Break the Barriers to ACO Shared Savings

written by Dave Halpert | October 21, 2015

The ACO performance results for 2014 are in, and they are troubling. While most ACOs were able to fulfill quality reporting requirements, only some reduced costs enough to qualify for shared savings. Many ACOs did cut costs—of the 353 ACOs, there were $411 million in total savings. But for most ACOs, it was not enough.

How can ACOs break through the barrier to shared savings in the near future? Here are four lessons from analyzing the CMS data:

The goal of Medicare's performance-based reimbursement is to save money and improve outcomes, as illustrated by both the Merit-Based Incentive Payment System (MIPS) and Alternate Payment Models (APMs). But if ACOs are to be sustainable, they have to deliver on shared savings. It's not enough to save money; if you have also invested heavily in infrastructure, recouping those up-front costs may wipe out any savings for several years.

Lesson 1: Meet Performance Goals, Not Reporting

ACO performance measurement is distinguished from other CMS programs by universal measures and the use of a patient population sample in reporting. There is very little flexibility regarding which patients are included in the reporting sample, and the choice of measures to report is limited. This is in stark contrast to PQRS, where groups doing registry reporting are able to select a set of measures from a larger pool and report on the majority of eligible patients. In short, groups cannot manipulate ACO performance results by choosing the best measure results to report.

Reporting quality is not the issue for ACOs. It may be cumbersome to extract data from the EMRs into the CMS tool, but only 5 percent of ACOs were unable to fulfill reporting

requirements in 2014. While this is admirable, it does not solve the shared savings dilemma. Since you are always compared to your past performance for patients on Medicare, you need better results across the spectrum to stand out from the crowd. But you will also need to grow your ACO with patients new to Medicare by adding more primary care providers, enriching your pool with new patients to offset the continued downward pressure on costs for the older population of patients you've had.

Lesson 2: Become an "Experienced" First-Time ACO by Leveraging Previous Quality Initiatives

The more experienced the ACO, the more likely that ACO will be able to achieve shared savings. Those who started in 2012 were twice as likely to succeed as those who started in 2014. This trend is also apparent when looking at overall savings. Even as those who held spending below their targets saved an additional $100 million between 2013 and 2014, proportionately, the influx of new ACOs has brought the per-ACO savings rate down by nearly a third among those who came in below their estimated costs.

Quality is also improving with time. Over the last year, performance averages improved for 27 of the 33 ACO measures. This is certainly reassuring for the program's stakeholders, but should also be a wakeup call for those considering creating an ACO. The bar is being raised each year, and the longer you wait, the more difficult it will be to keep up.

You will need to build on your previous experience to catch up to the experienced ACOs. If you have participated in PQRS Performance prior to the ACO, continue your performance measurement of all Medicare patients. Especially if you have used a Registry for reporting quality, you can transition to evaluating patients under ACO measures very easily and capture the underlying data you need, both to report quality and to identify patients for performance improvement efforts.

If you have also performed patient outreach in the past and achieved desired results, such as return visits, screenings or better care coordination, these can move into your ACO tool set. However, you need to evaluate carefully what produces results, since resources will be limited. A Registry partner with the research capabilities embedded in performance improvement will help you measure the effectiveness of your interventions.

Lesson 3: Cautiously Consider "Advance Payment"

Succeeding with an ACO takes infrastructure for performance measurement and improvement, an internal governing structure, providers and staff. This takes time to build and requires a start-up investment. For this reason, Medicare offers an option for "Advance Payment." By using this model, groups are able to take out a loan from Medicare, using expected savings as

collateral.

Unfortunately, many groups have found that start-up money doesn't automatically translate into positive results. The most recent Public Use File shows that, of the 36 ACOs who received advanced payment, *more than half of them were unable to generate enough savings to cover the amount of Advanced Payment they received, and some actually incurred losses—a double hit.*

Lesson 4: Carefully Build Your ACO Network and Initiatives

Why does one ACO succeed and another fail? Does the number of patients, the number of providers or the provider-to-patient ratio create an advantage?

Let's take a look at Medicare's Public Use Files and examine the 10 percent who saved the most and 10 percent who lost the most:

Category	10% with Most Savings	10% with Most Losses
Percent Who Started in 2012	82%	68%
Average Number of Attributed Patients	25,158	25,756
Average Number of Participating Providers	581	904
Average Number of Patients per Provider	78	56
Average Number of Primary Care to Specialist	2.35	0.95
Number Who Received Advanced Payment	2	2
Average Diabetes Composite Score	26	24
Average CAD Composite Score	66	68

On average, the most successful ACOs:

- Generally are more experienced, although a large number of ACOs in the Loss Group also started in the same year;
- Have fewer providers;
- Include a larger proportion of primary care providers to specialists; and
- Maintain a larger patient load per provider.

But there are other attributes that are identical between the groups, leading to a couple of hypotheses for good research:

The size of the patient population itself does not seem to determine success or failure, but
Equivalent quality scores mean that higher resource use occurred in the Loss Group to reach the same results.
A number of factors may be at play:

- Higher out-of-network traffic, with less patient outreach, loyalty or adequate referral decisions;
- Lack of coordinated care, leading to duplicate or higher cost tests and services;
- Improper attribution of patients to the ACO because of the primary-to-specialty imbalance.

Network configuration is likely one of the most important factors to evaluate. The fact that losses occurred with higher provider counts and heavy specialty concentration points to the challenges for large multi-specialty and academic groups in ACOs.

How Do You Break the Barrier to Savings?

There is no way to fake ACO success. The data shows that savings goals can be reached, but it happens through careful design and implementation. Here are some of the main takeaways:

- Establish a performance measurement program that allows you continually to evaluate outcomes and costs. The worst time to collect performance data is at reporting time, because the data are subject to the arbitrary results of the patient sample, and you can't do anything about the results. The main purpose for performance measurement is not just to benchmark your providers and patient results, but also to identify patients and providers for focused interventions.
- Build your ACO network with emphasis on primary care; use CMS data to determine historical costs and quality profiles of all your network participants;
- Evaluate the cost and quality of specialists before you direct patients to them, as a best practice for establishing a referral network that will deliver both good outcomes and lower cost.
- Evaluate your ACO patient population attribution to ensure that your patients have primaries in your network;
- Build patient loyalty and coordination of care by reaching out to patients and connecting them with primary care providers in the network. There are several services, such as Medicare Wellness Visits, that are instrumental for this;
- Establish a Performance Improvement program built on interventions to the problems you diagnosed in performance measurement. After risk adjusting your population and benchmarking your data, the real work can begin—testing interventions and redesigning processes to bring the costs down.

Sources:

Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014, CMS, 8-25-15
Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings, CMS, 8-25-15
Shared Savings Program Accountable Care Organizations (ACO) PUF, CMS, May 2015

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