Recent Experience and Future Outlook for ACOs and Bundled Payments

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IAC Institute for Accountable Care

Disclosure

I am Executive Director of the Institute for Accountable Care, an independent 501(c)(3) research organization created to conduct and facilitate research on the impact of accountable care strategies. The Institute is funding primarily by grants, contracts and fees for analytic services. It receives some funding from the National Association of ACO and earns service revenue from projects with individual ACOs.

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Today's Discussion

- ACOs and bundled payment – review of the evidence.
- Challenges facing ACO and bundled payment providers and programs.
- Options for improving the future performance of alternative payment models.

CMS Evaluation of Population-Based Payment Models

Model	Program Years	Annual Beneficiaries	Gross Savings (Losses) PBPY[1]		Net Savings (Losses)/PBPY[2]	
PGP Demo	2005 - 2010	44K	$171*	2%	$69	2%
Pioneer ACO (Yr 1)[3]	2012 - 2016	608K	$427*	4%	$134*	1%
NGACO	2016 - 2021	1.4M	$112*	1%	($38)	-0.3%
AIM (Year 1)	2015 - 2018	447K	$339*	3%	$280*	2%
MSSP	2012 - 2021	10.2 M (20)	NA		NA	

[1]Gross savings estimates are based on counterfactual studies (dif-in-dif with comparison groups)
[2]Net savings subtract shared savings payments from estimated gross savings.
[3]Pioneer Yr 2 net savings lower but positive and statistically significant.
4 AIM Year 2 and 3 net savings higher and statistically significant.
* Indicates statistically significant results.

Observations

- All ACO models had positive gross and net savings (except NGACO)
- Largest ACO model (MSSP) is not a pilot and was not evaluated by CMS

External Evaluation of MSSP

Author	Years Evaluated	Published	Gross Savings (Losses) PBPY	Net Savings (Losses)/PBPY
McWilliams	2012	NEJM	$114* 1.4%	NA
Colla	2013	JAMA IM	$196* 1.7%	NA
McWilliams	2014	JAMA	$147* 1.5%	$67* 0.7%
Markowitz[1,2]	2014	Annals IM	($5) p=.857	NA
Ouayogode´[3]	2014	Healthcare	$46*	NA
McWilliams	2015	NEJM	$300* Physician ACOs $37 Hospital ACOs	$132* Physician ACOs ($34) Hospital ACOs
MedPAC	2012 - 16	MedPAC	0.25% - 0.5%/year	NA
Dobson/Davanzo	2013 - 17	NAACOS	$111* 1.1%	$27* 0.25%

[1] Instrumental variable analysis accounting for non-random exit.
[2] Study conclusions critiqued as inaccurate by McWilliams et al (Incidental Economist (6.17.19). See also Milbank Q. 2020.
[3] Modeling adjusted to address provider and patient selection.

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CMS Evaluation of Episode Payment Models

Model	Program Years	Episode Volume	Gross Savings (Losses)/Episode		Net Savings (Losses)/Episode	
BPCI Model 2	2013 - 2018	254K/yr.	$947*	4%	($332)*	-1%
BPCI Model 3	2013 - 2018	51K/yr.	$1,503*	7%	($714)*	-3%
OCM (oncology)		266K	$297*	1%	($591)*	-2%
CJR[1]	2016 - 2024	38K/yr.	$1,323*	5%	($536)*	-4%
BPCI Advanced	2018 - 2023	208K/yr.	$646*	2%	($761)*	-4%

[1] Mandatory participation in 34 markets and voluntary participation in 33 markets.
* Indicates statistically significant results.

Observations

- Value of bundled payments – engaging medical specialists and providers not ready for PBPM
- Concerns about potential for gaming
- Likely favorable selection (i.e., 43% of hospitals and 53% of MD groups dropped out of BPCI between 2015 and 2017 – 70% of contracted bundles).
- Post-discharge spending $323 lower for ACO beneficiaries in medical bundles (Navathe 2021)

CMS Evaluation of Patient Centered Medical Home Models

Model	Program Years	Annual Beneficiaries	Gross Savings (Losses) PBPY		Net Savings (Losses)/PBPY	
CPC	2012 - 2016	321K	$108	1.0%	($72)	-1%
CPC Plus (Track 1)	2017 - 2021	1.4M	$36	0.3%	($198)*	-3%

* Indicates statistically significant results.

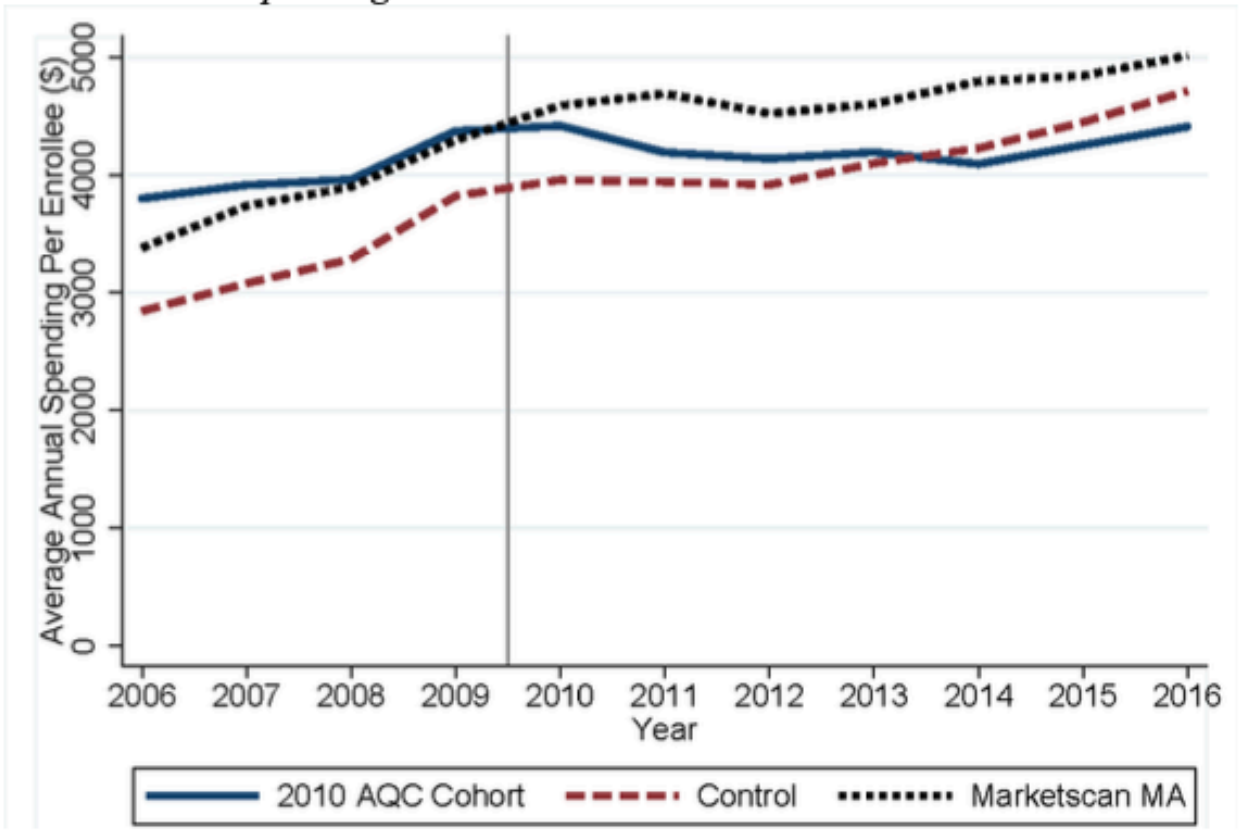
Observations

- PCMH models provide substantial resources to participating practices with very limited risk
- Given underfunding for primary care savings may not be a primary goal of these models

8-Year Spending Changes Under Commercial Global Payment in Massachusetts

Total Unadjusted Medical Claims Spending Under BCBS Alternative Quality Contract: 2010 Entry Cohort

*A. Total Medical Claims Spending**



Adjusted Savings vs. Controls

	% Savings	#Members
2009:	-11.7%	613K
2010:	-11.9%	240K
2011:	-6.9%	133K
2012:	-2.3%	700K

* Unadjusted plot of total medical claims spending per enrollee per year. "AQC" = Alternative Quality Contract. "Control" refers to the control group of commercially-insured enrollees in similar employer-sponsored plans across 8 Northeastern states (CT, ME, NH, NJ, NY, PA, RI, and VT) in the Truven (Marketscan) Commercial Claims and Encounters database. "Marketscan MA" refers to all Truven enrollees in Massachusetts, which includes Blue Cross Blue Shield of Massachusetts enrollees (not separable from enrollees of other private insurers in the state).

Source: Zirui Song et al. Health Care Spending, Utilization, and quality 8 Years into Global Payment, N Engl J Med. July 18, 2019

My Conclusions

Medicare population-based payment models (ACOs)

- By far largest and most successful category of Medicare APMs despite modest financial results
- Justification for strengthening and growing ACO models

Medicare episode-based payment models (full risk)

- Consistently reduced gross spending per episode but payments to providers exceeded savings except for CJR
- Important for engaging specialists but likely more effective under a "total cost of care" umbrella to combat selection/gaming

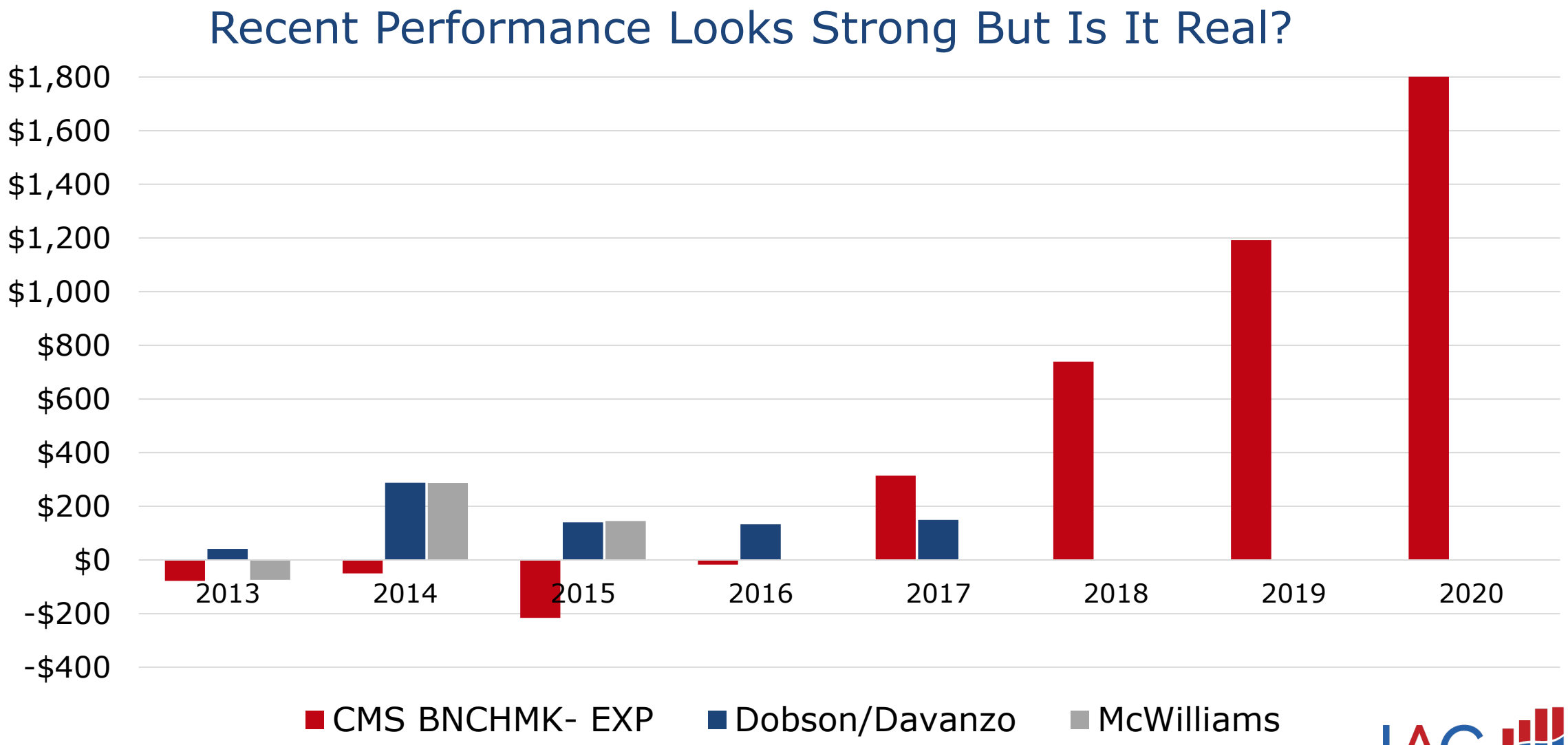
Medicare Patient Centered Medical Home Initiatives

- Modest spending reductions offset by substantial CMS investment in practice support

Overlapping Models Distort Financial Incentives & Evaluation

Improving Future APM Performance and Policy Considerations

ACO Savings (Net of Bonus): Benchmark vs. Counterfactual



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Understanding The Latest ACO "Savings": Curb Your Enthusiasm And Sharpen Your Pencils—Part 1

J. Michael McWilliams, Alice J. Chen

NOVEMBER 12, 2020 10.1377/hblog20201106.719550

Key Points

- Beginning in 2017 MSSP began constructing benchmarks based on a blend of historical spending and regional average
- New benchmark policy has led to selective exit of high-cost ACOs and entry of lower cost ACOs which make savings appear higher based on spending vs. benchmark but results in lower true savings
- MSSP has weak incentives for provider participation (especially for health system ACOs).
- Benefits of downside risk have been overstated. New downside risk requirements combined with weak incentives has led to lower MSSP participation.
- CMS has not articulated a coherent vision for MSSP in 2030 and beyond which makes ACOs more reluctant to take on the "switching costs" of transitioning from fee-for-service.

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Understanding The Latest ACO "Savings": Curb Your Enthusiasm And Sharpen Your Pencils—Part 2

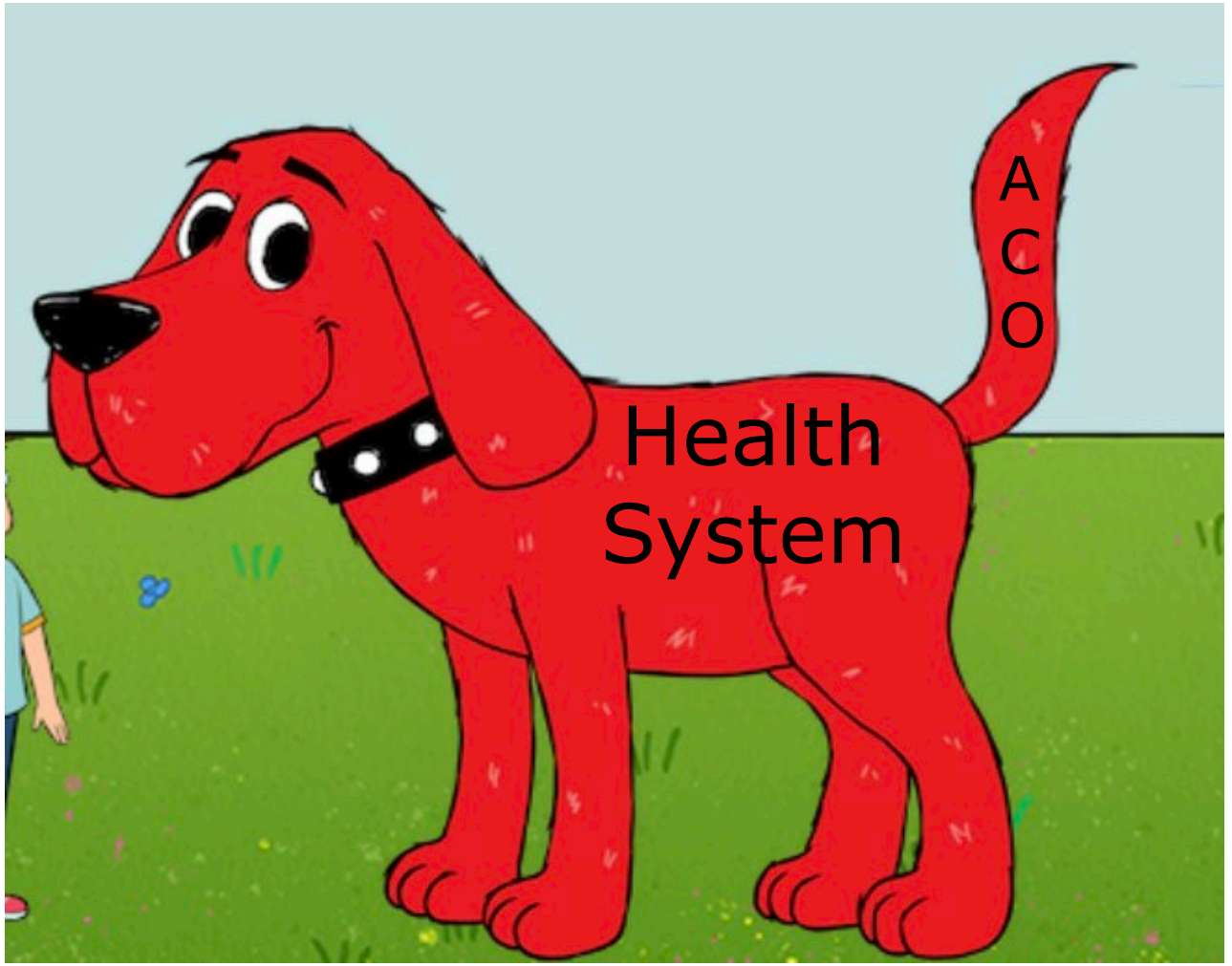
J. Michael McWilliams, Alice J. Chen

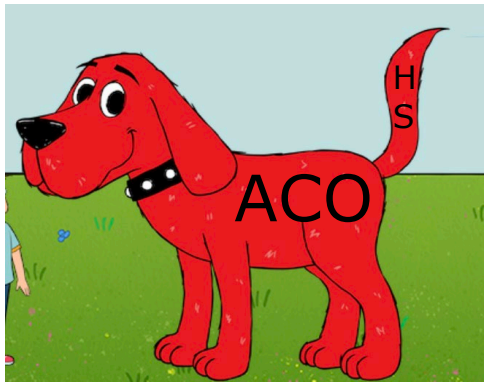
NOVEMBER 13, 2020 10.1377/hblog20201106.1578

Recommendations:

1. Eliminate rebasing based on historical spending but create a mechanism to bring high-spending ACOs closer to the regional average (i.e., differential growth rates)
2. Increase shared savings rates (particularly for ACOs with lower spending).
3. Limit downside risk requirements (at least for certain types of providers)
4. Simplify the APM portfolio with ACOs at the center
5. Improve risk adjustment (risk of favorable selection in shift to MA-like benchmarks)
6. Articulate a long-term vision for the MSSP

Other Challenges for ACOs





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Other Challenges for ACOs

- Difficulty of breaking fee-for-service stranglehold
- Lack of consistency in health plan APM approaches
- Limited involvement by large self-insured employers
- Potential displacement of current ACOs by new direct contracting entities backed by health plans and venture firms

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Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 2: Building On The ACO Model

Richard Gilfillan, Donald M. Berwick

SEPTEMBER 30, 2021 10.1377/hblog20210928.795755

Key Points

- A "MA Gold Rush" with valuations of MA-focused companies at $40 – 100K+ per covered life
- MA overpayments driven by risk-score optimization (Kronick et. al. estimates $200 - $400B 10 yr. cost)
- Full-risk "percent of premium" MA provider contracts incent providers to optimize coding; and MA plan provider ownership/joint ventures are growing.
- Direct Contracting (DC) program stated aim to firms that previously operate only in MA into traditional Medicare with a MA-like program -- majority of DCEs are health plan sponsored or venture-backed
- DCEs have more ability to grow risk scores versus MSSP which is capped at 3% over five years.
- Provider groups must select between MSSP and DC – anecdotes of DCEs "poaching" ACO providers

Policy Questions

- Is CMS willing to strengthen financial incentives for provider participation in ACOs despite lower short-term savings?
- Will CMS consider options for embedding episodes inside of population-based payment programs?
- How should CMS address the lack of consistency in approaches value-based programs across public and private payers?
- Will CMS address the fundamental problems with its risk adjustment policy?
- Is “shared savings” a transitional pathway to full risk
- Will CMMI look to grow Direct Contracting as an avenue into traditional Medicare for private insurers?

Where Do We Go From Here?

"Innovation Center models can define success as encouraging lasting transformation and a broader array of quality investments, rather than focusing solely on each individual model's costs and quality improvements."

Chiquita Brooks LaSure, Elizabeth Fowler, Meena Seshamani, Daniel Tsai

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Thank You

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