreement periods.² This stipulation provides a transition period for ACOs to prepare to take on risk as they move to two-sided-risk models (e.g., Track 2 or Track 3). (Because they are two-sided, Track 2 and Track 3 qualify as A-APMs and clinicians in them can be eligible for the 5 percent bonus on their fee schedule revenue as established in MACRA.) Furthermore, even beyond the shared savings/loss rate, there are model-specific limits on how much an ACO can earn in savings or pay in losses. These savings and loss limits vary for each model. For instance, Track 1 shared savings payments are capped at 10 percent of benchmark. Track 2 shared savings are capped at 15 percent of benchmark, while losses are capped at 10 percent of benchmark. For Track 3, shared savings are capped at 20 percent of benchmark, while losses are capped at 15 percent of benchmark.

Next Generation ACO Model

NextGen is a demonstration that began in 2016 and was based in part on the previous Pioneer ACO Model.

NextGen is a two-sided-risk, prospective-attribution demonstration run by the CMS's Center for Medicare & Medicaid Innovation (CMMI). For the 2017 and 2018 performance years, NextGen qualifies as an A-APM. NextGen ACOs can choose their level of shared savings and losses and can opt to share at either 80 percent or 100 percent of savings and losses. Both shared savings and losses are capped at 15 percent of the ACO's benchmark. Additionally, NextGen ACOs receive some regulatory flexibility because of their level of assumed risk. This flexibility includes waivers to expand the use of telehealth and to waive the three-day hospital stay rule before using a SNF.

ESRD Seamless Care Organizations

An ESCO is a disease-specific ACO model that applies to ESRD beneficiaries utilizing chronic dialysis services. ESCOs began in 2016 as a demonstration and are run by CMMI. Beneficiaries are assigned to ESCOs on a "first touch" basis, meaning that the first time an ESRD beneficiary utilizes an ESCO dialysis facility, he or she will be prospectively assigned to that ESCO. ESCOs are split into two tracks based on their size. Large dialysis organizations (LDOs) are organizations with 200 or more dialysis facilities, while non-large dialysis organizations (non-LDOs) are those with fewer than 200 dialysis facilities. In ESCOs, LDOs are automatically at two-sided risk, while non-LDOs have the option to be at one-sided risk or two-sided risk. For the 2017 and 2018 performance years, LDOs and non-LDOs at two-sided risk can qualify as A-APMs. For their first performance year, the shared savings/loss rate for LDOs is a maximum of 70 percent, and it is 75 percent in their second and future performance years; the limit on shared losses is equal to the shared loss rate for the year (e.g., 75 percent). Non-LDOs have a shared savings rate of 50 percent, with a limit on savings of 5 percent of benchmark.

Track 1+

Track 1+ is an asymmetric, two-sided-risk model with prospective attribution that began in 2018. It is a demonstration through CMS's CMMI authority and is jointly run with CMS's MSSP office. ACOs that join Track 1+ are eligible to earn up to 50 percent in shared savings, but because it is an asymmetric risk model, they are responsible for only 30 percent of shared losses. Additionally, the savings and loss limits vary based on ACO composition as follows:

- **Hospital Track 1+ ACOs**—Losses are capped at 4 percent of the ACO's benchmark.
- **Clinician-only Track 1+ ACOs³**—Losses are capped at 8 percent of ACO-participant FFS revenue. This model differs from the other ACO models because it sets a limit relative to FFS revenue instead of the ACO's benchmark, which is notable because FFS revenue tends to be much lower than the total Part A and Part B benchmark. In general, this loss threshold of 8 percent is lower (and thus more attractive) to ACOs than the benchmark standard.

While ACOs with hospitals may have less incentive to join the Track 1+ demonstration because they are not eligible for the lower risk limit based on FFS revenue, about half of the Track 1+ ACOs list hospitals as participating providers, indicating broad interest in the model. Savings for both types of Track 1+ ACO are limited to 10 percent of benchmark.

Vermont All-Payer Model

The other new ACO model in 2018, the Vermont All-Payer ACO Model demonstration, brings together Vermont's largest payers—Medicare, Medicaid, and commercial insurers—under one ACO model focused on health care value and quality. There is one ACO in the model, OneCare Vermont, with model specifics (e.g., benchmark methodology) varying slightly for each payer. The overall goals of the model, however, are similar across payers and are Vermont specific. In 2018, OneCare Vermont is responsible for 122,000 individuals across payers and has 10 participating hospitals from different systems across the state (D'Ambrosio 2017).⁴

Similar to other ACO models, providers participating in the Vermont All-Payer Model have the potential to earn shared savings and a quality bonus payment but are also accountable for shared losses. Because the model's providers assume risk for the patient population, the model qualifies as an A-APM for the 2018 performance year. Specific goals for the model include attributing to the ACO, by 2022, 90 percent of the state's Medicare beneficiaries (and 70 percent of all Vermont-insured residents) and limiting Medicare per capita expenditure growth to 0.1 to 0.2 percentage points below projected national Medicare growth. The model also includes 21 quality measures that focus on 3 areas prioritized by Vermont: reducing deaths due to substance use disorders and suicides, reducing prevalence and morbidity due to

**TABLE
8-2**

The number of Medicare ACOs increased from 2017 to 2018

	Number of ACOs		Assigned beneficiaries
	2017	2018	
MSSP (total)	480	506	10.5 million
Track 1	438	460	N/A
Track 2	6	8	N/A
Track 3	36	38	N/A
Track 1+	0*	55	N/A
Next Generation	45	58**	1.4 million
ESCOs	37	37	16,085
Total	562	656	N/A

Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program), N/A (not available), ESCO (ESRD [End-Stage Renal Disease] Seamless Care Organization). Count of assigned beneficiaries is based on the most recent data available; the total MSSP count is from 2018, the Next Generation count is from 2017, and the ESCO count is from 2016.

*Track 1+ started in 2018.

**At the start of 2018, there were 58 participating Next Generation ACOs. According to CMS's website, there are currently only 51 Next Generation ACOs, meaning that 7 ACOs appear to have dropped from the program. The Vermont All-Payer ACO model is included in the Next Generation count (even though it is a separate model) because, for 2018, OneCare Vermont is considered a Next Generation ACO.

Source: "Side-by-Side Comparison: Medicare Accountable Care Organization (ACO) Models" from the Kaiser Family Foundation; MSSP 2018 Fast Facts from CMS.

chronic conditions, and increasing access to primary care (Green Mountain Care Board 2018).

The only ACO in the model, OneCare Vermont, has been a Medicare ACO since 2013, first as an MSSP Track 1 ACO from 2013 to 2017. Starting in 2018, it transitioned into a NextGen ACO. In 2016, actual spending was above the benchmark, and OneCare Vermont generated losses of 4.6 percent relative to the benchmark. Vermont previously had other Medicare ACOs operating in the state, including the Track 1 ACO Community Health Accountable Care LLC, which had spending 16.9 percent above its benchmark in 2016 and is not a Medicare ACO in 2018.

Although the Vermont All-Payer ACO demonstration is a one-state model, it could be a starting point for all-payer models in other states. It could show, for example, the utility of having most of a provider's patient population in one payment model with one set of quality indicators. We will monitor developments.

Number of participating ACOs in 2018

In 2018, there are 656 Medicare ACOs (Table 8-2 shows the number of ACOs by program). Together, these ACOs

are now responsible for almost one-third of the Medicare FFS population.

ACOs are available in all 50 states (and the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam), although not in all areas of every state. MSSP Track 1, a one-sided model, is still the predominant model, accounting for nearly three-quarters of Medicare ACOs. However, MSSP Track 1 does not qualify as an A-APM; thus, most MSSP ACOs are not A-APMs.⁵ Track 1+, which qualifies as an A-APM, is in its first year and already has 55 ACOs. It is interesting to note that many ACOs include hospitals as participants, even though the financial incentives for hospitals and ACOs may appear to be in conflict. We discuss this apparent contradiction later in this chapter.

ACO quality and financial performance relative to CMS-designed benchmarks

This section summarizes the quality and financial performance of the ACO programs active in Medicare

in 2016, the latest performance data available at this time. Financial performance is discussed relative to the CMS benchmarks for each program. In the next section, we discuss estimates from the literature on financial performance relative to the counterfactual—that is, what spending would have been if the ACO did not exist. Benchmarks and counterfactuals differ because benchmarks are designed to fulfill policy goals—for example, to encourage clinicians to participate in ACOs or to increase equity across the country. Therefore, “savings” relative to benchmarks will not be the best estimate of program savings relative to the counterfactual. The latter is in some ways the better estimate of whether ACOs are saving the Medicare program money. But “savings” relative to the benchmarks is how the ACOs will determine whether they want to stay in the program; thus, CMS-computed “savings” are also important.

MSSP ACOs

The MSSP was established by PPACA and is a permanent part of the Medicare program. The first MSSP ACOs started in April 2012, and the program has grown rapidly to 506 ACOs as of 2018. The program currently consists of three tracks, each with its own savings and loss specifications: Track 1, Track 2, and Track 3.

MSSP ACOs generally perform well on quality metrics

MSSP, Pioneer, and the NextGen programs use the same set of measures to calculate an annual quality score for each ACO. The measure set in 2016 included 31 process and outcome measures covering the following 4 quality domains: patient experience measures (e.g., getting timely care), care coordination and patient safety (e.g., readmissions, screening for risk of falls), preventive health (e.g., influenza immunization), and at-risk populations (e.g., depression remission at 12 months). (See online Appendix 8-A, available at <http://www.medpac.gov>, for the full list of ACO quality measures.) The measures are reported through a combination of claims and administrative data, a CMS-provided web interface designed for capturing ACO-reported clinical quality measure data, and the ACO Consumer Assessment of Health Care Providers and Systems[®] patient experience survey.

In each ACO’s first performance year, the quality score is based only on whether the ACO completely and accurately reported quality data. In the ACO’s second and

future years, the ACO’s quality score is based on how the ACO performed relative to a prospective national FFS benchmark. In the MSSP program, ACOs with higher quality scores receive greater shared savings bonuses.

In 2016, only 4 of the MSSP Track 1 ACOs (1 percent of 438 ACOs) did not meet the quality standard because they did not report a complete set of data. (One of those ACOs dropped out in 2017.) All 22 of the ACOs participating in Track 2 or Track 3 met the quality standard. MSSP quality scores are high, with average quality scores of 93 percent for Track 1, 94 percent for Track 2, and 96 percent for Track 3.

We reviewed changes over time in some of the patient experience and population-based outcome measures that the Commission supports. The MSSP ACOs on average had strong patient experience results and high-performing readmission results from 2012 to 2016, with little change in results between years.

MSSP performance relative to benchmarks (relative savings)

Summarized financial results for the MSSP ACOs from 2013 to 2016 are shown in Table 8-3 (p. 220). The total benchmark amount for the MSSP ACOs is shown in the first row (e.g., \$81,377 million in 2016). The second row is the total amount of actual Part A and Part B Medicare spending for beneficiaries attributed to the MSSP ACOs (e.g., \$80,725 million in 2016). “Relative savings” are defined as the difference between the benchmark and the actual spending. In 2016, for example, Medicare spent \$652 million less than the benchmark in total, although some ACOs spent more than their benchmark and some less. Relative savings, by this definition, were less than 1 percent of the benchmark in each year, although this number is slowly increasing. Medicare then paid ACOs that saved enough to entitle them to share in savings (listed as “paid to ACOs” in the table), which is shown as a negative number in the next row, for example, –\$701 million in 2016. Some ACOs that were in Track 2 and Track 3, which are two-sided models, had actual spending greater than their benchmark and had to share that loss with Medicare. They paid Medicare the amount shown in the next row (“paid back to CMS”), for example, \$9 million in 2016. The net amount is the sum of relative savings, the amount paid to ACOs as shared savings, and the amount paid back to Medicare by ACOs as shared losses. For 2016, this net amount was –\$39 million.

**TABLE
8-3****Summary financial results of MSSP ACOs relative to benchmarks**

	2013		2014		2015		2016	
	Dollars (in millions)	Percent						
Benchmark	\$42,499	100.0%	\$52,885	100.0%	\$73,298	100.0%	\$81,377	100.0%
Actual Part A and Part B spending	<u>42,265</u>	<u>99.5</u>	<u>52,594</u>	<u>99.0</u>	<u>72,868</u>	<u>99.4</u>	<u>80,725</u>	<u>99.2</u>
Relative savings	234	0.5	291	0.6	429	0.6	652	0.8
Paid to ACOs	-316	-0.7	-341	-0.6	-646	-0.9	-701	-0.9
Paid back to CMS	<u>4</u>	<u>0.0</u>	<u>0</u>	<u>0.0</u>	<u>0</u>	<u>0.0</u>	<u>9</u>	<u>0.0</u>
Net	-78	-0.1	-50	-0.1	-216	-0.3	-39	-0.1

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). The number of ACOs was 220 for 2013, 333 for 2014, 392 for 2015, and 432 for 2016. There were originally 433 MSSP ACOs in 2016, but CMS reported data for only 432 ACOs. "Relative savings" is defined as the difference between the benchmark and the actual spending. "Net" is the sum of relative savings and amounts paid to ACOs and paid back to CMS. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS MSSP ACO public use files.

It may not seem logical that shared savings payments to ACOs can exceed total relative savings, and they cannot for any individual ACO. However, under the Track 1 MSSP model's one-sided risk, if actual payments exceed the benchmark, the ACO does not share losses with Medicare—

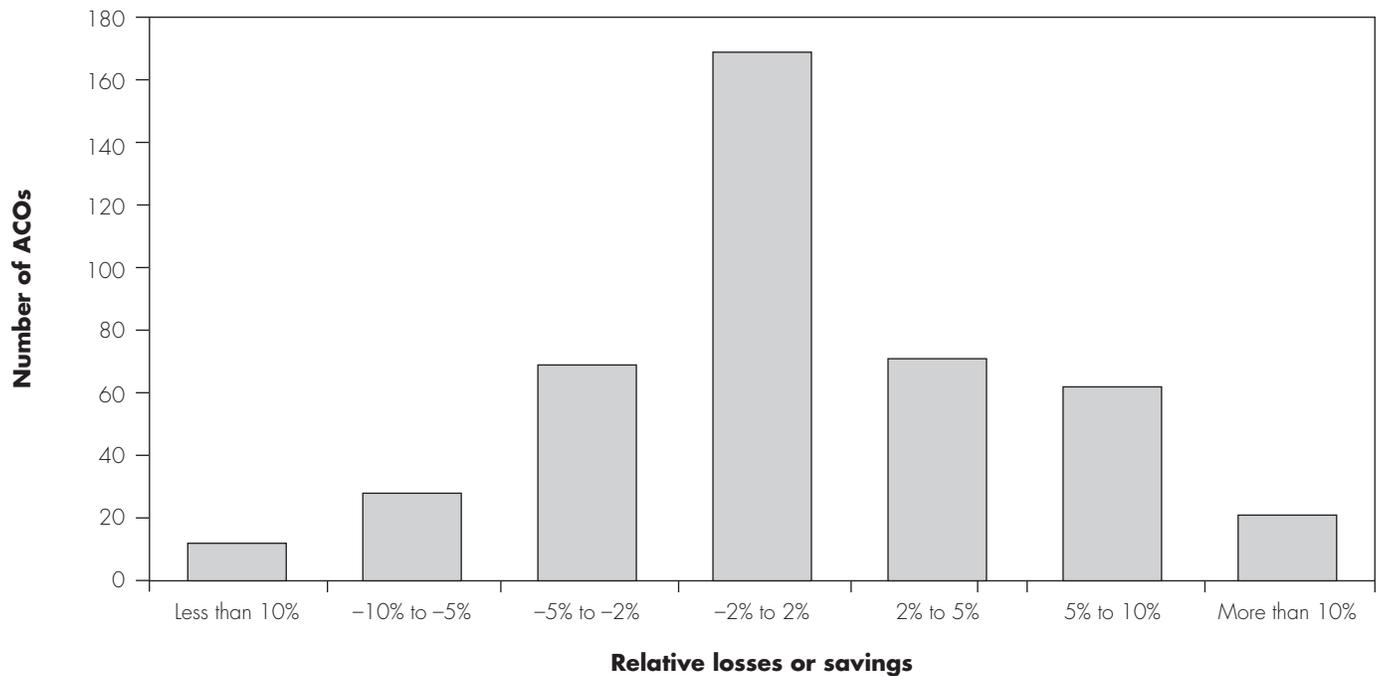
all losses are borne by the program. For example, under this model, if one ACO had savings of \$1 million and the other had losses of \$1 million, Medicare would pay shared savings of \$500,000 to the first and collect nothing from the second; thus, relative savings would be zero and the shared

**TABLE
8-4****Summary financial results of MSSP ACOs relative to benchmarks, by track, 2016**

	One-sided model		Two-sided models			
	Track 1		Track 2		Track 3	
	Dollars (in millions)	Percent	Dollars (in millions)	Percent	Dollars (in millions)	Percent
Benchmark	\$76,718	100.0%	\$688	100.0%	\$3,971	100.0%
Actual Part A and Part B spending	<u>76,177</u>	<u>99.3</u>	<u>647</u>	<u>93.9</u>	<u>3,901</u>	<u>98.3</u>
Relative savings	541	0.7	42	6.1	69	1.7
Paid to ACOs	-613	-0.8	-23	-3.4	-64	-1.6
Paid back to CMS	<u>0</u>	<u>0.0</u>	<u>0</u>	<u>0.0</u>	<u>9</u>	<u>0.2</u>
Net	-72	-0.1	18	2.7	14	0.4

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). In 2016, the number of ACOs was 410 in Track 1, 6 in Track 2, and 16 in Track 3. There were originally 433 MSSP ACOs in 2016, but CMS reported data for only 432 ACOs. "Relative savings" is defined as the difference between the benchmark and the actual spending. "Net" is the sum of relative savings and amounts paid to ACOs and paid back to CMS. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS MSSP ACO public use files.

FIGURE 8-1**Distribution of MSSP ACO savings and losses, 2016**

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).

Source: MedPAC analysis of CMS MSSP ACO public use files.

savings payments would be \$500,000. On net, the program would have paid out \$500,000 more than the amount predicted by the benchmarks, and we would assess that result as a net relative loss to the Medicare program.

The difference between one-sided and two-sided models is illustrated in Table 8-4, which shows the performance in 2016 of the ACOs in Track 1, the one-sided model, and the ACOs in Track 2 and Track 3, the two-sided models.

For Track 1 ACOs, the amount paid to ACOs in shared savings bonuses (\$613 million) exceeded the amount saved relative to the benchmarks (\$541 million), resulting in spending by the program exceeding expectations by \$72 million. In contrast, because Track 2 and Track 3 ACOs share in losses, these ACOs produced net savings for the Medicare program in 2016 relative to the benchmark (2.7 percent and 0.4 percent, respectively). All Track 2 ACOs generated savings relative to the benchmark, and 69 percent of Track 3 ACOs generated savings (11 of 16 ACOs).

There is variation in reported relative savings or losses across MSSP ACOs. Much of the savings and losses could be the result of random variation. As shown in Figure 8-1, 169 of the 432 of ACOs (almost 40 percent) had savings or losses of 2 percent or less. However, some had significantly greater savings or losses. Among the 83 ACOs with reported savings of over 5 percent, most are located in areas of high service use. For example, 20 of these ACOs with savings over 5 percent served beneficiaries in Florida, and 12 served beneficiaries in Texas. These data are not surprising in light of our 2016 report finding that a market's historical level of service use is the best predictor of reported ACO savings (Medicare Payment Advisory Commission 2016d). That analysis and its findings are discussed briefly below.

Factors contributing to MSSP ACO performance

Using 2014 data, we analyzed the contribution of three selected factors that might contribute to ACO performance relative to benchmarks: ACO type (hospital based, primary care based, or multispecialty practice based); size of the

**TABLE
8-5**

ACOs with the highest price-adjusted benchmarks were more likely to generate net savings to Medicare based on CMS's benchmarks, 2016

Quintile	Price-adjusted mean per capita ACO benchmark	Percent of ACOs:		As a share of quintile's benchmark:	
		Achieving savings relative to benchmark	Receiving shared savings	Shared savings payments	Net savings to Medicare based on CMS's benchmarks
1 (lowest price-adjusted benchmark)	\$7,911	38.0%	11.4%	0.2%	-1.3%
2	8,933	40.5	19.0	0.3	-1.5
3	9,733	55.7	22.8	0.4	-0.1
4	10,511	60.8	40.5	1.1	0.4
5 (highest price-adjusted benchmark)	13,160	77.2	59.5	2.3	2.0

Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program). Benchmarks in the second column have been price adjusted using CMS county-level standardized prices from 2015. Savings presented in the other columns are based on CMS's benchmarks. The last column is the net of relative savings minus the amount paid to ACOs as shared savings, plus the amount paid back to CMS as shared losses. Data exclude 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: MedPAC analysis of CMS MSSP ACO public use file.

ACO; and the historical level of service use in the ACO's markets. Because these variables are all correlated to some degree, we evaluated them in a multivariate model. We used service use rather than spending because spending includes service use and price. Service use (relative to the national average) is something that the ACO could theoretically control; price is outside of the ACO's control and is instead a result of Medicare payment policy. The common practice of assuming that the ACO's benchmark is a good proxy for service use is a poor assumption. Our analysis found that:

- historical service use in the area where an ACO's beneficiaries live is the factor that best explains savings relative to benchmark performance for ACOs;
- ACO size (10,000 or fewer beneficiaries) and southern location also have some statistically significant explanatory value; and
- the ACO's size may have a larger effect on its odds of financial success than its type—that is, whether the ACO is formed around a primary care practice, multispecialty practice, or hospital.

Using 2016 performance data, we find there continues to be a relationship between service use and MSSP performance (Table 8-5). We price adjusted the 2016 ACO benchmarks to approximate historical service use (that is, we removed regional pricing differences in the

benchmarks) and separated the ACOs into quintiles based on the price-adjusted benchmarks.⁶ In Table 8-5, those ACOs with the highest price-adjusted benchmarks are in the fifth quintile, while those with the lowest price-adjusted benchmarks are in the first quintile. When prices are standardized, we found that ACOs with the highest price-adjusted benchmarks—indicating higher levels of historical service use—were more likely to achieve savings relative to the benchmark and earn shared savings payments. Furthermore, ACOs with higher price-adjusted benchmarks were more likely to generate net relative savings for the program.

These results are not surprising. ACOs with benchmarks exhibiting high historical service use tend to have more service use to reduce; thus, they have more opportunities to generate savings. This tendency is highlighted by results for ACOs in the highest quintile of price-adjusted benchmarks (approximated service use): Over 77 percent of these high-use ACOs achieved savings relative to their benchmarks, and almost 60 percent received a shared savings payment. In contrast, only about 11 percent of ACOs with the lowest level of price-adjusted benchmark received shared savings. Similarly, shared savings payments were 2.3 percent of the benchmark for ACOs with the highest benchmarks, and the implied net relative savings for the program (total savings minus shared savings payments to ACOs) was 2.0 percent. The program lost 1.3 percent of the benchmark for ACOs with the

**TABLE
8-6**

Summary financial results of Pioneer ACOs relative to benchmarks

	2012		2013		2014		2015		2016	
	Dollars (in millions)	Percent								
Benchmark	\$7,598	100.0%	\$7,142	100.0%	\$6,931	100.0%	\$5,490	100.0%	\$3,381	100.0%
Actual Part A and Part B spending	<u>7,507</u>	<u>98.8</u>	<u>7,046</u>	<u>98.7</u>	<u>6,811</u>	<u>98.0</u>	<u>5,453</u>	<u>99.3</u>	<u>3,320</u>	<u>98.2</u>
Relative savings	91	1.2	96	1.4	120	1.7	37	0.7	61	1.8
Paid to ACOs	-77	-1.0	-68	-1.0	-82	-1.2	-34	-0.6	-37	-1.1
Paid back to CMS	<u>2.5</u>	<u>0.0</u>	<u>11</u>	<u>0.2</u>	<u>9</u>	<u>0.1</u>	<u>2</u>	<u>0.0</u>	<u>0</u>	<u>0.0</u>
Net	16	0.2	39	0.6	47	0.7	5	0.1	24	0.7

Note: ACO (accountable care organization). The number of Pioneer ACOs was 32 for 2012, 23 for 2013, 20 for 2014, 12 for 2015, and 8 for 2016. "Relative savings" is defined as the difference between the benchmark and the actual spending. "Net" is the sum of relative savings and amounts paid to ACOs and paid back to CMS. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS Pioneer ACO quality and financial results, performance years 1-5.

lowest benchmarks. Although, within each quintile, some ACOs achieved savings and others incurred losses relative to their benchmark, the general trend was that ACOs' relative savings were positively correlated with higher service use.

Pioneer ACOs generally performed well on cost and quality metrics

The Pioneer ACO demonstration was the first ACO design tested in Medicare, and it was focused on organizations that had some experience in taking risk. It started with 32 ACOs in 2012 and continued through 2016. No ACOs were allowed to join the demonstration after it started, but participating ACOs were allowed to leave, so the number of ACOs decreased as time went on; by the final year of the program, only eight ACOs remained. The Pioneer demonstration was judged to be successful in controlling cost and increasing quality by the CMS Office of the Actuary and was certified for expansion. Many of the lessons learned in the Pioneer demonstration (e.g., prospective attribution and allowing ACOs to share in a larger portion of savings) were used when designing the Next Generation ACO program and Track 3 of the MSSP.

Pioneer quality

In the Pioneer program, an ACO's quality score determined its savings/losses sharing rate. In 2016, all

Pioneer ACOs met the quality reporting requirement. Like the MSSP ACOs, they also had high quality scores, ranging from 89 percent to 96 percent. We reviewed changes over time in some of the patient experience and population-based outcome measures that the Commission supports. The eight ACOs that participated in all five years of the Pioneer program had consistently high patient experience results. On average, these Pioneer ACOs showed some meaningful improvement in two measures: health promotion and education (improvement of almost 5 percent) and health/functional status (3 percent improvement). All but one of the ACOs improved their hospital readmissions rates.

Pioneer performance relative to benchmarks (relative savings)

In the final year of the demonstration, there were 8 remaining Pioneer ACOs serving nearly 270,000 beneficiaries. Those remaining ACOs generated savings relative to their benchmarks, with a net relative savings of \$24 million in 2016 (Table 8-6).

The relative savings percentage, with and without taking into account shared savings, increased over the first three years, followed by lower savings in the fourth year. Two factors may partially account for this trend. First, ACOs that stayed in the program tended to be more successful

**TABLE
8-7**

Summary financial results of Next Generation ACOs relative to benchmarks, 2016

2016

	Dollars (in millions)	Percent
Benchmark	\$5,149	100.0%
Actual Part A and Part B spending	<u>5,101</u>	<u>99.1</u>
Relative savings	48	0.9
Paid to ACOs	-58	-1.1
Paid back to CMS	<u>20</u>	<u>0.4</u>
Net	10	0.2
Discount	53	1.0
Total relative savings	63	1.2

Note: ACO (accountable care organization). There were 18 Next Generation (NextGen) ACOs in 2016. "Relative savings" is defined as the difference between the benchmark and the actual spending. Benchmarks for NextGen ACOs are constructed with a built-in discount—an ACO-specific decrease to the benchmark—to ensure savings for the program. "Net" is the sum of relative savings and amounts paid to ACOs and paid back to CMS.

Source: MedPAC analysis of CMS Next Generation ACO quality and financial results, performance year 1.

than those that left. Hence, relative savings appeared to increase in subsequent years as the unsuccessful ACOs dropped out. Second, the decrease in relative savings in 2015 was likely due to the benchmarks being rebased. Rebasing takes into account any success achieved in the previous years. If relative savings were achieved in the first three years, the rebased benchmark will decrease before trending, making it more difficult to achieve relative savings in future years. This issue of how much rebasing should take into account ACOs' past success in controlling spending is discussed later in the chapter.

In 2016, four more ACOs left the Pioneer demonstration, and the remaining ACOs generated relative savings. This result is partly because these ACOs' per capita benchmark between 2015 and 2016 increased significantly. Four ACOs had an increase of 10 percent or more. Even so, after subtracting shared savings paid to the ACOs, the Medicare program saw net relative savings of less than 1 percent of the benchmark.

Next Generation ACOs have performed well on cost and quality metrics

The three program performance years for the Next Generation (NextGen) demonstration are 2016 to 2018, with an option for ACOs to extend their participation for

an additional two years. The NextGen demonstration qualifies as an A-APM. It has a few differences that distinguish it from the MSSP and Pioneer demonstrations, including higher risk sharing, new benchmark methodology, multiple payment models, and beneficiary engagement tools. The text box on the NextGen demonstration (pp. 226–227) summarizes these provisions.

Performance of NextGen ACOs (relative savings)

There were 18 NextGen ACOs in performance year (PY) 1 (2016); Table 8-7 shows summary financial results for 2016. Actual spending was less than the aggregate benchmark, resulting in relative savings of \$48 million (0.9 percent). After taking into account payments for shared savings and losses, there was net relative savings of \$10 million (0.2 percent). However, the benchmarks for NextGen ACOs are constructed with a built-in discount—an ACO-specific decrease to the benchmark—to ensure savings for the program (see the text box on the NextGen demonstration, pp. 226–227, for more information on the discount). Taking into account the discount, the demonstration saved \$63 million (1.2 percent) relative to the benchmark.

The ACOs varied in performance. Eleven NextGen ACOs had savings ranging from 0.1 percent to 4.1 percent, and

**TABLE
8-8**

Summary financial results of ESRD Seamless Care Organizations relative to benchmarks, 2016

2016

	Dollars (in millions)	Percent
Benchmark	\$1,415	100.0%
Actual Part A and Part B spending	<u>1,340</u>	<u>94.7</u>
Relative savings	75	5.3
Paid to ESCOs	-51	-3.6
Paid back to CMS	<u>0</u>	<u>0</u>
Net	24	1.7

Note: ESCO (ESRD (End-Stage Renal Disease) Seamless Care Organization). There were 13 ESCOs in 2016. "Relative savings" is defined as the difference between the benchmark and the actual spending. "Net" is the sum of relative savings and amounts paid to ESCOs and paid back to CMS.

Source: MedPAC analysis of CMS ESCO quality and financial results, Performance Year 1.

the other seven had losses ranging from 0.1 percent to 2.6 percent. Because 2016 was the first year of the NextGen ACOs, any ACO that fully and accurately reported quality data received a 100 percent score for quality; all NextGen ACOs received 100 percent in 2016.

ESRD Seamless Care Organizations

As part of the Comprehensive ESRD Care (CEC) Model, nephrologists, dialysis clinics, and other providers can join together to create ESCOs, which are ACO-like models for the ESRD population. Similar to other ACO models, ESCOs are responsible for their attributed population's quality and financial outcomes, with larger ESCOs liable for shared losses.

ESCOs have performed well on cost metrics (relative savings) and average on quality metrics

There were 13 ESCOs in PY1 (2016). All 13 produced savings relative to their benchmarks, with 12 ESCOs producing enough savings to earn shared savings payments. These shared savings payments ranged from \$1 million to \$12 million. Quality in PY1 was essentially pay for reporting, so all ESCOs that completely and accurately reported quality data received a quality score of 100 percent. In total, the demonstration saved 1.7 percent relative to the benchmark (Table 8-8).

ESCOs are a good test case for ACOs. The population is well defined and has a chronic condition that dominates their care. Most beneficiaries on dialysis are treated at a dialysis facility three times a week and see their nephrologist at least monthly. Thus, the ESCO has many opportunities to communicate with its patients and coordinate their care, and attribution should be clear.

ESCO quality

The measure set for the CEC currently includes 11 process measures (e.g., advance care plan, influenza immunization), 1 outcome measure (i.e., standardized mortality ratio), and 6 patient experience measures based on the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems® survey. In the first year of the program, all 13 ESCOs received full credit for the quality score because they completely and accurately reported data to calculate quality measure results. Analysis of the 2016 results recently released by CMS shows that the ESCOs' patient experience results are around the national average for dialysis facilities (e.g., rating of kidney doctors, rating of dialysis center).

Beginning in the second year of the program (2017), each ESCO earns quality points on a sliding scale based on its performance compared with a national benchmark or its improvement from its previous year results. The

Next Generation ACO demonstration: Key provisions

The Next Generation (NextGen) accountable care organization (ACO) demonstration builds on CMS's experience with previous ACOs but has a few differences, including higher risk sharing, new benchmark methodology, and new beneficiary engagement tools.

Risk sharing

The NextGen program allows for higher risk sharing for ACOs; Arrangement A allows ACOs a shared savings (or loss) rate of up to 80 percent, and Arrangement B ACOs can have a sharing rate of up to 100 percent. Savings and losses are shared at first dollar instead of requiring an ACO to exceed a minimum savings or loss rate. There is also a limit on shared savings or losses for the ACO: 15 percent of the benchmark.

Benchmarks

The prospective benchmark calculation for the NextGen ACOs differs from Pioneer and Medicare

Shared Savings Program ACOs and is intended to promote savings, better reward ACOs that are already efficient, and provide certainty as to the benchmark at the beginning of the year.⁷ Benchmarks for the first three performance years are calculated based on historical expenditures as in the other ACO programs, but the baseline for calculating the benchmark will come from one year of data (2014) instead of three years of data. The baseline 2014 expenditure data will then be trended based on regional projections for the current year and risk adjusted. After trending and risk adjustment, the benchmark is discounted; the discount can be thought of as an automatic decrease to the benchmark, making it slightly more difficult to generate savings. The size of the discount differs for each ACO because the discount is adjusted to take into account both a national and regional efficiency ratio. ACOs that are more efficient than their market or the nation will receive a more favorable (smaller) discount to their benchmark. The intent of this approach is to rectify previous benchmarking methods that in some sense penalized already efficient providers.

(continued next page)

total points earned for each measure is multiplied by the measure weight and summed to produce the ESCO total quality score, which is used to determine the ESCO's eligibility for shared savings. Data are not yet available for 2017.

ACO quality and financial performance results according to other researchers

In this section, we discuss estimates from the literature of how much ACOs have saved the Medicare program. Each study's estimate depended on the choice of counterfactual, meaning the study's estimation of what spending would have been for the beneficiaries attributed to ACOs in the absence of the ACO. The studies often used a comparison group to determine the counterfactual. Because the studies' counterfactuals differ from the ACOs'

benchmarks, the estimated savings in the various studies differ from the relative-savings computations that are used when CMS distributes shared savings. We discuss how various savings estimates compare with the savings CMS has computed using administratively set ACO benchmarks.

Savings relative to benchmarks and other estimates of savings can differ

Savings relative to CMS-constructed benchmarks and other estimates of ACO savings can differ because CMS constructs benchmarks to fulfill certain policy goals. For example, in our early work on ACOs, we maintained that the appropriate trend for the benchmark should be the national increase in FFS spending stated in absolute dollar terms and that the benchmark should be stated in standardized dollars (Medicare Payment Advisory Commission 2009). The rationale for that design was that an area that had historically low service use would see a relatively large trend increase, and one that had

Next Generation ACO demonstration: Key provisions (cont.)

In addition to the prospective benchmark calculation, NextGen ACOs also have the opportunity to choose one of four ways to receive payment from CMS: standard fee-for-service (FFS), FFS and infrastructure payments, population-based payment (PBP), and (starting the second year) partial capitation. Under the FFS and infrastructure option, ACOs receive their usual FFS payments and an additional payment to be put toward infrastructure. At the end of the year, these infrastructure payments are subtracted from the savings an ACO would receive or are added to the loss amount an ACO owes. The PBP option reduces FFS claims by a percentage and then pays ACOs this reduction in per beneficiary per month (PBPM) payments. ACOs then receive both PBPM payments and reduced FFS payments. In the final option, partial capitation, CMS estimates expenditures for a given ACO on a PBPM basis, and then participating ACOs receive PBPM payments at the start of each month that cover the expected cost of ACO-aligned providers. Choosing the partial capitation option places responsibility on

ACOs to pay claims for services provided by ACO participants that have written agreements with the ACO. CMS will continue to pay claims to other providers and reconcile payments with the NextGen ACO's target after the year is complete.

Beneficiary engagement

NextGen ACOs are designed to focus on greater beneficiary engagement by allowing beneficiaries to align themselves with the ACO and providing incentives for using ACO services. Incentives can include reward payments to beneficiaries for using ACO-affiliated providers and allowing a more flexible Medicare benefit, such as covering skilled nursing facility stays without a prior three-day hospitalization. Beneficiaries will be able to align with an ACO by filling out a form that confirms that they use a specific provider or practice. This voluntary alignment process began in 2016, and beneficiaries who submitted an alignment form were added to the prospective list of beneficiaries starting in performance year 2 (2017). ■

historically high service use would receive a relatively low trend increase. Thus, our option would not reward areas of the country with already high service use. Actual policy kept the national trend, but spending was not stated in standardized dollars. In other words, the trended benchmark was not designed to necessarily best predict spending for an area's beneficiaries but rather to meet the goal of being equitable across the country. While CMS's benchmark is designed to fulfill certain policy goals, other groups have used other methods to provide an alternative assessment of whether ACOs save Medicare money. These alternative assessments use a counterfactual—that is, what spending on the beneficiaries in the ACO would have been in the absence of the ACO—to estimate savings.

Savings estimates in literature (program savings)

To determine what spending would have been for beneficiaries in the absence of an ACO, most studies relied on comparing changes in ACO spending with changes in

spending for a control group. For instance, one study used a 20 percent sample of beneficiaries to compare changes in spending for beneficiaries in ACOs with changes in spending for a group of beneficiaries served by non-ACO providers in ACO service areas (McWilliams et al. 2016). Under this scenario, McWilliams estimated that MSSP net savings in 2014—including bonus payments paid to ACOs—were \$287 million, or 0.7 percent of spending for ACO beneficiaries (McWilliams 2016a, McWilliams 2016b).

Using the same methodology to analyze the performance of Pioneer ACOs, McWilliams and colleagues estimated that Pioneer ACOs saved \$118 million (1.2 percent of spending for ACO beneficiaries) relative to expected spending in their first year (2012), or \$42 million (0.3 percent of spending) when bonus payments paid to ACOs are subtracted from total savings (McWilliams et al. 2015).

L & M Policy Research, the group CMS contracted with to formally evaluate the Pioneer ACO program, estimated

\$280 million (3.7 percent of spending) in savings for the first year of the Pioneer ACO program (L & M Policy Research 2015, Nyweide et al. 2015, Office of the Actuary 2015).⁸ The comparison group in L & M's analysis included all "FFS Medicare beneficiaries who are not aligned or assigned to a Medicare ACO in the Pioneer ACO's local, or 'near' market."⁹ This analysis did not restrict the comparison group to ACO-attributable FFS beneficiaries. Thus, savings might be overstated because, to be attributable to an ACO, beneficiaries had to have a primary care visit. FFS beneficiaries who did not have a primary care visit in the baseline year were only in the control group, not in the ACO. The problem is that these individuals tend to have low baseline spending and high spending growth, which could have made the comparison group appear to grow faster than it would have if it included only ACO-attributable beneficiaries.

Another analysis examined the combined performance of both MSSP and Pioneer ACOs in 2012 and 2013. It created a control group by utilizing "a random 40% sample . . . of continuously enrolled fee-for-service beneficiaries with at least 1 evaluation and management visit in a calendar year" (Colla et al. 2016). That analysis found that, together, MSSP and Pioneer ACOs saved approximately \$592 million (about 1.1 percent of the benchmark) in 2013.

When CMS' Office of the Actuary (OACT) certified that expanding the Pioneer ACO Model would reduce spending for the program, it conducted a market-level analysis (Office of the Actuary 2015). OACT's analysis compared FFS spending growth in markets with heavy MSSP and Pioneer penetration with markets that had few ACOs. For markets with low rates of ACO penetration, FFS per capita spending decreased by 0.3 percent from 2011 to 2014, whereas for markets with high rates of MSSP ACOs, per capita spending decreased 1.2 percent, and in markets with high rates of Pioneer ACOs, it decreased by 2.1 percent. OACT's findings that FFS spending growth decreased more in Pioneer ACO markets, taken in conjunction with Pioneer ACOs' ability to save money relative to their benchmarks and L & M's positive evaluation results, led OACT to certify that Pioneer ACOs were successful in reducing spending.

Given the CMS benchmarking analyses, studies in the literature, and the work by OACT, it appears the ACO programs have generated savings estimated in the 0 percent to 2 percent range. ACOs also generally appear

to improve the quality of care received while generating savings (Government Accountability Office 2015, Office of Inspector General 2017, Pham et al. 2014). While these savings may appear modest, they are more than most care coordination demonstrations have achieved, including the most recent Comprehensive Primary Care initiative (Dale et al. 2016, Nelson 2012).

Spillover estimates

In addition to the direct savings from reduced spending on beneficiaries in ACOs, indirect savings of two kinds (spillover and reduced MA benchmarks) are also possible, according to researchers. McWilliams's (2016) research on MSSP ACOs considers potential additional savings accrued through spillover effects. Under this theory, ACO providers furnish better coordinated care to all their patients, thus "spilling over" to their non-ACO FFS beneficiaries. The magnitude of the spillover effect is expected to be modest and has not been tested empirically. Another indirect benefit could result from reduced MA benchmarks over time, as a county's FFS spending on which MA benchmarks are based is reduced. This effect presupposes savings from ACOs. In fact, spending in some counties with MSSP ACOs could have increased, particularly if shared savings payments are included as FFS spending, and could result in an increase in MA benchmarks, although the magnitude would probably be small in either direction.

Sources of savings

Research shows that how ACOs generate savings does not necessarily align with preconceptions. Early in the development of ACOs, some speculated that savings would accrue through better coordinated care and subsequent reductions in unnecessary inpatient capacity, tests, imaging services, and post-acute care (PAC) use (Fisher et al. 2007). Data from the Alternative Quality Contracts (AQC)s, a commercial predecessor to Medicare's ACOs, indicated that savings could be generated through these avenues, specifically by decreasing utilization of procedures, imaging, and tests and by referring patients to less expensive providers (Song et al. 2014). While AQC)s were successful in these areas, Medicare ACOs—especially those in the MSSP—have largely created savings by decreasing PAC utilization. A recent study by McWilliams and colleagues found that, while MSSP ACOs were scaling back inpatient capacity slightly, they were generating a higher proportion of their savings by decreasing PAC

utilization—specifically SNF use (McWilliams et al. 2017b). Pioneer ACOs likewise reduced PAC utilization to generate savings, in addition to having lower rates of inpatient stays, imaging, tests, and procedures, similar to the AOCs (L & M Policy Research 2015, McWilliams et al. 2014).

Additionally, while many expected ACOs to focus on coordinating care for high-risk patients to save money, a recent study found that those savings have yet to occur in the MSSP program. When comparing ACO savings in 2014 for high-risk and low-risk patients, savings between the two groups were relatively similar for the cohort of ACOs that began in 2012 (McWilliams et al. 2017a). For ACOs that entered the program in 2013, more savings were accrued for low-risk patients than high-risk patients. Furthermore, the study found MSSP ACOs did not reduce hospitalizations for ambulatory care-sensitive conditions.

New tools to allow ACOs to manage care

While the ACO program has grown in numbers of ACOs and beneficiaries, it continues to evolve. The recently passed Bipartisan Budget Act of 2018 (BBA of 2018) included several changes to Medicare’s ACO programs, including incentives for beneficiaries to see ACO providers, use of telehealth, and beneficiary assignment. Many of these changes are consistent with past Commission positions on ACOs. These changes are expected to make the program more attractive to providers by enhancing the tools they have to improve quality and reduce costs.

ACO Beneficiary Incentive Program

Starting no later than 2020, the Secretary is to establish an ACO Beneficiary Incentive Program, which would allow ACOs to pay beneficiaries up to \$20 for each qualifying primary care visit with an ACO provider. ACOs will have to apply to run such a program, which will be available only to two-sided-risk ACOs. Incentive payments will not factor into an ACO’s benchmark, and incentive payments could be funded through previous shared savings payments. The Commission has previously supported giving ACOs more options for incentivizing beneficiaries to use their ACO providers so that ACOs have more leverage in coordinating their beneficiaries’ care (Medicare Payment Advisory Commission 2014b).

Telehealth

The BBA of 2018 expanded the use of telehealth for two-sided-risk ACOs with prospective attribution. Under the BBA of 2018, qualifying ACOs are no longer subject to a geographic limitation on the telehealth originating site and are allowed to use the beneficiary’s residence as an originating site. Currently, some ACO demonstrations allow for expanded use of telehealth (e.g., NextGen), but ACOs are required to submit a waiver to utilize the benefit. In its recent telehealth discussions, the Commission has supported the expanded use of telehealth for risk-bearing ACOs because the ACOs are at risk for cost (unlike providers in traditional FFS) (Medicare Payment Advisory Commission 2018).

Expanded prospective attribution

ACOs in retrospective attribution models (i.e., MSSP Track 1 and Track 2) beginning or renewing their agreements on January 1, 2020, and beyond can choose to have their beneficiaries assigned prospectively. The Commission has long been in support of prospective attribution because it gives providers more certainty at the start of the performance year about which beneficiaries are in their ACOs and allows for better coordination of care throughout the year (Medicare Payment Advisory Commission 2015a, Medicare Payment Advisory Commission 2014a). However, benchmarks for ACOs changing attribution will need to be recomputed to reflect the beneficiaries in the baseline who would have been attributed under prospective attribution versus retrospective attribution.

Attribution based on voluntary identification by beneficiaries

According to the BBA, the Secretary will also establish a process by which beneficiaries will be informed of their option to voluntarily identify a principal primary care provider. If the designated primary care provider participates in an ACO, the beneficiary will be automatically attributed to that ACO. A similar process is already in place for the MSSP. Currently, beneficiaries can log on to MyMedicare.gov and designate a clinician as their “primary clinician” who is responsible for coordinating their overall care (Centers for Medicare & Medicaid Services 2017a). Clinicians in ACOs have some latitude to encourage beneficiaries to designate them as their primary clinician. However, to date it appears that few beneficiaries are being aligned under this mechanism.

Long-term issues for Medicare ACOs

Medicare ACOs were created to help moderate the growth in Medicare spending and improve quality of care for beneficiaries by giving providers greater responsibility for costs and quality. ACOs have grown rapidly (about a third of Medicare FFS beneficiaries are now in ACOs), and several new initiatives have been designed to expand ACOs. Performance to date shows high quality being maintained, some savings relative to benchmarks, and slightly greater savings relative to what Medicare spending would have been without ACOs. However, several issues confront Medicare ACOs—particularly as they transition to models with two-sided risk—that will need to be resolved for the program to be successful in reaching its goals.

Because two-sided risk models are more likely to result in savings for the Medicare program, the following questions arise: Can hospitals and ACOs viably coexist and, if so, what does that mean for ACOs moving to two-sided risk? Should asymmetric models be continued even if they present the risk of excess spending for Medicare? What approaches to setting benchmarks should be used? What method should be used to distribute the 5 percent bonus for clinicians participating in A-APMs? What relationship will specialists have with ACOs? Are ACOs a path to MA plans or are they an end in themselves?

Are hospitals a viable participant in ACOs?

In general, hospitals have greater financial resources than most clinician groups, which can make accepting downside risk easier for an ACO with a hospital participant than an ACO without one. In fact, about half of risk-bearing MSSP ACOs (Track 1+, Track 2, and Track 3) list hospitals as participating providers. Thus, it may be important for hospital-based ACOs to thrive to make two-sided ACO models more available.

There is a concern, however, that hospitals may be reluctant to reduce service volumes to meet ACO spending targets because they do not want to reduce their own FFS revenue. However, the data show that ACOs with hospitals can meet spending targets. We examine how they are meeting spending targets and conclude that hospital-based ACOs may continue to be part of the ACO landscape into the future.

Conflict between hospital and ACO incentives

It may at first appear that the incentives for ACOs and hospitals conflict. In an FFS payment environment,

a hospital has an incentive to increase the volume of Medicare admissions as long as the payment for an additional patient exceeds that patient's variable cost and the hospital has excess capacity. (In our March 2018 report, we found that the average hospital occupancy rate was 66 percent and that variable costs were 8 percent less than Medicare payments. Therefore, most hospitals have an incentive to increase the volume of Medicare admissions (Medicare Payment Advisory Commission 2018).) At the same time, ACOs have an incentive to keep Medicare spending for their attributed beneficiaries below a target amount—their benchmark. If they do so, they can share savings with Medicare. One way to reduce or constrain spending is to reduce inpatient admissions. Thus, it would appear that the incentives for hospitals and ACOs are in conflict.

While ACOs may eventually have some effect on admissions, it appears to date that ACOs have not caused a large reduction in inpatient admissions, despite rhetoric to the contrary. We examined changes in inpatient admissions and considered why the trends should not be surprising. Assuming trends continue, opportunities for cooperation between ACOs and hospitals may exist, and concerns about the conflicting incentive may be less germane.

Reducing post-acute care (not inpatient care) is the primary source of ACO savings

In interviews we conducted in 2012 and 2013, many ACO leaders expected to generate savings by reducing the volume of inpatient care. In particular, physician leaders of ACOs saw the hospital as a key driver of spending, and reducing unnecessary hospital admissions as a key source of savings. However, a review of the literature finds that reducing PAC has been a much bigger source of ACO savings than reducing inpatient admissions (McWilliams et al. 2017a, McWilliams et al. 2017b). Similarly, the AQC program, a commercial ACO program, did not generate significant reductions in inpatient facility fees or inpatient professional fees (Song et al. 2014). In contrast, AQC savings were generated by reducing spending on outpatient facility fees and professional fees—often by shifting services to lower priced providers (Song et al. 2012). Thus, decreased hospital revenues from the actions of ACOs may be due to a shift of outpatient services to lower priced settings rather than a decline in the number of admissions. The finding that ACOs do not cause big reductions in inpatient spending is consistent with the following three findings.

First, in FFS Medicare, inpatient service use varies little by region (Medicare Payment Advisory Commission 2017b). Our analysis of claims data from 2014 found that across 484 market areas, inpatient use for market areas at the 90th percentile of use was 1.16 times that for market areas in the 10th percentile of use. In contrast, PAC use for market areas at the 90th percentile of use was 1.88 times that of market areas in the 10th percentile of use. Across all markets, the ratio of the maximum to minimum service use was 1.49 for inpatient and 5.66 for PAC use. This finding suggests ACOs would have a greater opportunity for savings by reducing spending on PAC services in high-use areas than by reducing spending on inpatient services.

Second, we found that admission and revenue growth vary by hospital, but ACOs and MA plans are not the driving forces. To see whether ACOs and MA plans have had a material effect on hospital volumes in recent years, we examined whether county-level ACO penetration in 2015, MA penetration in 2015, and growth in MA penetration from 2011 to 2015 were associated with reductions in either all-payer admissions or revenue at hospitals from 2012 to 2016. We also tested to see whether hospitals that were in an ACO tended to have lower volume or revenue growth.¹⁰ We add in MA penetration because, if MA penetration does not materially affect hospital inpatient volume, then there is little reason to expect ACOs to materially affect hospital inpatient volume.

Our test consisted of a linear regression in which we controlled for, among other things, population growth and hospitals' size. The level of ACO penetration, MA penetration, growth in MA penetration, and whether the hospital participated in an ACO all failed to have a statistically significant effect on the change in a hospital's total admissions or total revenue. While hospitals in markets with ACOs and growing MA penetration saw small declines in inpatient use, it was not higher than in the average market. This finding suggests either that MA plans and ACOs have a limited impact on Medicare inpatient admissions or that hospitals are able to replace lost Medicare admissions with other patients. In contrast, population and hospital size were highly significant. For each 1 percent increase in population, hospital admissions increased by 0.8 percent. We also found that smaller hospitals tended to lose discharges faster than larger hospitals. The net finding, that admission and revenue growth vary by hospital, but ACOs and MA plans are not the driving forces, suggests that hospitals can coexist with MA plans and ACOs.

Third, another way to examine whether MA plans significantly reduce inpatient use is by analyzing their bids for self-reported spending on inpatient care. We find that MA plans and FFS Medicare devote similar shares of their overall spending to inpatient care. This finding suggests that MA plans do not reduce inpatient care to a larger degree than they reduce other services on average, which differs from data from 20 or 30 years ago. There is some evidence that HMOs historically had 35 percent to 40 percent fewer admissions per capita than indemnity plans or Medicare FFS (Duggan et al. 2018, Newhouse 1993). However, those studies used data from 2003 or earlier. Since that time, FFS discharges per capita have fallen by about 25 percent, making reductions from the lower FFS baseline more difficult. ACOs, which have fewer tools than MA plans to control admissions, should not be expected to achieve greater reduction than MA plans.

In light of these findings, it appears that the greatest opportunity for ACOs to control spending is in post-acute care, not inpatient care. While ACOs may eventually lead to small reductions in inpatient use, we have not seen evidence to date that they materially affect hospital revenue.

Should asymmetric models be continued?

One way to encourage ACOs to take on risk is to make the models asymmetrical—that is, to make the share of savings greater than the share of losses or to put higher caps on savings than on losses. A policy question is whether such models should be a temporary path to increase ACO participation in these models (and give clinicians an opportunity to participate in A-APMs) or be a permanent part of the program.

For example, the Track 1+ model has two asymmetries. First, the model has a shared savings rate of 50 percent and a shared loss rate of 30 percent. Second, the loss cap is lower than the savings cap for all types of Track 1+ ACOs. There are two choices for the loss cap, both of which are less than the 10 percent of the benchmark cap on gains. The first choice is 4 percent of the benchmark; the second is 8 percent of the Medicare FFS revenue for the ACO participants. This choice is limited to ACOs whose only participants are clinicians or clinicians plus a small rural hospital. This amount will also be much less than 10 percent of the benchmark.¹¹

This design gives Track 1+ ACOs certain advantages over ACOs in the Track 1 model, despite the downside risk in Track 1+ not present in Track 1. In Track 1+, providers are at risk for losses, but the ACOs' clinicians are eligible

for the 5 percent incentive on their physician fee schedule (PFS) payments because these ACOs are considered A-APMs. The 5 percent incentive considerably ameliorates the risk of being in Track 1+ because the maximum risk in Track 1+ for ACOs with only clinicians as participants is 8 percent of their FFS Medicare revenue. If they automatically get a 5 percent bonus, risk is essentially limited to 3 percent of Medicare FFS revenue. If the ACO is likely to break even—that is, has a roughly equal probability of showing a loss or a gain—we calculate that the clinicians would see more financial advantage in Track 1+ than in Track 1. A recent analysis by Avalere found that, in aggregate, MSSP ACOs would have fared better in 2016 by \$966 million if they had all been in Track 1+ rather than Track 1 (Avalere Health 2018).

By statute, CMS can introduce other MSSP models as part of permanent Medicare law if those models are estimated not to increase Medicare spending relative to the Track 1 model (CMS has done so for the Track 2 and Track 3 models). However, Track 1+ is a demonstration under the authority of CMS's Center for Medicare & Medicaid Innovation (CMMI), not an additional MSSP model. Therefore, the Track 1+ model does not have to meet that requirement, and ACOs can join even if the model increases spending.¹² If Track 1+ were incorporated into permanent Medicare law, the costs would have to be offset.

It appears that Track 1+ could put the Medicare program at risk of financial loss if Track 1+ ACOs' losses relative to the benchmark are greater than ACOs' relative savings because of the model's asymmetries. If Track 1+ were incorporated into permanent Medicare law, the costs may need to be offset if performance is essentially random. If it is demonstrated that ACOs are modifying their behavior from what they would have done if not in ACOs and reducing spending, then this issue will not arise. Currently, ACOs can be in Track 1+ for only one three-year agreement period. Policymakers must decide whether the asymmetries in Track 1+ are appropriate and whether the model is a success; if it is a success, policymakers will need to decide whether aspects of the model should be extended to other ACO models (or CMS should continue the Track 1+ model).

Whether Track 1+ will cost Medicare more relative to what spending would otherwise have been or relative to Track 1 will depend on the ACOs' performance. Because of the possibility of sharing in losses, clinicians in Track 1+ could be more likely to succeed at controlling spending

than in Track 1 or in unconstrained FFS and could indeed save money for the program while possibly increasing quality. It seems to be a popular model thus far; in 2018, 55 ACOs entered the Track 1+ model. Therefore, it will likely increase the availability of A-APMs for clinicians to join. Whether the increased availability of A-APMs is worth the possible increased cost to the program is an important policy question. The Commission will track the progress of the Track 1+ model over the next few years to see whether the model is saving or costing the Medicare program relative to Track 1 and FFS Medicare.

How should benchmarks be set initially and rebased for subsequent agreement periods?

One of the most important policy questions when designing ACO and MA payment policy is how to set the benchmarks. The goal of a benchmark for an individual ACO is to create incentives to encourage the ACO's providers to increase quality while restraining overall Part A and Part B spending. However, a benchmark that accomplishes that goal may not be the best estimate of what spending for those beneficiaries would have been in the absence of the ACO. We need to know the latter to ensure that, at the national level, the ACO program is reducing Medicare spending over the long term while improving quality or at least keeping it constant. Thus, to determine whether an ACO program is "working," we need to know whether it is creating useful incentives at the individual ACO level and savings at the national level.

Two approaches to setting benchmarks

Generically, there are two approaches to setting benchmarks in Medicare: regional benchmarks, as used in the MA program, or historical spending, as used in the ACO programs. For example, in MA plans, the benchmark is set based on five years of historical FFS spending in each county, adjusted for the beneficiaries' hierarchical condition category (HCC) coding scores. This approach creates incentives for MA plans to devote resources to coding, and the result has been more coding in MA plans than in FFS Medicare. (Under this coding incentive, MA beneficiaries appear to be getting sicker quicker compared with beneficiaries in FFS Medicare, whose providers—paid differently from MA plans—lack the same incentive to code their patients at the greater intensity levels.) In addition, coding practices across MA plans vary widely. We have made recommendations to address MA's higher level of coding in aggregate and the variation by plan (Medicare Payment Advisory Commission 2016c).

In part to get around the dependence on risk adjustment using HCC scores, ACOs were built on a model that looks at historical spending for a fixed group of people or a fixed group practice and examines how spending for the ACO's beneficiary population changes from one year to the next. This approach incorporated the assumption that the population of beneficiaries and providers in each ACO would be relatively stable. However, the "churn," or movement of beneficiaries (and, in some cases, providers) in and out of ACOs, has been larger than anticipated, with one study finding only 66 percent were consistently assigned over two years and about 20 percent of beneficiaries left the ACO each year (McWilliams et al. 2014). Although changes in provider participation are dealt with by recalculating baseline spending, churn in attributed beneficiaries could be an issue for benchmarking if those who lose ACO alignment have systematically different characteristics from those coming into alignment. For example, those leaving the ACO could be very high cost and those entering could be very low cost, in which case the ACO's benchmark would need to be refined.

Population dynamics

In a preliminary analysis, we compared a control population with MSSP ACO-aligned beneficiaries located in the same metropolitan areas. We found that beneficiaries attributed to MSSP ACOs for two consecutive years had spending growth about 3 percent lower than beneficiaries who were not in an ACO in either year. We also found that beneficiaries who were attributed in the first year and lost attribution to the ACO in the second year (and thus were in an ACO for only one year) had spending growth that was even further below the control group. Conversely, those who were attributed to an ACO in the second year and not in the first had much higher spending growth than the control group. That is, the people who lose alignment to the ACO have low spending growth, and those who join have high spending growth. (We also found that MSSP ACOs do not appear to materially affect end-of-life spending.) Savings estimates for MSSP ACOs should be evaluated taking these findings into account.

There are several potential explanations for these findings. For example, a beneficiary may become sick, see an ACO clinician repeatedly, and have increased spending. Because the plurality of care will now be with an ACO clinician, this case could result in the beneficiary being aligned with the ACO when she otherwise would not have been, and it would be consistent with findings in our preliminary analysis. At the same time, beneficiaries who stop seeing clinicians because their principal condition improves

may have lower spending and lose attribution to their ACO because their plurality of care is no longer with the ACO clinician. This scenario is also consistent with our findings. A consistent relationship between service use and attribution (or loss of attribution) could be an issue. One way to limit the effect of attribution on changes in spending is to use prospective attribution. Under prospective attribution, the year of data used to attribute an individual differs from the performance year data used to evaluate spending relative to the benchmark. Therefore, an episode of illness that results in a beneficiary being attributed to an ACO will be in a previous year and thus in the benchmark.

This preliminary analysis suggests that, although MSSP ACOs are to some extent controlling the spending growth for beneficiaries who are continuously attributed, there is a tendency for ACOs to have beneficiaries leaving who have lower growth in spending and beneficiaries joining who have higher growth in spending. Attribution is related to service use, which could be a source of concern when setting benchmarks or estimating savings.

Rebasing benchmarks

In our February 2015 comment letter on the MSSP ACO proposed rule, we noted a basic conflict in the benchmark-setting mechanism and in the dynamics of rebasing (Medicare Payment Advisory Commission 2015b). (Rebasing is the process of setting ACO benchmarks at the start of each three-year agreement period subsequent to the first period.)

On the one hand, if benchmarks are rebased strictly on the historical experience of the ACO's patients, the benchmark will incorporate the efficiencies the ACO has realized in the first three years and further improvements will be difficult to achieve. If an ACO were in the program for repeated periods, this increased difficulty could make it less desirable for an ACO to continue with the program. Such a result does not seem equitable for an ACO that has improved its efficiency—particularly if its benchmark to begin with was below the level of ambient FFS spending in its region.

On the other hand, one could set benchmarks using an approach similar to that for MA plans (HCC-adjusted local FFS spending). A regional benchmark could be calculated using FFS spending, and that amount multiplied by the HCC score for each attributed beneficiary would be summed to calculate the ACO's benchmark. However, under such an approach, ACOs would be able to calculate

their benchmarks in advance, and only ACOs that are already below their regional benchmark would participate. ACOs that had spending above the regional average would not participate because they would likely have actual spending above their benchmark. Thus, efficient ACOs would likely receive a shared savings bonus for doing what they would have done anyway, and inefficient ACOs that needed an incentive to control spending would not participate. The result would likely cost the Medicare program more and not improve quality appreciably. In addition, if HCC scores were used in benchmarking, some of the same issues that have been well documented in MA would arise—with the variability in coding intensity across practices and the incentives to spend more money on coding being the most problematic.

One approach to this challenge is to blend historical experience and the regional average when rebasing benchmarks. This approach is now being taken in MSSP when benchmarks are rebased every three years. Essentially, the average of the ACO's risk-adjusted expenditures over the past three years is compared with the FFS region's risk-adjusted expenditure average. If the ACO's per capita risk-adjusted expenditures are higher than the regional average, the benchmark is reduced toward the regional average; if the ACO's expenditures are lower, the benchmark is raised toward the average. This approach rewards ACOs whose original benchmarks (i.e., the benchmarks at the start of the three-year agreement period) were below the regional average, penalizes those with original benchmarks above the regional average, and compresses rebased benchmarks in a market toward the regional average (Centers for Medicare & Medicaid Services 2017b).

The NextGen program has initially taken a different approach to accounting for efficiencies and regional variation. NextGen ACO benchmarks incorporate a discount to the historical spending for an ACO's beneficiaries. That discount varies in size from 0.5 percent to 4.5 percent. A larger discount reduces the benchmark more than a smaller discount. The size of the discount varies based on the ACO's efficiency relative to FFS spending in its region and relative to the national average of FFS spending. ACOs that are efficient in comparison with their region get a smaller discount, as do ACOs in a region that is efficient compared with the national average. Over time, however, the NextGen program will also face pressure to blend benchmarks to avoid a downward spiral in benchmark levels.

The blending in MSSP rebasing and the NextGen discount adjustment are both attempts to deal with the issue of setting benchmarks that are equitable while still creating incentives for savings at the ACO level and trying to ensure that Medicare program spending does not increase. Efforts should continue to monitor whether ACO programs overall are saving money while maintaining or improving quality. It is important to remember that benchmarks will always incorporate policy goals, such as increasing equity across the nation or encouraging participation in two-sided-risk ACOs, and will not—and are not intended to—represent the best counterfactual to ACO participation.

Should the 5 percent bonus for clinicians in A-APMs be distributed differently to encourage A-APM participation?

One step to encourage clinicians to continue to expand their participation in meaningful payment reform models would be to make their eligibility for the 5 percent A-APM incentive more certain. Under current policy, clinicians who participate in an A-APM can qualify for a 5 percent A-APM incentive payment established in MACRA. The incentive payment is applied to all of a clinician's PFS revenue from the prior year. But to qualify for the incentive payment, the clinician must meet either the threshold for share of revenue derived through an A-APM or for share of patients coming through the A-APM. The numerical threshold for share of revenue is set in statute and increases over time. In 2019 and 2020, to be eligible for the 5 percent incentive, clinicians must have at least 25 percent of their PFS revenue in an A-APM, 50 percent in 2021 and 2022, and 75 percent in 2023 and later. The "patient count" thresholds are set by CMS. CMS has set lower thresholds for the patient count option of 20 percent in 2019 and 2020, 35 percent in 2021 and 2022, and 50 percent in 2023 and later. This lower threshold appears to enable a larger share of participating clinicians to qualify for the bonus.

In addition, there is an "all-payer" option starting in 2021, which requires CMS to determine what share of a clinician's revenue or patients is coming through A-APM-like arrangements for other payers. CMS has started the process of collecting information for the all-payer option. In the 2019 advanced notice for MA plans, CMS proposed collecting from MA plan sponsors lists of clinicians and the contracts those clinicians hold with MA plans that qualify as A-APM-like contracts.¹³

In our June 2017 report to the Congress, we described a way to simplify the incentive award process (Medicare

Payment Advisory Commission 2017a). The proposal was to eliminate the threshold calculation and instead apply the 5 percent A-APM incentive payment only to the clinician's PFS revenue derived from an A-APM (instead of to all of a clinician's PFS revenue). This proposal would greatly simplify the system and make it more equitable. For example, under the current system, clinicians with 24.9 percent of their revenue coming through an A-APM get no bonus, and clinicians with 25.0 percent of their revenue coming through the A-APM get a 5 percent incentive bonus on all of their PFS revenue. The proposed system would eliminate such payment "cliffs" or discontinuities. Instead, under our proposed refinement, the bonus would be certain because the incentive would depend solely on the clinician's revenue coming through the A-APM, whatever that level may be. (Additionally, such a refinement would help avoid uncertainty for clinicians who would be concerned they could lose the incentive payment as the threshold rises from 25, to 50, to 75 percent in later years.)

A benefit of this policy is that the patient count and all-payer options would no longer be necessary and could be eliminated because, under this revised design, the bonus is applied only to the share of revenue coming through the A-APM. Under the current all-payer option, CMS must calculate the clinicians' total revenue from all payers and determine what share came through A-APM-like contracts. That determination could represent a large administrative burden on all parties and intrusion of the government into the business relationship between MA plans and clinicians.

Whether the proposed approach would result in more or less spending is not clear. On the one hand, more clinicians would be eligible for some payment (e.g., in 2019 and 2020, all those with less than 25 percent of revenue through the A-APM). On the other hand, the actual payments for some clinicians would be lower; for example, a clinician with 30 percent of revenue through an A-APM would get a 5 percent payment adjustment on 30 percent of PFS revenue, not on 100 percent of PFS revenue. How these changes balance out would need to be estimated.¹⁴

What relationship will specialists have with ACOs?

Another concern is that specialists are not perceived to have a role in ACOs because attribution to ACOs is predominantly dependent on primary care visits, and

thus specialists are not required for an ACO to meet the minimum number of attributed beneficiaries. Also, some could be concerned that specialists would attract high-need patients to the ACO, thereby increasing its costs. However, if the patients are high cost to begin with and are thus in the historical baseline, the ACO's benchmark will reflect those higher costs. In fact, one could argue that those beneficiaries may be the ones who could most benefit from the better care coordination that the ACO is designed to provide.

Our analysis of the 2016 MSSP ACO public use file indicates that about 60 percent of ACO-participating physicians are specialists.¹⁵ Being on the participant list does not mean that a physician will share in savings or help manage the ACO. Each individual ACO has the latitude to decide on the relationship of the physician to the ACO as to who shares savings and how much.

ACOs may have an incentive to involve specialists because specialists who practice in a conservative, cost-effective style and avoid unnecessary testing and procedures could help control costs and increase the quality of care for beneficiaries attributed to the ACO. At the same time, participating in an ACO could be attractive to specialists. Participating in the ACO would give the specialist access to a patient's claims history and possibly alert the specialist when the patient was admitted to a hospital or visited an emergency room. Thus, the specialist might be able to better coordinate patient care. (In the case of two-sided-risk ACOs that are A-APMs, specialists also could be eligible for the 5 percent A-APM bonus on their PFS revenues.) Specialists could also receive more referrals from the ACO's primary care clinicians if they had a relationship with the ACO. This arrangement could prove mutually beneficial to both primary care clinicians and specialists.

Furthermore, there could be a role for specialty-focused ACOs. For instance, the success of ESCOs—a specialty-focused ACO model—indicates that specialty providers could develop their own ACO-like models, which could be done by submitting a proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). If accepted by the PTAC, the model could be recommended to the Secretary as a potential new demonstration for CMMI, creating even more opportunities for specialists to participate in ACO-like models. The Commission will monitor the relationships between specialists and ACOs as the ACO models continue to evolve, and we will examine whether it is possible to ascertain the level of participation

in ACOs by specialists and whether the degree of specialists' participation affects ACOs' performance.

Are ACOs only a transition step to MA?

The ACO program is large, continues to expand, and continues to evolve. However, some suggest that MA plans are the more efficient model and that, eventually, ACOs should evolve into MA plans. As a matter of policy, the question is whether all ACOs should be encouraged to become MA plans or whether there are circumstances in which it is better for ACOs to remain ACOs (Medicare Payment Advisory Commission 2016b).

In the past, the Commission has discussed how no one model is the low-cost model in all parts of the country (Medicare Payment Advisory Commission 2014c). In some markets, the tools that MA plans have to manage service use result in substantial savings. In other markets, ACOs or FFS is the lower cost model. For analytical purposes, that report synchronized the benchmarks at 100 percent of FFS spending for all three models. In fact, in 2018 we estimate MA benchmarks (including quality bonuses) will average 107 percent of FFS spending.

One particularly important factor is that, although MA plans have more tools to control service use, they also have higher administrative costs. Data from the major insurance companies indicate that, on average, administrative costs in MA plans are approximately \$1,300 per beneficiary. Among those costs are costs for marketing, both directly to beneficiaries and through brokers; enrolling members; negotiating with providers; paying claims; and providing other insurance functions, such as prior authorization. MA plans also have to qualify as state-licensed insurers, which could entail considerable costs and financial resources.

Our discussions with ACOs suggest their administrative costs, in contrast to those of MA plans, are close to \$200 per beneficiary per year. ACOs do not have the costs of advertising, enrolling, negotiating contracts, and paying claims. Their administrative costs include the expense of setting up and managing the ACO, which should include data analysis and reporting quality measures. However, some companies can provide those services under contract, and some ACOs are using that approach.

Therefore, which model will generate greater savings depends on whether the MA plan's reduction in spending on medical services offsets its higher administrative cost relative to an ACO's spending and costs. There are two basic possibilities:

- If MA health care spending reductions compared with ACO health care spending reductions are greater than \$1,100, then MA plans would be expected to be the lower cost model.
- If MA health care spending reductions compared with ACO health care spending reductions are less than \$1,100, then ACOs would be expected to be a lower cost model than MA.

The amount of service use that MA plans will be able to reduce relative to FFS Medicare and ACO use will depend on several factors. One may be the initial level of service use and fraud in the market. Data suggest MA plans can generate substantial savings in some high-use markets such as Miami. However, if there is less than \$1,300 of unnecessary spending to cut, then FFS Medicare could be a lower cost model. Second, ACO savings could be affected by the ACO's providers' position in the market. One conceptual advantage of MA plans is their ability to lock beneficiaries into a defined provider network. If an ACO's participants constitute the dominant health system in a market, then the ACO model with its lower costs may be more efficient because the ACO should have a similar ability to control utilization.

However, benchmarking could still be an issue even if an ACO is in a dominant market position. Under a historically based benchmark, a regionally based benchmark (based on regional FFS spending), or a blend, an ACO with a dominant market position would have to improve on its own performance over time because its benchmark will reflect its own performance. In contrast, MA benchmarks are based on FFS spending, not MA spending. Thus, MA plans do not face the issue of their own historical performance dictating their benchmark. In addition, MA benchmarks are adjusted so that they are a higher percentage of FFS spending if the county has lower FFS spending relative to the national level. In some counties, MA benchmarks are 115 percent of the FFS average (see the Commission's *MA Payment Basics* document, available at <http://medpac.gov/documents/payment-basics>, for a fuller discussion).

Thus it is not clear a priori whether ACOs are in all circumstances a stepping stone to MA or should remain as ACOs. The challenge going forward is to set MA and ACO benchmarks in such a way that the models can compete and the most efficient model can gain market share in each individual market.

Conclusion

ACOs in Medicare continue to show some success in meeting their goal of high-quality care and lower costs relative to their benchmarks. In addition, some analysts find that their success may be understated by their performance relative to their benchmarks and that they could be saving Medicare more than the benchmarks would indicate. In either case, two-sided-risk ACO models show more savings relative to one-sided models. However, a number of issues confront Medicare two-sided-risk

ACO models if they are to persist in the long term. Some issues, such as the 5 percent incentive in MACRA, could have relatively straightforward solutions, and others, such as the role of hospitals and specialists in ACOs, are more nuanced. Challenges such as asymmetric models and setting benchmarks could require policymakers to decide whether a preference should be given to one model (MA, ACO, FFS) over another and whether that preference should be temporary. ACOs in Medicare have proven to be a popular choice for providers, but whether they remain that way in the long run may depend on the choices policymakers make going forward. ■

Endnotes

- 1 Services that qualify for attribution are defined in regulation. Use of primary care services is required in statute.
- 2 One-sided-risk ACOs can cost money in aggregate for the Medicare program because CMS pays shared savings to successful ACOs but does not collect losses from unsuccessful ACOs (i.e., ACOs that exceed their benchmark).
- 3 These clinician-only ACOs can include hospitals and qualify for the lower loss limit if these hospitals are small, rural hospitals with 100 or fewer beds.
- 4 In 2016, OneCare Vermont was responsible for 43,685 Medicare beneficiaries.
- 5 There are other models that qualify as A-APMs, including the Bundled Payments for Care Improvement Advanced Model, Comprehensive Care for Joint Replacement Model (Track 1: Certified Electronic Health Record Technology), Comprehensive Primary Care Plus Model (CPC+), and the Oncology Care Model (two-sided-risk arrangement). The Commission has questioned the inclusion of the CPC+ model and the Oncology Care Model as A-APMs (Medicare Payment Advisory Commission 2016a).
- 6 We did not adjust for health status because we were using ACO-level, not beneficiary-level, data. Thus, this evaluation is only an approximation of service use.
- 7 Certainty—that is, informing the ACOs of their benchmark at the beginning of the year—may require modifying the definition of two-sided risk if ACOs can withdraw from the program after learning what their benchmarks will be. For example, 3 of the 21 Next Generation ACOs dropped out of the program early on after learning what their benchmarks would be. This practice could affect program savings over time.
- 8 There is no explicit mention whether these savings are net of shared savings payments paid to Pioneer ACO providers.
- 9 The near market includes counties where ACO providers were located in the first performance year, plus all contiguous counties.
- 10 We used American Hospital Association data to identify hospitals that participated in an ACO. MA and ACO penetration data were from CMS.
- 11 Eight percent of revenue for a physician-only ACO is likely to be much less than 10 percent of the benchmark. We calculate that 5 percent of benchmark is the upper bound on risk under the revenue risk model.
- 12 Unlike other CMMI ACO demonstrations in which CMMI has chosen a limited number of ACOs to participate after a competition of sorts, ACOs can join Track 1+ simply by applying; if they meet the requirements, they are in the demonstration. In fact, the application process goes through CMS's MSSP office, not CMMI.
- 13 See pages 43–44 of the memo to Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties about advance notice of methodological changes for calendar year 2019 for Medicare Advantage capitation rates, Part C and Part D payment policies, and the 2019 draft call letter from February 1, 2018 (available at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf>).
- 14 The president's budget included this idea of a proportional incentive for A-APM participation but did not include an estimate of savings or spending. See page 67 of "Putting America's Health First," available at <https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf>.
- 15 ACOs are made up of taxpayer identification numbers (TINs), and any clinician billing through that TIN is automatically on the participant list. Specialists make up about two-thirds of physicians treating Medicare FFS beneficiaries.

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