Researchers Explore Year One of Pioneer ACO Experiences

Cost Savings Outweigh Quality Improvement Gains

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News Staff – CMS' Pioneer accountable care organization (ACO) program launched in 2012 with 32 health care organizations on board and ready to test a payment model in which a network of health care professionals and organizations would join forces to provide health care services for a defined population of patients.

Now, researchers from three Boston-area institutions -- Harvard Medical School, Brigham and Women's Hospital, and Beth Israel Deaconess Medical Center -- have collaborated on research examining how the various ACOs performed in the first year of the program. The article detailing that research, "Performance Differences in Year 1 of Pioneer Accountable Care Organizations," was published online April 15 in the New England Journal of Medicine.

Background and Study Methods

In the ACO payment model, a network of health care professionals is paid to provide coordinated comprehensive care to patients and assumes responsibility for the cost and quality of that care. The end goal is twofold: ACOs aim to improve quality of care and health outcomes for patients while lowering the cost of that care.

CMS' Center for Medicare and Medicare Innovation designed the Pioneer ACO Model specifically for physicians, health care professionals and organizations already experienced in providing coordinated care for patients across care settings.

Story Highlights

- New research published in the New England Journal of Medicine examines how 32 accountable care organizations (ACOs) participating in CMS' Pioneer ACO model initiative performed in the first year of the program.
- Authors compared spending for Medicare beneficiaries enrolled in the Pioneer ACOs with that for beneficiaries assigned to a control group.
- In 2012, the per-beneficiary spending in the ACO group decreased by $29.2 per quarter for an overall savings of 1.2 percent; performance on quality measures showed either small but significant improvements or no significant change.
For the study, researchers conducted a "difference in differences analysis" of Medicare fee-for-services claims; they compared spending for a random sample of Medicare beneficiaries enrolled in the selected Pioneer ACOs with that for other beneficiaries assigned to a control group. Researchers measured costs before (from 2009-2011) and after the Pioneer ACO contracts began in 2012.

They also calculated changes in spending for ACO subgroups, defined as

- those with and those without clear financial integration between hospitals and physician groups,
- those with higher and those with lower baseline spending and
- the 13 ACOs that left the Pioneer program after 2012 and the 19 ACOs that remained.

Noting that ACO contracts included 33 quality measures related to patients’ experiences, care coordination, preventive care and disease control, the researchers included four additional measures: screening mammography for women 65 to 69 years of age, all-cause 30-day readmissions, and hospitalizations for two conditions for which appropriate ambulatory care has been shown to reduce the need for inpatient care -- chronic obstructive pulmonary disease and congestive heart failure.

**Research Highlights**

Regarding spending and quality changes, researchers found that before the ACO contract period, quarterly Medicare spending per beneficiary was similar in both the ACO and control groups. In 2012, the per-beneficiary spending in the ACO group decreased by $29.2 per quarter for an overall savings of 1.2 percent.

The researchers also noted that changes in total spending included estimated savings related to spending on acute inpatient care, hospital outpatient care, and post-acute care such as that provided in skilled nursing facilities. However, spending on outpatient care in office settings increased for the ACO group in 2012, "partially offsetting the lower spending on hospital outpatient care," they said.

Furthermore, regarding changes in performance on quality measures in the ACO group compared with the control group, study authors reported either

- small but significant improvements or
- no significant change.

Regarding performance differences, the authors found that ACOs with baseline spending above the local average showed greater estimated cost savings ($39.4 more per beneficiary per quarter) when compared with ACOs with baseline spending below the local average.

In addition, ACOs serving high-spending areas saw greater savings ($56.3 more per beneficiary per quarter) than ACOs serving low-spending areas.

When the researchers examined data from the 13 ACOs that quit the Pioneer program after 2012, they found that estimated savings in those ACOs were close to the savings in the 19 ACOs that remained in the program ($33.0 per beneficiary per quarter vs. $26.1 per beneficiary per quarter).

In total, authors calculated that when aggregated to the entire ACO population, total Medicare spending was about $118 million lower than expected, "a sum that falls between the actuarial calculation of $87 million by the CMS and an estimate of $147 million in a previous evaluation," wrote the authors.

Furthermore, "Our estimate exceeds the $76 million in bonuses paid by CMS to Pioneer ACOs by $42 million," they wrote.
Discussion Points

The researchers noted that estimated savings were similar regardless of whether ACOs had financial integration between hospitals and physicians, and they suggested that provider consolidation of that sort "may not be necessary in order for ACOs to achieve lower spending in Medicare."

The authors suggested that the research could have important implications for payment policy in Medicare ACO programs.

For instance, because the authors found no link between estimated savings and continued participation in the Pioneer ACO, "Sustaining or expanding participation in a Pioneer-like ACO program will probably require greater and more reliable awards for ACOs that reduce spending than those currently in place."

They also suggested that analysts proposing changes to ACO payment rules "should consider lost savings from organizations that withdraw from the ACO programs in response to current incentives. Stronger incentives to participate in ACO programs would diminish the share of savings appropriated by Medicare for a given ACO but could lead to more ACOs generating savings," they said.

Lastly, the authors suggested a gradual lowering of benchmarks for high-spending ACOs compared with those for lower-spending ACOs.

"Constraining growth in benchmarks for ACOs with high spending could be important for establishing equitable benchmarks and fostering healthy competition among ACOs," they wrote.

Researchers listed several study limitations, including that their estimate of savings did not include CMS' costs to administer an ACO program or the costs incurred by ACOs to implement strategies to limit spending.

"Increased understanding of these costs, the evolution of ACO performance over time, and the extent to which Medicare ACO contracts affect care for patients served by ACOs but not covered by the contracts will be needed to characterize the potential for long-term savings to society from Medicare ACO initiatives," the authors concluded.