

# Differences in Savings and Quality by Type of ACO Model

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## ABSTRACT

**Objectives:** The evolution in the accountable care organization (ACO) payment model initiatives by CMS reflects an increased understanding of the benefits and hurdles of using such an advanced payment model. As the Medicare Access and CHIP Reauthorization Act requires Medicare providers to choose an incentive-based payment track, which can include participation in an ACO, understanding what is achievable in the different types of ACO models is important. The most recent version, the Next Generation ACO (NGACO) model, increases both the risk and financial reward that providing organizations can realize relative to other types of Medicare Shared Savings Program (MSSP) ACOs. This study aims to examine the differences in savings and quality scores across MSSP ACOs and NGACO.

**Study Design:** Observational retrospective study of ACO-level data.

**Methods:** In this study, we used panel data to estimate fixed effects regressions comparing ACO savings and quality scores across the 2 ACO types (NGACO and MSSP) using publicly accessible aggregated ACO data. We studied 737 unique ACOs (680 MSSP ACOs and 74 NGACO) in our sample, with 17 ACOs switching from one type of ACO to the other from 2016 to 2018.

**Results:** On average, the NGACO had more aligned beneficiaries, but no statistically significant differences emerged in average gross savings (\$1.90 million for NGACO vs \$2.21 million for MSSP ACOs;  $P=.78$ ) after adjusting for size and fixed effects. We also found mostly insignificant differences across 37 quality measures used to calculate the share of savings that ACOs receive.

**Conclusions:** NGACO and MSSP cost and quality data show similar performance, suggesting that increasing financial risk to health systems may not affect performance.

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The Affordable Care Act in 2010 established an innovation center within CMS and facilitated the testing of various payment reform models focused on improving patient care and population health without increasing costs and lowering them where possible.<sup>1-3</sup> As part of these efforts, CMS rolled out the Medicare Shared Savings Program (MSSP) in 2012, which allowed eligible providers to create accountable care organizations (ACOs) with the hope that increased coordinated care would result in savings that could be shared as long as quality standards were met.

As evidence emerged about how ACOs worked and their effectiveness compared with prior payment models in both cost and quality, CMS has tested and refined additional aspects of the ACO programs.<sup>4-6</sup> The Pioneer ACO model included providers that largely already had the requisite infrastructure and care coordination practices in place, and they were able to show improvements in quality, but evidence on cost savings was mixed.<sup>7,8</sup> CMS also initiated the broader MSSP in 2012, with less stringent risk-sharing requirements. To address concerns about the significant start-up costs for an ACO without that existing infrastructure, CMS designed a Medicare Advance Payment (AP) ACO model that provided an up-front fixed payment to participating ACOs and then a monthly payment thereafter based on the number of attributed beneficiaries. These advanced payments were to be recouped from shared savings in the first agreement period only. The Medicare ACO Investment Model (AIM) then built on the AP ACO model by allowing more ACOs (entering MSSP in 2012-2016) to defray the capital investments necessary to form and maintain an ACO. Empirical evidence to date on these advanced alternative payment models (APMs) is mixed, with the AP model demonstrating little effect on quality and an overall increase in total spending per beneficiary per month (PBPM),<sup>9</sup> whereas the AIM has shown savings of \$381.5 million, but the program includes only 14 (of 47) AIM ACOs still in the shared savings program.<sup>10</sup> Nonetheless, since the initiation of the MSSP, ACO

participation has grown to 517 ACOs with 11.2 million aligned beneficiaries nationwide in 2020.<sup>11</sup>

The Next Generation ACO (NGACO) model, rolled out in 2016, offered higher levels of risk and reward than earlier ACO models, mechanisms that enabled a graduation from traditional fee-for-service reimbursements to population-based payments, and tools to support better patient engagement and care management. One important goal of the NGACO model, as stated by CMS, “is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service beneficiaries.”<sup>12</sup> This model, which will run through 2021, has more than 45,000 providers and more than 1.2 million aligned beneficiaries.<sup>13</sup> The evaluation results to date suggest divergent effects in the first 2 years, with nearly \$117 million in increased spending among the 2016 cohort of participating ACOs and more than \$86 million in reduced spending among the 2017 cohort.<sup>13</sup> Further understanding the relationships between increased financial risk and performance in cost and quality between MSSP and NGACO programs may have important implications for health systems and individual health care providers in terms of deciding to accept varying levels of risk in these advanced APMs.

In this study, we examined NGACOs using publicly available ACO data from CMS that included NGACOs and MSSP ACOs from 2016 to 2018. We aimed to investigate the extent to which ACO performance on reported cost and quality measures varied for beneficiaries participating in NGACOs relative to those participating in the lower-risk MSSP ACO models.

## METHODS

### Data and Measures

We used publicly available data from 2016 to 2018 from CMS that aggregated all quality measures, net costs, and savings rates from all MSSP ACOs. We included NGACOs and all other MSSP ACOs with active agreements, hereafter denoted as an ACO type of “NGACO” and “MSSP,” respectively.

We focused on outcome measures that are reported consistently across the different ACO types, which included 37 quality measures categorized by CMS under patient/care-giver experience, care coordination/patient safety, preventive health, and at-risk population. We also examined a key cost measure: gross savings/losses, calculated as the total benchmark expenditures minus the total aligned beneficiary expenditures. Benchmark expenditures in the NGACO model are set each performance year prospectively, using expenditures, risk scores, and quality measures from a 1-year historic baseline that is regionally detrended with the intention to avoid

penalizing successful performance.<sup>14,15</sup> For the other MSSP ACOs, benchmarks can vary based on agreement start date and risk track (1- or 2-sided) but broadly weigh more heavily on an ACO’s recent expenditures without the regional detrending.<sup>16</sup> For either type of ACO, if expenditures on all ACO-aligned beneficiaries exceed that benchmark, it will have losses. We included the number of aligned beneficiaries and the calendar year as covariates in regression models.

### Statistical Analysis

We used panel data analyses, accounting for ACOs that we observed over multiple years. We calculated descriptive statistics and compared means using 2-sided *t* tests by ACO type (MSSP vs NGACO).

We also estimated linear regressions to adjust for the number of aligned beneficiaries in each ACO and the calendar year. Finally, we estimated fixed effects regressions to adjust for time-invariant ACO characteristics—for example, the state or health care market in which the ACO is operating or the ACO’s key partners (to the extent that these characteristics did not change). The regressions followed this form:

$$outcome_{it} = \beta_1 NGACO_{it} + \beta_2 Benes_{it} + \tau_t + \eta_i + \varepsilon_{it},$$

where *outcome* is one of the outcome measures for ACO *i* in year *t*, *NGACO* is an indicator for ACOs participating in the NGACO program, *Benes* is a continuous measure of the number of attributed beneficiaries,  $\tau$  is a vector of year fixed effects, and  $\eta$  is a vector of ACO fixed effects. To adjust for multiple comparisons, we applied a Bonferroni correction and considered differences statistically significant with a *P* value < .002. All analyses were performed using Stata version 16 (StataCorp).

## RESULTS

In our sample, there were 737 unique ACOs over the 3-year period; 17 switched from one type of ACO to the other. Thus, there were 680 MSSP ACOs and 74 NGACOs in our sample (see **Table 1**). On average, NGACOs had about 9000 more aligned beneficiaries than MSSP ACOs (*P* < .001). The savings rate was between 1% and 2%, on average, and not statistically different across the 2 groups, even after adjusting for differences in the number of aligned beneficiaries and calendar year and in our fixed effects estimation. NGACOs appeared to have higher average gross savings, at about \$4.5 million, relative to MSSP ACOs at \$2.38 million (*P* = .04), but once we adjusted for the ACO size and calendar year and ACO fixed effects, this difference became smaller in magnitude and statistically insignificant (adjusting for ACO size/year: *P* = .82; adjusting for ACO size/year and ACO fixed effects: *P* = .78).

**Table 1.** Means and Frequencies, by ACO Type<sup>a</sup>

	MSSP	NGACO	P
Number of ACOs			
In 2016	432	18	
In 2017	472	44	
In 2018	548	50	
Unique ACOs	680	74	
Switched from NGACO to MSSP over 3 years	1		
Switched from MSSP to NGACO over 3 years		16	
Number of aligned beneficiaries, mean (95% CI)	18,577 (5270-55,845)	27,603 (9968-80,373)	<.001
Savings rate, mean (95% CI)			
Unadjusted	1.30% (-5.93% to 9.25%)	2.00% (-3.30% to 6.64%)	.36
Adjusted	1.14% (0.83%-1.44%)	1.40% (0.45%-2.34%)	.60
Adjusted and ACO fixed effects	1.22% (1.12%-1.55%)	1.22% (-0.61% to 3.05%)	.91
Gross savings/losses (in millions \$), mean (95% CI)			
Unadjusted	2.38 (-9.49 to 15.80)	4.45 (-9.30 to 18.30)	.04
Adjusted	2.22 (1.61-2.84)	2.45 (0.53-4.38)	.82
Adjusted and ACO fixed effects	2.21 (2.05-2.92)	1.90 (-0.67 to 6.76)	.78

ACO, accountable care organization; MSSP, Medicare Shared Savings Program; NGACO, Next Generation ACO.

<sup>a</sup>Adjusted means were obtained following regressions controlling for the number of aligned beneficiaries in the ACO and the calendar year. Adjusted and ACO fixed effects results were obtained following regressions with the same controls and ACO fixed effects. *P* value shows level of significance of difference in means.

In **Table 2**, we present adjusted score components in the patient/caregiver experience domain based on the fixed effects regression results. Scores are not significantly different by ACO type, except that the Consumer Assessment of Healthcare Providers and Systems patients' rating of providers is slightly higher among NGACOs relative to MSSP ACOs, but after adjusting for multiple comparisons, this does not meet our level of significance ( $P = .02$ ).

Next, we examined adjusted score components in the care coordination and patient safety domain. In **Table 3**, we present the predicted means from the fixed effects regression results. Only the difference in ACO8, the risk-standardized measure for all-condition readmissions, approaches statistical significance ( $P = .019$ ), with NGACOs having slightly higher readmission rates.

In **Table 4**, we present adjusted score components for preventive health and at-risk populations. Here we found marginally significant differences for some at-risk population measures. NGACOs had a lower percentage of beneficiaries with depression with remission at 12 months<sup>17</sup> ( $P = .016$ ) and lower use of aspirin or another antiplatelet among patients with ischemic vascular disease ( $P = .007$ ).<sup>18</sup>

## DISCUSSION

Our analyses suggest no significant difference in gross savings/losses between MSSP ACOs and NGACOs after adjusting for the number of aligned beneficiaries and ACO fixed effects. Also, no consistent differences emerged between the 2 payment models in most quality measure domains.

Our findings have significant potential implications for both health care systems and health care providers participating in single-sided vs double-sided risk advanced APMs. The lack of difference in gross savings/losses and quality measure domains between MSSP ACOs and NGACOs may influence the decision of an ACO's leadership to participate in either of these programs. Our analysis suggests that, on average, gross savings/losses between MSSP and NGACO models were not significantly different and that other differences between programs (such as risk to an ACO) may be more important factors in determining program participation. In contrast, it is unclear if individual providers may be influenced to join or remain in a payment model with an increased risk like an NGACO, as individual providers' exposure to such risk/rewards are likely influenced by other factors not evaluated in this study (eg, employed vs affiliated provider contracts, gainsharing).

Our work differs from most of the CMS-sponsored evaluation studies of ACOs because we are not using individual beneficiary-level data, but our findings are consistent with

**Table 2.** Mean (95% CI) Adjusted Patient/Caregiver Experience Components of Score, by ACO Type<sup>a</sup>

Component		MSSP	NGACO	P
ACO1	CAHPS: Getting Timely Care, Appointments, and Information	82.50 (82.33-82.67)	82.02 (80.59-83.45)	.54
ACO2	CAHPS: How Well Your Providers Communicate	93.11 (93.05-93.18)	93.63 (92.20-93.26)	.08
ACO3	CAHPS: Patients' Rating of Provider	92.06 (92.00-92.13)	92.73 (92.20-93.26)	.02
ACO4	CAHPS: Access to Specialists	82.88 (82.75-83.02)	82.08 (80.93-83.22)	.20
ACO5	CAHPS: Health Promotion and Education	60.27 (60.12-60.42)	60.91 (59.64-62.19)	.92
ACO6	CAHPS: Shared Decision Making	70.32 (70.16-70.49)	69.59 (68.20-70.99)	.34
ACO7	CAHPS: Health Status/Functional Status	72.60 (72.52-72.69)	72.18 (71.45-72.90)	.28
ACO34	CAHPS: Stewardship of Patient Resources	26.88 (26.69-27.08)	26.59 (24.92-28.26)	.75

ACO, accountable care organization; CAHPS, Consumer Assessment of Healthcare Providers and Systems; MSSP, Medicare Shared Savings Program; NGACO, Next Generation ACO.

<sup>a</sup>Means reported were obtained following regressions controlling for the number of aligned beneficiaries in the ACO and the calendar year and ACO fixed effects. P value shows level of significance of difference in means.

several of the studies examining earlier CMS ACO models.<sup>9,12</sup> A final evaluation of the NGACO model is still under way, but our findings suggest very few differences in the key outcomes that will be used for generating savings payments between the NGACO and MSSP models. However, we note that selection is still a significant concern, as the providers and organizations that have chosen to participate in an MSSP ACO or NGACO are likely very different from those who did not but who may be considering forming one in response to the Medicare Access and CHIP Reauthorization Act (MACRA). As earlier research has found, there are significant start-up and infrastructure costs and hurdles

to forming an ACO, which may influence which providers decide to participate in an ACO vs choosing the Merit-based Incentive Payment System payment track to receive reimbursement for their Medicare beneficiaries.

### Limitations

Our analysis includes the following limitations: First, we do not observe data for all ACOs at all points in time and we have no pre-ACO data, which would allow us to explore and possibly adjust for potential selection effects. Second, although we are able to estimate fixed effects models to adjust for time-invariant characteristics of the ACOs, ACOs likely adapted their behaviors over time in ways that would affect their performance and quality measures. Thus, our work should be considered exploratory and descriptive and not causal. Nonetheless, understanding to what extent there might be differences is useful for providers considering how to respond to MACRA. We also note that some of CMS' quality measures are not risk adjusted (eg, patient experience and process measures).

### CONCLUSIONS

The results of this study provide evidence that ACOs in the NGACO model perform similarly to organizations participating in the MSSP model on publicly reported quality and cost measures. These findings suggest that ACO models with increased financial risk to providers may not significantly affect performance on such cost and quality measures.

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**Table 3.** Mean (95% CI) Adjusted Care Coordination/Patient Safety Components of Score, by ACO Type<sup>a</sup>

Component		MSSP	NGACO	P
ACO8	Risk Standardized, All Condition Readmission	14.90 (14.88-14.92)	15.16 (14.96-15.37)	.019
ACO35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure	18.43 (18.38-18.49)	18.65 (18.18-19.12)	.40
ACO36	All-Cause Unplanned Admissions for Patients With Diabetes	47.14 (46.80-47.48)	48.86 (45.96-51.76)	.28
ACO37	All-Cause Unplanned Admissions for Patients With Heart Failure	76.12 (75.41-76.83)	80.58 (74.49-86.67)	.18
ACO38	All-Cause Unplanned Admissions for Patients With Multiple Chronic Conditions	60.03 (59.71-60.34)	62.59 (59.85-65.33)	.09
ACO43	Prevention Quality Indicator: Ambulatory Sensitive Condition Acute Composite	65.62 (64.41-66.84)	68.58 (57.33-79.84)	.63
ACO12	Medication Reconciliation Post Discharge	79.37 (77.65-81.10)	94.91 (79.11-110.72)	.08
ACO13	Falls: Screening for Future Fall Risk	73.73 (73.00-74.46)	70.56 (64.32-76.81)	.35
ACO44	Use of Imaging Studies for Low Back Pain	65.62 (64.41-66.84)	68.58 (57.33-79.84)	.63

ACO, accountable care organization; MSSP, Medicare Shared Savings Program; NGACO, Next Generation ACO.

<sup>a</sup>Means reported were obtained following regressions controlling for the number of aligned beneficiaries in the ACO and the calendar year and ACO fixed effects. *P* value shows level of significance of difference in means.

**Table 4.** Mean (95% CI) Adjusted Preventive Health Components of Score, by ACO Type<sup>a</sup>

Component		MSSP	NGACO	P
ACO14	Preventive Care and Screening: Influenza Immunization	71.35 (70.88-71.81)	72.34 (68.38-76.30)	.65
ACO15	Pneumococcal Vaccination Status for Older Adults	73.42 (72.97-73.86)	71.10 (67.30-74.91)	.27
ACO16	Preventive Care and Screening: Body Mass Index Screening and Follow-up Plan	73.95 (73.37-74.52)	70.30 (65.37-75.24)	.18
ACO17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	83.70 (82.89-84.51)	85.05 (78.05-92.05)	.73
ACO18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	61.56 (60.85-62.27)	57.94 (51.89-63.99)	.27
ACO19	Colorectal Cancer Screening	65.44 (65.00-65.89)	65.03 (61.25-68.81)	.84
ACO20	Breast Cancer Screening	70.30 (69.88-70.71)	70.56 (64.32-76.81)	.89
ACO27	Diabetes: Hemoglobin A1C Poor Control (>9%)	16.49 (16.10-16.88)	19.28 (15.91-22.65)	.13
ACO28	Controlling High Blood Pressure	72.21 (71.89-72.52)	69.80 (67.13-72.48)	.10
ACO30	Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet	87.53 (87.06-88.00)	81.63 (77.61-85.65)	.007
ACO40	Depression Remission at Twelve Months	8.30 (7.72-8.88)	1.75 (-3.21 to 6.71)	.016
ACO42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	79.99 (79.56-80.41)	78.28 (74.63-81.93)	.39

ACO, accountable care organization; MSSP, Medicare Shared Savings Program; NGACO, Next Generation ACO.

<sup>a</sup>Means reported were obtained following regressions controlling for the number of aligned beneficiaries in the ACO and the calendar year and ACO fixed effects. *P* value shows level of significance of difference in means.

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