Insight

Accountable Care Organizations: What the Demonstration Projects Tell Us

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In the past week a number of reports have come out with new information about the Medicare Accountable Care Organization (ACO) programs created by the Affordable Care Act (ACA). Official reports claim the continued success of these programs, while more detached parties note that "Medicare's ACO programs so far have produced inconsistent results."[1] What has been consistent is the steady decline in the number of ACOs willing to participate in the program which has been described as "financially detrimental."[ii]

WHAT ACOS ARE

The Centers for Medicare & Medicaid Services (CMS) define ACOs as: "Organizations of providers that accept accountability for a population of Medicare beneficiaries, coordinate all of the services received across the care continuum, and encourage investment in infrastructure and redesigned care processes for high-quality and efficient service delivery." Each Medicare ACO is required by the ACA to have a minimum of 5,000 Medicare beneficiaries, though this number may vary slightly between markets.[iii] Medicare ACOs must also achieve certain Quality Improvement Measures; there are thirty-three benchmarks, and ACOs must meet 70 percent of these objectives in each of the four domains: patient experience, preventive care, at-risk populations, and care coordination and patient safety.

Medicare ACOs currently have the option of participating in one of two tracks: an upside or an upside-downside risk model. Upside only risk tracks require that the ACOs meet their 70 percent quality improvement threshold and keep Medicare costs at least two percent below Medicare's anticipated cost growth in order to share in cost savings above 2 percent.[iv] ACOs in the upside-downside risk track must meet their quality improvement benchmarks and achieve the same level of cost savings for Medicare to share in the savings.[v] However, upside-downside risk ACOs receive a larger portion of their savings because they also take the risk that if they do not achieve savings they will share in the losses as well.[vi]

Start-up fees for ACOs have been reported to be around $2 million and other annual fees for maintaining and administering an ACO are between $6million and $14 million.[vii] With overhead so high, an ACO would have to save money every year (no shared losses), and make at least a 20 percent profit for three consecutive years in order to break even.

MEDICARE ACO PROGRAMS SO FAR

Physician Group Practice Demonstration

The Physician Group Practice Demonstration (PGP Demo) was very similar to ACOs in that it was the first pay-for-performance initiative for physicians under the Medicare program. This program, which ran between 2005

and 2010, attempted to incentivize physician groups to coordinate care delivery among their patients.[viii] The program would reward groups that succeeded in achieving cost efficiency without sacrificing quality by allowing them to share in cost savings. The goals were to: encourage coordination of Part A and Part B services, promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams, and reward physicians for improving health outcomes.[ix] The PGP Demo lasted five years, and in that time of the ten PGPs selected by CMS to participate in the program only two managed to demonstrate any cost savings the first year, four shared in smaller average savings the second year, five saved the third and fourth year, and only four shared in savings the fifth year.[x]

The results of this demonstration have been challenged though, because it is unclear whether the PGPs that showed savings really cut costs, or if they were up-coding or more thoroughly reporting all care in order to raise the spending benchmark. These doubts, echoed by CMS' own independent evaluators raised questions about the viability of a larger program where participants are not hand-picked.[xi]

Pioneer Demonstration

The Pioneer ACO program was the forerunner to the implementation of widespread ACOs as designed by the ACA.

In July 2013 CMS published a press release entitled "Pioneer Accountable Care Organizations Succeed in Improving Care, Lowering Costs."[xii] This was a curious title, as the rest of the report demonstrated that they did not.[xiii]

Of the 32 ACOs, hand-picked by CMS for their infrastructure and experience, one-third of them opted to leave the program after the first year – two left the Medicare ACO market entirely, and seven moved to the less risky Medicare Shared Savings Program (MSSP) program.[xiv] A little over one-third of the ACOs had savings, though not all were eligible to share in those savings, and two suffered shared losses.[xv]

The Pioneer program cost ACOs about $64 million in start-up costs, and saved Medicare only about $76 million. While $76 million seems like a large number, it pales in comparison to the $492 billion Medicare spent that same year.[xvi]

In 2014, the second year of the program, the CMS press release was titled "Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth;"[xvii] and unsurprisingly, the rest of the report goes on to demonstrate that they again did not. Pioneer results reflected all aspects of the program: quality improvement was measured and patient experience reportedly improved in most areas, particularly in screenings for fall risk, tobacco use, patient exposure to health promotion materials, and controlling high blood pressure.[xviii] Per capita spending growth was .45 percent lower than in Medicare fee-for-service, and the 23 remaining ACOs generated an estimated $41 million in savings (though this number is still subject to revision), but were also responsible for undisclosed losses.[xix] In the aftermath of the second year of the Pioneer program, three more ACOs dropped out of the program and will instead be joining the less risky MSSP.[xx] Nineteen of the original 32 ACOs will continue into the Pioneer Demonstration Project's third year.[xxi]

Medicare Shared Savings Program (MSSP)

The MSSP is the implementation of the ACA provisions calling for ACOs in Medicare. In the first year of the MSSP, the success rate was slightly lower than in the Pioneer program, and about the same as in the PGP

Demo: of 114 ACOs in MSSP, only 29 succeeded in sharing in savings.[xxii] Those 114 ACOs were only able to generate about $128 million in savings, though their start-up costs would have been 4-6 times as much. Only four MSSP ACOs opted to take the upside-downside risk, and of those, half shared in losses.[xxiii]

More concerning is the fact that in response to requests from ACOs, the quality standard benchmarks mandated by the ACA were not required in the first year of this demonstration.[xxiv] Instead, ACOs were given credit for having achieved their benchmarks as long as they had simply submitted a report on the state of their organization's quality improvement efforts.[xxv] Although this might appear unrelated to the cost savings, it casts doubts on whether the ACOs that did achieve savings would have been able to do so if they had been subject to the full mandates of the law.

Like in the PGP Demo, it is unclear what affect these cost savings had on quality, especially because ACOs were exempted from meeting the Quality Improvement benchmarks for this time period. For example, NOVAHealth (a Pioneer ACO) reported 56 percent fewer readmissions, but it also reported 45 percent fewer admissions overall, which could indicate that NOVAHealth was grossly over-admitting before, or that reductions in admissions, and therefore cost savings, resulted from stinting on care.[xxvi]

FINAL THOUGHTS

The data on ACOs reveals conflicting results. It is unclear whether participation in an ACO contributes to decreased costs; the fact that half of the MSSP ACOs that elected to take the upside-downside risk shared in losses indicates that shared savings may have been as much a fluke as the shared losses.

The data also shows that start-up costs are extremely high, and only a small percentage of ACOs will be able to recuperate start-up and administrative expenses. Few will likely want to participate in a program with such a risk of loss, but without that risk there would remain no incentive to control quality.

The lack of enforcement of the Quality Improvement measures has the effect of rendering most of these results meaningless because capital investments in quality improvement were not required; had they been, even ACOs with shared savings would have been liable to losses for non-achievement or because the capital investments ate up their share in the savings.

All we know, after over a decade of demonstration projects is that even in an artificially created, absolute best case scenario, only 25 percent of ACOs demonstrated signs of success.

[1] Mark C. Shields, Pankaj H. Patel, Martin Manning and Lee Sacks, *A Model For Integrating Independent Physicians Into Accountable Care Organizations*, 1 Health Aff. 161, 161 (2011).