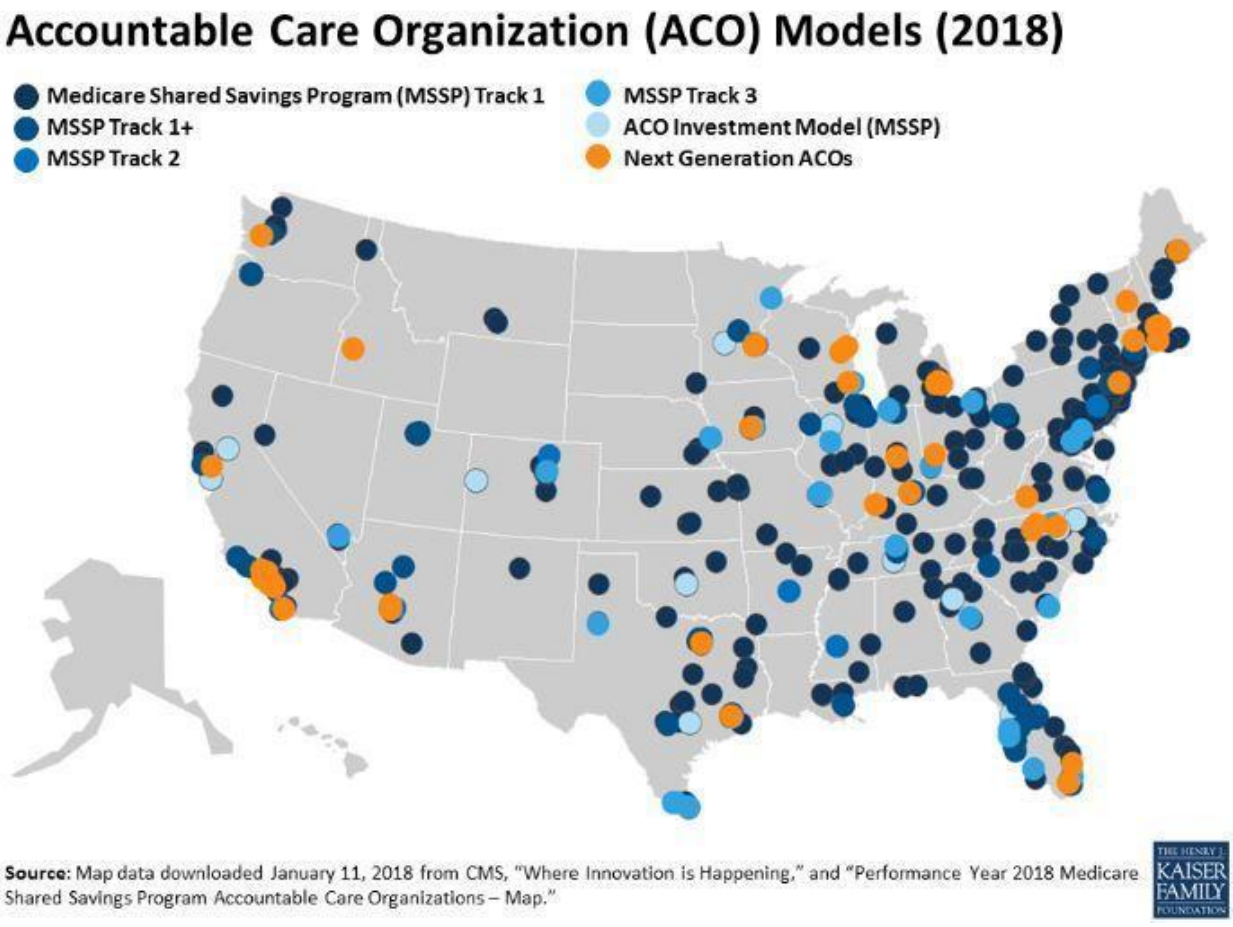
2. ACOs and Similar APMs

Background

The rise of Accountable Care Organizations (ACOs) in recent years demonstrates the latest wave of cost control in healthcare through value-based care. ACOs are hospitals and other healthcare providers that form partnerships, collaborate, and most importantly share accountability for the care delivered to their patients.[1] By coordinating care, ACOs are meant to reduce redundancies in healthcare and allow patients to receive more streamlined care, ideally lowering the total cost to the system while maintaining quality.

As of 2018, there are 561 ACOs, according to the Centers for Medicare & Medicaid Services (CMS). These organizations are clustered in urban and suburban areas across the United States.[2] There are 10.5 million American patients attributed to a Medicare ACO.[3] Provider integration helps drive formation of ACOs, with ACOs being more likely to form in areas where there is more hospital risk sharing, larger integrated systems, and physicians practicing in large groups.[4]



There are different ACO models in Medicare, each with a unique set of features such as level of financial risk, beneficiary involvement, and upfront payments for infrastructure costs.[5] Pioneer ACOs ended in

2016 and included financial risk and reward for all participating ACOs based on overall Medicare spending relative to benchmark spending and quality. Next Generation ACOs are the second iteration of Pioneer ACOs where there is both upside and downside financial risk and there are several payment structures with increasing levels or risk and reward incentives to lower spending while meeting quality goals. Medicare Shared Savings Program (MSSP) ACOs are a permanent ACO program with multiple tracks that allow the organization to pick between sharing savings and losses or sharing savings only. Advance Payment ACOs ended in 2015 and were a subset of MSSP where up-front payments were given to ACOs for infrastructure development and operations for smaller or rural providers that could share in savings after CMS recouped payments. The ACO Investment Model (AIM) is another subset of MSSP that has multiple options for upfront and monthly pre-payments to encourage smaller and rural providers to participate; these ACOs are eligible for shared savings and encourage the transition to models where the organizations take on risk.

While there is widespread agreement that increased cost transparency, better care management, and a greater emphasis on public health and prevention can lower overall expenditure on healthcare, the opinions of key stakeholders differ regarding how to implement effective changes. Private market employer benefit designers are more optimistic that ACOs will be an effective cost cutting tool.[6] By contrast, physicians are only moderately convinced that ACOs are an effective model for delivering cost-effective care.[7] As many ACOs are physician led, the support and leadership of physicians is necessary for ACOs to be successful.[8]

Medicare ACO Strategy

		2012	2013	2014	2015	2016	2017	2018
Pioneer ACO Model	Designed for experienced organizations operating in ACO-like arrangements Higher levels and multiple options of savings and risk than the MSSP Possible transition to population-based payment in year 3	*32	23	20	12	9	no longer active	no longer active
Advance Payment ACO Model	Upfront advances and monthly payments for certain eligible, physician-based and rural providers already in or interested in the MSSP		*35	35	35	no longer active	no longer active	no longer active
ACO Investment Model (currently runs through 2018)	Upfront advances and monthly payments given on expected shared savings for MSSP ACOs to test pre-paid savings in rural and underserved areas.					*45	45	45
Medicare Shared Savings Program (ongoing)	Track 1 Earn up to 50% of shared savings No risk of loss Payment capped at 10% of benchmark		*217	399	340	412	438	460
	Track 1+ Earn up to 50% of shared savings Risk loss is 30% fixed Payment capped at 10% of benchmark							*55
	Track 2 Earn up to 60% of shared savings Risk loss from 40%-60% Payment capped at 15% of benchmark		*3	3	5	6	6	8
	Track 3 Earn up to 75% of shared savings Risk loss from 40%-75% Payment capped at 20% of benchmark					*16	36	38
Next Generation ACO Model (currently runs through 2020)	Earn 80%-100% of shared savings Minimum Savings Rate not utilized Optional All-Inclusive Population-Based Payments Includes telehealth, 3-day skilled nursing facility, and post-discharge home visit waivers					*18	45	58
Comprehensive ESRD Care Model (currently runs through 2020)	Multiple options of savings and risk Designed for End-Stage Renal Disease beneficiaries receiving dialysis services First ACO with disease specific focus					*13	37	37

*Green = one-sided risk Blue = two-sided risk * = year program started Source: Txcin*

How Have ACOs Performed So Far?

The first Medicare ACO models rolled out in 2012. Since then, all models have shown lower gross spending on Medicare services, but only ACO models involving risk for shared losses were associated with net Medicare savings.[9] 56% of MSSP ACOs spend less than their 2016 non-ACO comparison organizations, but CMS payments in shared bonuses exceeded those savings, leading to a net loss for Medicare for several models. Next Generation ACOs achieved net Medicare savings of $63 million when compared to benchmarks, likely because this model requires both upside and downside financial risk and offers multiple payment structures with increasing levels of risk and reward for lowering overall spending and reaching quality goals with more options to waive some Medicare coverage requirements.[10]

Table 1. Risk-bearing ACO Models Generated Net Medicare Savings Relative to Benchmarks (2016)

Type of ACO	No. of ACOs	At-Risk for Shared Losses?	Gross Medicare Spending on Services *(in millions)*	Medicare Payments to ACOs for Shared Savings *(in millions)*	ACO Payments to Medicare for Shared Losses *(in millions)*	Net Medicare Spending *(in millions)*
All MSSP ACOs	432	—	-$652	$701	-$9	+$40
MSSP Track 1	410	No	-$541	$61	n/a	+$72
MSSP Track 2	6	Yes	-$42	$24	$0	-$18
MSSP Track 3	16	Yes	-$69	$64	-$9	-$14
Pioneer	8	Yes	-$61	$37	$0	-$24
Next Generation	18	Yes	-$48	$58	-$20	-$63*
All ACOs	**458**	—	**-$761 million**	**$796 million**	**-$29 million**	**-$47 million**

NOTE: (-) Reduced spending (Medicare savings); (+) Increased spending (Medicare costs); *Incorporates $53 million in discounted benchmarks, plus $10 million in Medicare's share of savings. Analysis excludes the Comprehensive ESRD Care Model.

SOURCE: Kaiser Family Foundation analysis of 2016 public use files for MSSP, Pioneer, and Next Generation ACOs, and unpublished CMS data.

Further, CMS reports that ACOs score as well or better than non-ACO providers for quantifiable quality metrics such as diabetes care, preventive services, and readmissions.[11] Fewer than 1% of ACOs did not meet quality performance standards.

How the ACO model is saving money may be surprising. Participation in MSSP models is associated with significant reductions in fee for service spending, but unexpectedly, it appears reductions in hospitalizations represent a minority of these savings.[12] Similarly, savings were not concentrated among high-risk patients, who only account for 38% of savings. Rather, care coordination and ambulatory care focused management efforts are responsible for the majority of savings.

Outside of quantifiable effects on cost savings and maintenance of quality, it is possible the benefits of ACOs are delayed because of the initial effort and time incurred to change the way a health system functions. ACOs have been an organizing force for providers to collaborate on improving care and

reducing costs by changing the way they approach delivering care.[13] Determining the long-term impact of this increased cooperation may be difficult.

What's Next for the ACO Model?

ACOs appear to be committed to continuing their focus on accountable care, as can be seen by the average number of contracts and covered lives which show that many ACOs are entering additional contracts beyond their first one.[14] They are transforming their infrastructure and care delivery models. As no-risk models are shown to not have net savings for Medicare, ACOs are adopting more contracts with greater levels of risk. However, some ACOs report that they will leave the MSSP if they are forced to assume risk.[15]

As more organizations switch toward ACO models, there will likely be more discussions regarding appropriate benchmarking.[16] As benchmarks are important for determining whether an organization is rewarded or financially punished, special attention must be given to compensate systems appropriately without risking quality. Incentives cannot effectively encourage hospitals to focus on savings instead of care; high risk patients cannot be refused so that the organization will look better compared to its counterparts. Thus, benchmarking features must be implemented gradually to encourage widespread, responsible participation in the program.

Though it can be difficult to predict healthcare reforms and priorities, the appointment of Adam Boehler as director of the Center for Medicare and Medicaid Innovation (CMMI) may show that this administration is more open to innovation and risk sharing.[17] Alex Azar, the HHS Secretary, has said that previous federal efforts to encourage ACOs were underwhelming but that we must move forward with a system that rewards value.[18] Azar believes current ACO performance has been lackluster due to not giving providers enough room to experiment and likely blames their voluntary nature, in contrast with Tom Price who opposed mandatory pay models.[19] CMS announced in March that it will provide $30 million to support innovative new ideas over the next three years by partnering with physicians, patients, and other important stakeholders.[20]

Bundled Payments

Bundled payment arrangements reimburse multiple providers for a single, predefined episode of care. "Episodes of care" include all care delivery for designated conditions or within a given timeframe. The Medicare Bundled Payments for Care Improvement (BPCI) Program, the nation's largest bundled payment program, was begun in 2013 with the intention of moving away from fee-for-service Medicare payments and integrating care for Medicare beneficiaries, both for inpatient hospital stays or post-acute care episodes.[21] Bundled payments are meant to incentivize enhanced efficiency and coordination of care, especially for hospitalizations and complex conditions where patients see multiple specialists. BPCI currently has 1,522 participants, including hospitals, academic medical centers, medical groups, and other healthcare organizations.

In January 2018, Medicare launched a new voluntary episode payment model program, BPCI Advanced, which will test bundled payments for 32 Clinical Episodes, aiming to align incentives for healthcare

providers who participate.[22] BPCI Advanced will qualify as an Advanced Alternative Payment Model under the Quality Payment Program (other advanced APMs: Next Generation ACOs, Medicare Shared Savings Program Tracks 2 & 3, Oncology Care Model, Comprehensive Care for Joint Replacement, and Comprehensive Primary Care Plus).[23] Providers or facilities that meet Advanced APM requirements and quality thresholds earn a 5% incentive and are exempt from Merit-based Incentive Payment System (MIPS) reporting requirements.[24] BPCI Advanced currently has 438 participants.

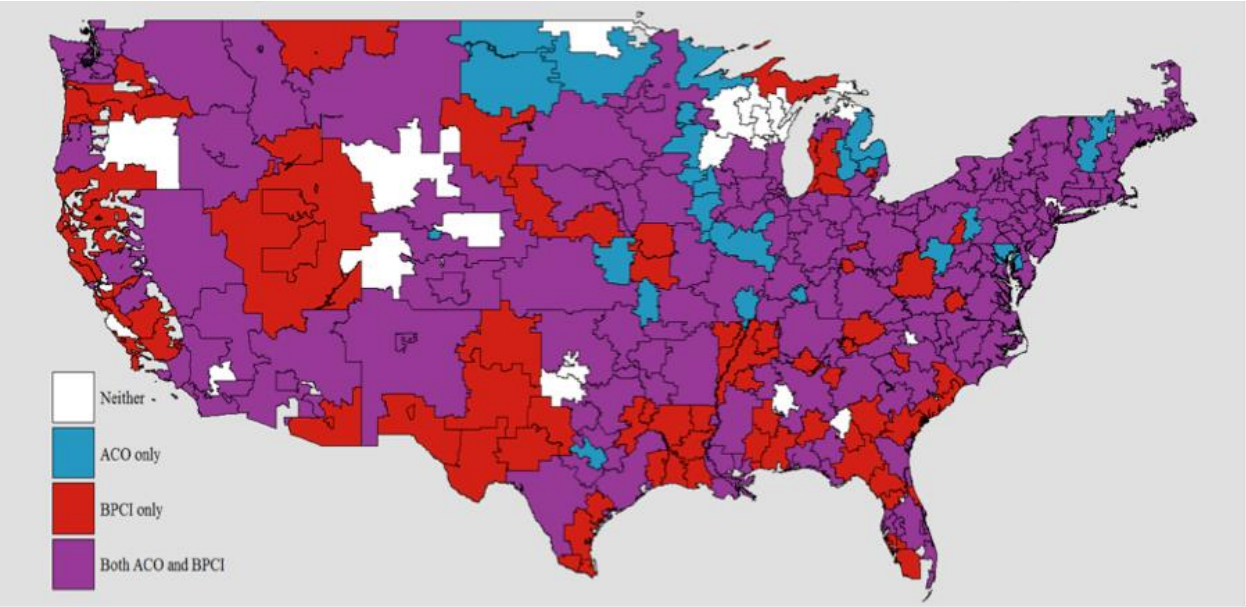
Bundled payments, while more popular with providers than other potentially more financially risky value-based payment models, also pose challenges to providers seeking to provide care efficiently. For example, if a hospital is on the hook for a patient's entire episode of care, and that patient is extremely high-risk due to factors out of the provider's control, such as multiple co-morbidities or non-adherence to medications, then the bundled payment might not adequately cover costs. Proactive care coordination is required, and electronic health records do not always have the necessary interoperability to give providers all of the information they need to preemptively coordinate services.

Bundled payment models are showing promise: A 2017 study published in JAMA and another 2017 study from the Altarum Institute both found that in the first 21 months of the BPCI Program, Medicare payments to BPCI participants for lower joint replacements had decreased without negatively impacting quality outcomes.[25,26] The Altarum study was done in response to a JAMA editorial positing an increase in procedure volume as a result of BPCI participation.[27]

ACOs and bundled payments have both become important features of Medicare's APM approach. According to a Health Affairs blog from April 2018, the overlap of these two programs could cause unintended consequences.[28] Since the programs overlap to such a great degree, it will be important to ensure that the MSSP and BPCI programs complement each other (this is true especially when the same provider is participating in both programs simultaneously) rather than add additional layers of complexity to the coordination of care.

Summary

ACOs are becoming more prevalent in the US, and government consensus seems to be that bold risk sharing models may be an effective free-market solution to rising healthcare costs. Initial CMS data show that two-way risk sharing models such as Next Generation ACOs do result in (arguably modest) net Medicare savings. However, it is unclear whether these results can be replicated and are sustainable across all healthcare organizations. Under the current administration, it is likely that more substantial cost savings will be demanded of ACOs, and innovative experimentation will be expected to fill knowledge gaps about effectiveness.



Source: Joshua M. Liao et al. "BPCI Advanced Will Further Emphasize The Need To Address Overlap Between Bundled Payments And Accountable Care Organizations," *Health Affairs* Blog, April 17, 2018

2.1 ACOs and Similar APMs: Discussion Questions

- Can value-based payment as currently structured meaningfully impact healthcare prices?
- Can value-based payment as currently structured lead to reduced healthcare costs?
- Given the needs of hospital systems to fill beds, can a hospital-led ACO succeed?
- Are current ACO financial incentives sufficient to drive provider behavior change?
- What are the biggest barriers to more widespread adoption of ACOs?
- Would a regulated utility model (i.e., fixed profit margins) work for ACOs by allowing concentrated and highly integrated systems while preventing monopolistic pricing?
- Is the current Administration likely to take action that will accelerate ACOs/APMs?
- Should ACOs be required to accept downside risk to be eligible for upside benefits?
- Should health systems be required to operate under an ACO model as a condition of Medicare participation?
- Can the government use tools such as risk adjustment, as in the Medicare Advantage program, to encourage providers to assume risk?
- To what degree is the Medicare program driving accountable care, vs. the commercial market and Medicaid? Will this change in the future?
- How can physicians be encouraged to embrace accountable care?
- How fast should the transition to accountable care be? What are the consequences of rapid and forced transitions?
- Are current ACOs representative of most US healthcare organizations, or is there strong self-selection in early adopters? Can current findings reasonably be extrapolated to all other healthcare organizations in the US?
- How will the rise of ACOs affect small community hospitals and rural communities?