

# The Need to Level the Playing Field Between Accountable Care Organizations and Medicare Advantage

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CMS's Medicare Shared Savings, or accountable care organization (ACO), program faces considerable challenges. Most immediately, the 2014 results released by CMS in September show the ACO program's performance was actually worse than in 2013. Once again, approximately one-fourth of ACO providers (86 of 333) received earned shared savings, with the majority of savings concentrated among a small number of participants. The earned shared savings among these 86 was on average 33% less compared with that in 2013, in part, because quality performance scores reduced total shared savings by 12%. In 2014, successful ACOs spent only \$29 (0.28% less) per beneficiary than the 67 worst-performing ACOs, proving that CMS has only managed to financially coerce some high-cost providers to decrease unwarranted utilization. Essentially, the ACO program's savings at \$1.5 billion represents only a fraction of the total 2-year spending by Medicare at over \$1.15 trillion. The Medicare Shared Savings program has not made a difference in bending the cost curve.<sup>1</sup>

ACOs need to be successful in their own right for primarily 2 inter-related reasons. First, the number of ACO participants needs to continue to grow rapidly since ACOs are the primary alternative payment model (APM) expected to meet HHS Secretary Burwell's stated goal of having 50% of traditional fee-for-service Medicare payments tied to quality or value by the end of 2018<sup>2</sup>—Medicare Advantage (MA) payments are not counted toward meeting this quality or value goal. Second, until the ACO program is redesigned to produce improved odds at achieving shared savings, provider participation will decline, and the decline could conceivably accelerate because, knowing Medicare fee-for-service is increasingly moving toward risk-based performance

agreements, providers will choose instead to contract with MA plans.

ACO performance implications aside, there is a larger, systemic challenge or question facing the Shared Savings program. How do ACO providers compete against MA plans? More specifically, how do they compete when their growth and success is effectively impeded by MA?

At least 3 factors explain why MA hinders the ACO program: first, MA plans—which currently serve 17 million Medicare recipients, or well over twice as many beneficiaries, as ACO providers—are expected to increase their enrollment from approximately 31% to 40% of all Medicare recipients (or 22 million beneficiaries) over the next 5 years. This growth represents an ever-increasing crowd-out problem for the ACO program since Medicare beneficiaries participate in either program or remain in fee-for-service. Second, MA markets are highly concentrated. In the 2850 counties that serve 84% of all Medicare beneficiaries, a single MA plan dominates. The absence of competition between and among MA plans undermines the potential to control Medicare program spending and promote quality.<sup>3</sup> Market domination or prominence, and all its attendant advantages, also makes it difficult for ACOs to compete. These 2 factors are, in part, a function of a third factor: MA plans performing under decidedly more favorable program rules.

For CMS to be successful in establishing ACOs as APMs and, in turn, successfully reducing Medicare cost growth, the agency needs to level the Medicare playing field for ACO providers. Although there are currently many dissimilarities or inequities between the 2 programs' regulations, there are at least 6 that need to be addressed: 1) in the MA program, beneficiaries

choose to enroll, whereas ACO beneficiaries are assigned; 2) MA benchmarks are based on spending by the county in which the MA beneficiaries reside, but ACO benchmarks are based on their assigned beneficiaries' historical utilization; 3) MA beneficiary risk adjustment scores can increase, but ACO risk scores cannot; 4) MA plans can earn extra payments for quality achievement, but ACOs cannot; 5) MA plans, unlike ACOs, can provide beneficiaries with additional or supplemental benefits; and 6) MA is administrative pricing and, therefore, considered cost neutral (why MA payments are, again, not included in the Secretary's quality and value-payment goals), but ACOs are designed to score Medicare savings.<sup>4</sup> Because CMS has a far freer hand to reform the ACO program, and since substantial changes to the MA program are politically difficult, instead of further pursuing its current path to improve the ACO program in isolation, CMS should reform the program, such that the chances of success for ACO providers approximate that of MA. This can be accomplished only if ACO and MA program rules equate.

### MA Enrollment vs ACO Assignment

Let's begin with how patients participate in each program. In MA, Medicare beneficiaries choose to join or enroll in MA. Enrollment is annual, and beneficiaries are able to choose from an average of 18 MA plans. There are other specifics concerning MA enrollment. For example, beneficiaries must choose among health maintenance organizations, preferred provider organizations, special needs plans, and other types of plans in which to enroll.

Under the ACO program, beneficiaries are assigned to an ACO, or if a beneficiary previously received the plurality of his or her primary care services from a primary care physician or physicians within an ACO, they are assigned to that specific ACO. Beneficiaries are then made aware that they were assigned to an ACO, as they are given the opportunity to refuse sharing their claims data with their ACO provider. Despite this, many ACO-assigned beneficiaries still have no knowledge that they have been assigned, or even what an ACO is, in part because CMS limits an ACO's communication with its beneficiaries. (There is, in fact, legitimate debate whether there is any actual benefit in informing the beneficiary that they've been assigned to an ACO; some beneficiaries react negatively when learning about an ACO or that they've been assigned [eg, they think because the provider is incented to reduce costs they will stint on their care]).

The reason participation between programs differs is because CMS does not want to restrict beneficiary choice. Although assigned to an ACO, the beneficiary can still see a Medicare provider outside their assigned ACO or in another ACO, or even enroll in an MA plan; this is because CMS believes beneficiary choice is sacrosanct, inviolable. In theory, this is an admirable

goal, but in practice, it's unworkable. First, it's worth noting that CMS does not see the MA enrollment requirement as compromising beneficiary choice, and it assigns beneficiaries to an ACO without their consent. More practically, allowing ACO-assigned beneficiaries free range creates a significant problem for ACOs. With beneficiaries exiting and entering an ACO in any performance year because they knowingly (or not) receive the plurality of their primary care from their ACO or another organization, an ACO's ability to effectively manage their assigned patients, within and beyond the performance year, is compromised. Since problems with unstable assignment or patient churn is considerable, CMS are considering an incremental step toward formal enrollment, which would allow beneficiaries to attest that they are participating in an ACO. Even if CMS allows for attestation, Medicare beneficiaries are still likely to be reluctant to shop for Medicare coverage of any kind because they find, in the words of a recent Kaiser Family Foundation survey, the experience "confusing," "daunting," "frustrating," and "overwhelming." This is the case because health insurance information remains notoriously opaque.<sup>5</sup> To compound the issue further is the fact that a large number of Medicare beneficiaries—approximately 3 in 10 (or 17 million)—suffer from some form of cognitive or mental impairment.

In the agency's latest ACO demonstration, the Next Generation ACO model, CMS will allow beneficiaries to voluntarily align, meaning if a beneficiary confirms their relationship with a Next Generation ACO, they will be assigned to the same ACO in the subsequent year even if they did not receive a plurality of their care from the Next Generation ACO.<sup>6</sup> These beneficiaries would also be eligible for a cash incentive to maintain their relationship with the ACO, which would incent them to remain under the ACO's care. CMS could readily employ this, or a stronger alignment provision in the ACO program, with nominal financial risk.

### Financial Benchmarking and Risk Scoring

MA plans are paid a per member per month (PMPM) fee based on how the plan's bid compares with the county benchmark costs that CMS sets. If the MA bid exceeds the benchmark, MA beneficiaries pay the difference in higher premiums; if the bid is below the benchmark, beneficiaries can pay lower out-of-pocket costs and receive supplemental benefits. Unspent PMPM monies constitute plan profit.

An ACO's benchmark is based on its assigned beneficiaries' average costs over the span of the immediate past 3 years. Both payment sums are updated to reflect performance year costs. If the ACO's total fee-for-service performance year billing totals less than its benchmark, and if in the case of Track 1 ACOs, the savings meets or exceeds a certain percent that ensures savings is

not the result of random variation (termed the medical savings rate [MSR]), the ACO earns shared savings, or up to 50% of total savings.

Though these explanations are somewhat simplified, there are currently 3 clear differences between MA and ACO programs: first, MA payments are capitated, whereas ACO payments are not, or are not yet. The 3 ACOs currently participating in Track 2 are obligated to repay any reimbursement monies in excess of their benchmark. Beginning in 2019, ACOs with 6 years of participation experience will be required to contract as an at-risk Track 2 or 3 ACO if they wish to continue in the program.<sup>7</sup> Program payments will then be de facto capitated. Second, an ACO's financial benchmark reflects the costs of its assigned beneficiaries. In MA, payment is based on the average costs of a total county fee-for-service population.

Third, risk adjustment is also distinctly different. Although both programs use Hierarchical Condition Categories risk scores, in MA, risk scores are based on the health histories and demographic information of the county's Medicare population; ACO risk scores reflect the ACO's patient population. Additionally, MA plans are infamously noted for upcoding their patients, which means, at least on paper, their beneficiaries are sicker than a comparative fee for service beneficiary population. For this reason, CMS deflates MA risk scores by a certain percent in an effort to mitigate overpayment; MA plan coding can and does improve PMPM reimbursement. ACO risk scores for newly assigned ACO beneficiaries (ie, those not previously assigned) reflect both health history and demographic data. To avoid upcoding for continuously assigned ACO beneficiaries, CMS only increases their risk scores using demographic data.

Here, MA enjoys a clear advantage over the ACO model. Leaving aside their risk adjustment advantages, MA plans are required to simply meet, not beat, average fee-for-service (FFS) costs. In fact, beginning in 2017, Medicare will have to pay MA plans in counties in the bottom spending quartile up to 115% of FFS.<sup>8</sup> Meanwhile, MA plans in top quartile spending counties will be paid 95%. Again, the program is designed to be cost neutral; ACOs, as they're forced over time to accept downside risk, will be increasingly required to reduce spending, and do so for an assigned beneficiary population. Financially, the 2 payment models do not compare. If CMS applied the same, or similar, benchmark methodology—for example, base ACO benchmarks using MA county benchmark data—the 2 programs would then be financially comparable.<sup>6</sup>

### Quality Achievement

MA plan quality is currently measured by 32 measures in 5 weighted domains: prevention screenings, managing chronic conditions, member experience with their plan, member complaints, and plan

customer service. There are currently 33 ACO quality measures in 4 domains: patient/caregiver experience, care coordination and patient safety, preventive health, and at-risk populations. The 2 measure set questions are only somewhat related; for example, both sets include influenza immunization, weight or body mass index, colorectal and mammography screening measures.

ACO providers score points based on quality measure performance and can earn additional points for significant year-over-year improvement. An ACO's total quality performance score ultimately determines its percent of shared savings, assuming of course that the ACO's total reimbursement for the year is below its benchmark—and that the savings percent meets or exceeds the MSR percent. ACO quality performance offers no potential reward. Even if an ACO, regardless of track, has a perfect quality score, it receives no more than its full percent of earned shared savings.

In 2014, 6 ACOs earned shared savings, but because they did not report their quality measures accurately and/or completely, they were not paid; and, theoretically an ACO can perform below the minimum quality score in which case if they earned savings they'd not be paid any. For MA plans, quality scoring is dramatically different: all plans are rated between 1 and 5 quality stars using CMS' 5-Star Quality Rating System. If the plan receives 4 or 5 quality stars, it is rewarded a higher benchmark and is allowed to keep a larger share of any rebate. In 2015, one-third of MA plans—representing 65% of MA plan beneficiaries—were rated 4 or more stars. For plans with 5 stars, beneficiaries can enroll anytime during the year, so high star-rated plans use the designation to their marketing advantage.

It is well-recognized that CMS's quality performance benchmarking efforts need improvement. The Medicare Payment Advisory Commission (MedPAC) went so far as to state in a 2014 report that “the Commission has become increasingly concerned Medicare's current quality measurement approach has gone off the track.” In that same 2014 report, MedPAC offered the thoroughly sensible proposal to align quality measurement between MA plans and ACOs—that is, use the same set of population-based outcome measures for both payment models.<sup>9</sup> In sum, Medicare's quality measures need to be less process-based, fewer in number, and less burdensome on providers; they should instead be more aligned or harmonized between and among programs, patient-centered, and outcome-focused. Toward this end, CMS is working with the American Health Insurance Plans to identify quality measures in 6 core clinical areas and to limit the number of measures to 10 per domain.

### Supplemental Benefits

As noted above, if the MA plan's financial bid is below the county benchmark, the plan's rebated amount must be used to provide

plan beneficiaries with reduced premiums or out-of-pocket costs, or provide supplemental health benefits. The supplemental benefits that MA plans can offer are wide-ranging, including additional hospital days, alternative therapies, chiropractic and counseling services, dental and oral health services, enhanced disease management, eye exams and eye glasses, fitness benefits, health education, meals and nutritional education, podiatry and telehealth and remote monitoring services, and transportation. It is worth noting that most MA plans also offer Part D prescription drug coverage and—likely the most significant supplement benefit—unlike fee-for-service or ACO care, MA plans include catastrophic coverage in that plans are required to cap annual beneficiary out-of-pocket costs.

ACOs can neither reduce nor waive out-of-pocket beneficiary expenses. CMS has floated the idea of approving a limited number of payment waivers that would allow ACOs, for example, to provide home health services to beneficiaries that do not meet the home bound requirement or provide telehealth services to beneficiaries not residing in rural areas. To date, CMS has only approved a skilled nursing facility (SNF) waiver that would allow an ACO beneficiary to receive SNF care without a prerequisite 3-day inpatient hospital stay. This waiver was approved beginning in 2017 for Track 3 ACOs only.<sup>7</sup> ACO services do not cover Part D; unlike MA plans, however, they do cover hospice care costs.

CMS allows MA plans to offer supplemental benefits because these costs are consumed by the rebate, and again, because MA plans are paid a PMPM capitated rate. An ACO that has paid all its fee-for-service charges, has its payments reconciled against its benchmark after year's end. Because over 99% (or 419) of current ACOs participate in Track 1—where annual reimbursement totals in excess of the benchmark are not owed or repaid—in effect, CMS does not trust ACO providers to utilize additional services wisely or in a cost-efficient manner. Regardless, the effect results in a distinctly uneven playing field.

### Cost Efficiency

As designed, MA plans are paid county fee-for-service rates, and as such, the program constitutes administrative pricing. Arguments can be made that MA does save money: for example, CMS does keep a percent of plan rebates and supplemental benefits, catastrophic coverage may lower the demand by MA beneficiaries to buy Medigap policies, and MA enrollment has a positive spillover effect by reducing local fee-for-service spending in that MA physicians typically provide the same care for its non-MA beneficiaries as they do for their MA beneficiaries. The argument can also be made that the government could make MA more competitive or cost-efficient by, for example, setting payments at the second lowest cost plan. Regardless, the Congressional Budget Office does not score the MA program for savings.

Again, the ACO program is designed to drive lower cost growth by financially incenting provider participants to reduce historical costs, and beginning in 2019, by requiring providers to accept downside risk.<sup>7</sup> The problem here, is that ACO providers are exactly that: providers. Typically organized by physician groups, ACOs have limited or no experience managing risk-based agreements. Subsequently, unlike MA plans, they lack the skillset required to take on financial risk, which includes providing for risk reserve capital, stop-loss insurance, and meeting related state law requirements. This single factor substantially explains why even successful ACO remain in the no-risk Track 1. On a limited basis, CMS does offer ACOs additional payments to help providers build infrastructure to improve care management. However, these payments are limited, and CMS requires providers to repay these monies in full.<sup>10</sup>

CMS has said little about how, if at all, it intends to bridge the risk-competency gap between MA plans and ACO providers. The agency could, for example, withhold a percent of fee-for-service ACO payments as some state Medicaid plans do, and either retain the savings if the ACO exceeds their annual financial benchmark, or return the withheld amount to the ACO along with its portion of earned shared savings, if the ACO beat its benchmark. Without a fix, this single issue will likely cause many ACO providers to leave the program or to “time out” after 6 years or after they are no longer allowed to participate in Track 1.

### Conclusions

In a recent essay published in *The New England Journal of Medicine*,<sup>11</sup> CMS leadership admitted, “We are therefore striving to maintain comparable business cases for ACO initiatives and Medicare Advantage.” This statement is welcomed, as the agency finally recognized that the programs do not operate in isolation. Beyond recognizing the problem, the authors added only, “some disparities in program requirements will persist because of statutory provisions and other factors.” Agency officials also admitted in the essay, “Our programs are not premised on the expectation that ACOs should evolve into Medicare Advantage plans.”

One can question the sincerity of the second comment in light of absolute lack of specificity surrounding the first. Regardless, in 2016, the Medicare Advantage market will comprise, appreciably, the entire Medicare population. The industry will offer over 2174 plans (4% more than in 2015); nearly 60% of these plans will charge a monthly premium of \$0 (37%) or between \$2 and \$50 (21%); over half of plans will offer supplemental vision, hearing, and dental benefits; and nearly 90% of all plans will offer a Part D prescription drug benefit.<sup>12</sup> Without a way of organizing, reimbursing, and awarding (ACO) physicians on par with (MA) plans, it is impossible to imagine either how the ACO program

can compete with MA, or how the secretary's Medicare quality and value payment goals will be met.

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