Executive Summary

Estimates of Savings by Medicare Shared Savings Program Accountable Care Organizations

Program Financial Performance 2013-2015

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Executive Summary

For too many patients, the U.S. health care system provides inconsistent quality and fragmented care that costs too much. Most health policy experts agree that moving away from fee-for-service (FFS) payment that rewards volume and toward value-based payment that rewards providers for improving outcomes and controlling cost is essential for improving the health care system's performance. The Accountable Care Organization (ACO) model is a market-based solution to fragmented and costly care that begins to align financial incentives to encourage local physicians, hospitals, and other providers to work together and take responsibility for improving quality, reducing waste to help keep care affordable, and enhancing patient experience.

The Medicare Shared Savings Program (MSSP) is the largest value-based payment model in the country with 561 ACOs covering 10.5 million Medicare beneficiaries. [1] The MSSP creates incentives for ACOs to improve care by allowing them to share savings they generate by achieving defined quality and cost goals. The program allows ACOs to gradually take on financial risk for managing spending growth. Such an approach gives ACOs time to build the infrastructure—the care coordination, information technology, and data analytics capabilities—to transform practice and manage risk successfully.

Evidence shows that MSSP ACOs collectively have measurably improved quality and saved Medicare money. [2] At the same time, Medicare beneficiaries attributed to ACOs maintain total choice in seeing any Medicare provider they want. ACOs also are slowing cost growth more broadly in local health care markets through spillover effects in changing care delivery for patients not included in ACOs.[3]

However, there is disagreement about the degree of savings achieved by ACOs participating in the MSSP. The Centers for Medicare & Medicaid Services (CMS) calculates savings based on a benchmarking methodology where actual spending is compared with targets based on each ACO's historical spending trended forward using the national average rate of growth in Medicare spending per beneficiary. Researchers have found that this method systematically understates the actual savings generated by MSSP ACOs. [4] The Medicare Payment Advisory Commission (MedPAC), for

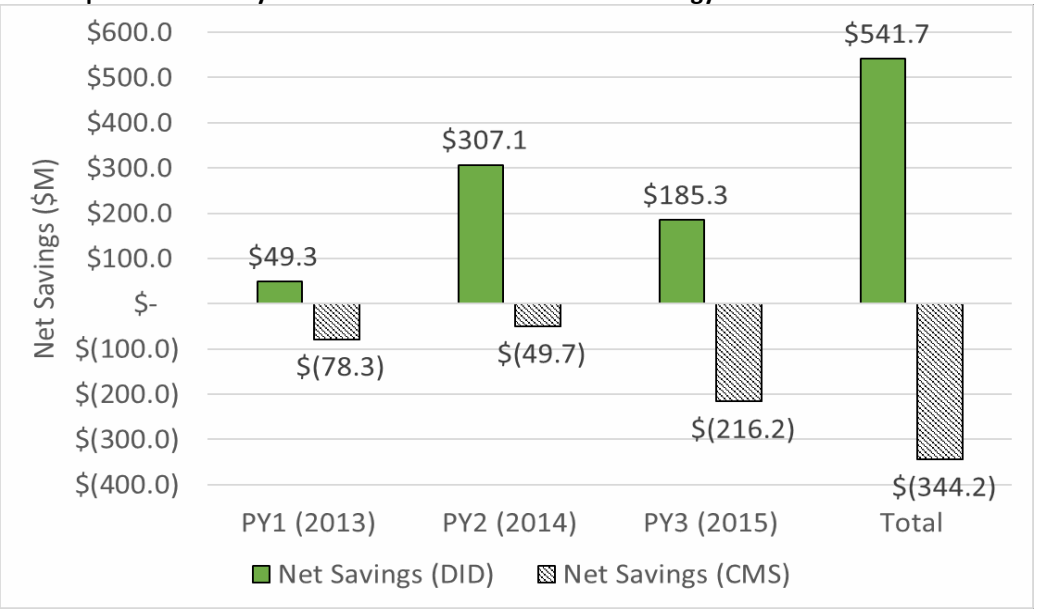
[1] CMS Medicare Shared Savings Program Fast Facts, January 2018. Retrieved https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf.
[2] Medicare Program Shared Savings Accountable Care Organizations Have Shown Potential for Reducing Spending And Improving Quality. (2017, August). *US Department Health and Human Services Office of Inspector General*. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf.
[3] Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success. 42 CFR Parts 414 and 425. Fed. Reg. August 2018.
[4] Chernew ME, Barbey C, McWilliams JM. Savings Reported by CMS Do Not Measure True ACO Savings. Health Affairs Blog. June 19, 2017.

example, concluded that ACOs may have saved the Medicare program up to 2 percent more than indicated by the benchmarking methodology based on studies using comparison groups.[5]

Dobson | DaVanzo & Associates was commissioned by the National Association of Accountable Care Organizations (NAACOS) to conduct an independent evaluation of MSSP ACO cost savings.

We estimate that ACOs in the MSSP generated savings of $1.84 billion during performance years 2013-2015, or nearly twice the $954 million in savings estimated by the CMS benchmarking methodology. Further, we found that the MSSP generated net savings of $541.7 million from 2013-2015 after accounting for shared savings bonuses earned by ACOs (Exhibit ES-1).

Exhibit ES-1: Net Federal Savings in the Medicare Shared Savings Program for 2013-2015: Dobson | DaVanzo Analysis versus CMS Benchmark Methodology



Source: Dobson | DaVanzo analysis of ACO RIF Data, CMS DUA 28643 and CMS MSSP Public Use Files, 2013-2015

Our study used a difference-in-differences regression analysis—the gold standard for program evaluation—and found savings similar to other independent research studies.[6,7] Based on Medicare FFS claims data from 2011-2015, the analytic sample included claims for 100 percent of ACO-attributed beneficiaries and a comparison group of roughly 90 percent of Medicare FFS beneficiaries who were eligible to be assigned to an ACO but were not assigned because they did not receive a majority of their care from an ACO.[8] This extremely large sample with claims data for

[5] Medicare Payment Assessment Commission. Report to Congress. June 2018.
[6] McWilliams, J. M. (2016, October). Changes n Medicare Shared Savings Program Savings From 2013 to 2014. *JAMA*, *316*(16), 1711-1713. Retrieved from https://jamanetwork.com/journals/jama/fullarticle/2552452.
[7] McWilliams, J.M., et al. (2016, June). Early Performance of Accountable Care Organizations in Medicare. *NEJM*, *374*, 2357-2366.
[8] Comparison group beneficiaries were enrolled in Medicare Parts A & B and not Part C and had a primary care service (ACO eligible) but were not assigned to an ACO as they did not receive the plurality of primary care expenditures with an ACO.

24 million to 26 million Medicare beneficiaries per year gives the analysis substantial statistical power.

In contrast, the CMS method of measuring ACO savings is based on an administrative formula to determine whether ACOs will receive shared savings. It is problematic when this financial target setting approach is used as if it were a program evaluation. Indeed, when independently evaluating both the Pioneer ACO and Next Generation ACO programs, CMS contractors used a difference-in-differences regression approach to estimate savings rather than the CMS benchmarking methodology used to set financial targets and calculate bonuses or penalties. [9,10] The CMS benchmarking methodology addresses the question "How has ACO spending changed compared to prior years' spending?" While this may be an appropriate way to set performance benchmarks, it produces a biased estimate of program savings when compared to what may have occurred if the ACO program had not been in place. Instead, evaluation of program savings should incorporate a carefully designed comparison group or counterfactual to account for prevailing trends to address the question: "How have ACOs changed expenditures compared to providers not participating in the ACO program?"

The CMS administrative payment and savings estimates do not accurately reflect ACO savings and produce incorrect inferences for policymaking. [11] Thus, it is important that external evaluators approach the question of MSSP ACO savings independently and with rigorous methods to better inform CMS, Congress, and other policymakers.

[9] Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Evaluation Findings from Performance Years One and Two. (2015, March). Centers for Medicare and Medicaid Innovation. https://innovation.cms.gov/Files/reports/PioneerACOEval-Rpt2.pdf.

[10] First Annual Report: Next Generation Accountable Care Organization (NGACO) Model Evaluation. (2018, January). Center for Medicare and Medicaid Innovation. https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf.

[11] Medicare Program Shared Savings Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality. (2017, August). *US Department Health and Human Services Office of Inspector General*. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf.