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ACOs Achieving Quality with Shared Savings

This article is the first in a three-part Health Capital Topics series focusing on quality trends in *Accountable Care Organizations* (ACO). The driving purpose behind the development and implementation of ACOs is to shift reimbursement in the healthcare industry to incentivize "*quality care rather than quantity of care,*" by encouraging healthcare providers to find methods by which to improve care coordination and safety, as well as promote preventive health services.[1] This series will focus on how ACOs can improve the quality of healthcare delivered to consumers.

The *Centers for Medicare & Medicaid Services* (CMS) has developed and implemented two federal ACO programs to support the creation and sustainability of ACOs – the *Pioneer ACO Model* and the *Medicare Shared Savings Program* (MSSP). These two Medicare ACO models provide various levels of shared savings for ACOs that commit to providing quality care. The *Advanced Payment Model*, which operates under the MSSP,[2] provides resources to MSSP ACOs that could benefit from added support for creating the infrastructure and network to support an ACO,[3] particularly smaller ACOs with less access to capital.[4]

The potential amount of shared savings that an ACO may achieve differs depending on the type of Medicare ACO model utilized. MSSP ACOs still receive payments under a *Fee-For-Service* (FFS) reimbursement model, but when the ACOs enter the program, they can choose one of two tracks, which will afford ACOs shared savings if the ACO actually saves money, and quality performance standards have been met.[5] The two tracks are:

(1) Track 1: Shared Savings Only for the Initial Agreement. "*Shared savings are calculated for each performance year…[but] ACOs are not held accountable for losses.*"[6] Under this track, ACOs are eligible for up to 50% of the shared savings.[7]

(2) Track 2: Shared Savings and Shared Losses for All Years of the Agreement. "*ACOs will be eligible for a higher sharing rate, with a higher performance payment limit…[but] share in losses in return for the opportunity for a higher share of savings.*"[8] Under this track, ACOs are eligible for up to 60% of the shared savings.[9]

To determine any shared savings and losses, CMS establishes an annual benchmark based on the previous three years of data on per-beneficiary expenditures, and adjusts for absolute growth in national per capita expenditures.[10] Additionally, under Track 1, a *Minimum Savings Rate* (MSR) is calculated to ensure that expenditure levels below the benchmark are not just yearly fluctuations, creating a corridor around the established benchmark which must be met or exceeded.[11] For Track 2, a *Minimum Loss Rate* (MLR) is calculated to aid in establishing whether the ACO must share in losses. CMS describes the calculations required to determine eligibility for shared savings as follows:

> *"To calculate savings or losses, the ACO's per capita, risk-adjusted Medicare expenditures in each performance year is compared to its updated benchmark. If actual expenditures are lower than the updated benchmark and savings meet or exceed the MSR, the ACO may receive shared savings. Under the two-sided model only, if actual expenditures are higher than the benchmark and losses meet or exceed the MLR, a loss is incurred."*[12]

To determine the actual dollar amount of savings, both Pioneer and MSSP ACOs must meet or exceed 33 quality benchmarks (which are expected to increase to 37 in 2015[13]) that fall into one of the following four categories/domains:

(1) Patient/caregiver experience;

(2) Care coordination/patient safety;

(3) Preventive health; and,

(4) At-risk population.[14]

Both Pioneer and MSSP ACOs have a "*ramp up*" period to start achieving these quality benchmarks based on their number of years in the program, with each year progressively holding ACOs more accountable for meeting or exceeding quality benchmarks. The breakdown is as follows:

(1) *Performance Year 1* is a pay-for-reporting arrangement, whereby as long as an ACO accurately reports on all 33 measures, as well as meets their MSR, then they will be eligible for shared savings;[15]

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(2) *Performance Year 2* transitions to the pay-for-performance model, whereby ACOs are required to report on 25 of the 33 measures, on which their performance will be assessed, (with the remaining eight measures in a pay-for-reporting arrangement) as well as meet their MSR, to be eligible to receive shared savings;[16] and,

(3) *Performance Year 3* will continue as a pay-for-performance model, whereby ACOs are required to report on 32 of the 33 measures, on which their performance will be assessed (with the remaining measure in a pay-for-reporting arrangement), as well as meet their MSR, in order to be eligible to receive shared savings.[17]

Under the pay-for-performance model, starting in year two, ACOs must be at least in the 30th percentile (or achieve 30% of the total points) in each domain to earn points, and in the 90th percentile (or achieve 90% of the total points) to achieve maximum points.[18] These points fall into the four aforementioned quality domains, with each domain contributing 25% to the total score. This total score is weighted, with the resulting percentage applied to the Maximum Sharing Rate (50% for Track 1 and 60% for Track 2) to determine the amount of shared savings.[19]

The Pioneer ACO Model follows a similar methodology for calculating shared savings as described for MSSP ACOs, as stated above, but with a greater risk potential per year since it operates solely under Track 2, whereby ACOs are responsible for sharing in losses. Pioneer ACOs share in saving and losses as follows:

(1) In *Performance Year 1*, Pioneer ACOs are eligible for up to 60% of shared savings and shared losses;[20]

(2) In *Performance Year 2*, Pioneer ACOs are eligible for up to 70% shared savings and shared losses;[21] and,

(3) In *Performance Year 3*, if minimum average annual savings have been met in the previous two years (determined by CMS), then the ACO will enter into a population-based payment model, which is "*a per-beneficiary per month payment amount intended to replace a significant portion of the ACOs Fee-For-Service payment with a prospective payment.*"[22]

The switch to a population-based payment model is intended to allow Pioneer ACOs the flexibility to invest in infrastructure and other care coordination measures, as well as provide services which are not currently covered under the FFS system.[23]

While all of the Medicare ACO programs intend to reward organizations for quality care with shared savings payments, a recent study by Avalere Health Center for Payment and Delivery Innovation™ (Avalere) found a disconnect between achieving quality care and earning shared savings.[24] The MSSP ACOs that were able to achieve higher quality scores did not always earn shared savings because they did not meet their MSR, outnumbering those who did earn savings by three to one.[25] There were 49 ACOs that were able to achieve shared savings because they met their MSR, and for *Performance Year 1*, accurately reported on all 33 quality measures. Of the MSSP ACOs achieving savings, 59% (29 out of the 49) had below average quality scores.[26] This study was based on "*Performance Year 1 quality performance results for ACOs with 2012 and 2013 agreement start date,"* according to a report released by CMS last month. [27]

Of the top five quality measures most commonly achieved by ACOs, only one, "*All Conditions Readmissions,*" was an outcomes measure. The remaining four measures were either patient survey based, or processes with no associated outcome, i.e., *Medication Reconciliation*.[28] For the five least achieved benchmarks, all five quality measures came from the "*Care Coordination/Patient Safety and At-Risk Population*" domains, which are outcomes based measures,[29] indicating that it may be more difficult to improve outcomes than originally thought, thereby triggering concern that the ACO model may not yet be very effective at changing quality outcomes.

Pioneer ACO quality data was also recently released, which finally demonstrated Performance Year 2 results, whereby ACOs were required to meet performance targets in order to be eligible for shared savings.[30] The Performance Year 2 results yielded the same top five areas of quality improvement as the MSSP ACOs mentioned earlier; however, Pioneer ACOS improved in various other measures, such as:

(1) Tobacco use assessment and cessation intervention;

(2) Aspirin use; and,

(3) Percent of beneficiaries with IVD who use Aspirin or other antithrombotic.[31]

Overall, ACOs improved on all quality measures except for five (i.e., Shared Decision Making; ASC Admissions: COPD or Asthma in Older Adults; ASC Admissions: Heart Failure; Medication Reconciliation; and, Proportion of Adults who had blood pressure screened in past two years) over the previous year.[32] At least three of those five measures were outcomes based, further strengthening the argument that outcomes measures may be difficult to improve, even in an ACO model.[33]

Financial results were also released by CMS in September 2014, which reported that 53 MSSP ACOs and 11 Pioneer ACOs, out of a total of 243 Federal ACOs, earned bonuses totaling $445 million, while Medicare saved $372 million.[34] Forty-one MSSP ACOs spent more than predicted; however, the majority of these ACOs are in their first performance year and function under the one-sided risk model, and as such, are not liable for sharing in any of these losses.[35] One ACO that participated in the two-sided risk model will

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have to repay Medicare $4 million because it exceeded its established benchmark by $10 million.[36] Of the 23 Pioneer ACOs, three lost money and three are delaying reconciliation until after three years of experience.[37] Pioneer ACOs also found that health spending slowed up to 5.4% (a decrease from 7% the first year) among ACOs that were able to reduce medical bills for patients, and increased by up to 5.6% (an increase from 5% the first year) for ACOs that saw elevated costs.[38] After the first two years of performance data, only 19 of the original Pioneer ACOs remain in the program, with most leaving due to feared financial risk, and tensions surrounding Medicare's changes to payment models.[39]

Overall, CMS is reporting that quality of care is improving, with Pioneer ACOs increasing their mean quality score from 71.8% in 2012 to 85.2% in 2013, and MSSP ACOs improving on 30 out of 33 quality benchmarks for their year one results.[40] As more results are published, "*quality care rather than quantity of care*" will continue to be an important focus, and further refined to maximize the success and sustainability of the ACO model.

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