



Original Research

Determinants of success in Shared Savings Programs: An analysis of ACO and market characteristics



Mariétou H. Ouayogodé*, Carrie H. Colla, Valerie A. Lewis

The Dartmouth Institute for Health Policy & Clinical Practice, Geisel School of Medicine at Dartmouth, Williamson Translational Research Building, Level 5, 1 Medical Center Drive, Lebanon, NH 03756, USA

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ABSTRACT

Background: Medicare's Accountable Care Organization (ACO) programs introduced shared savings to traditional Medicare, which allow providers who reduce health care costs for their patients to retain a percentage of the savings they generate.

Objective: To examine ACO and market factors associated with superior financial performance in Medicare ACO programs.

Methods: We obtained financial performance data from the Centers for Medicare and Medicaid Services (CMS); we derived market-level characteristics from Medicare claims; and we collected ACO characteristics from the National Survey of ACOs for 215 ACOs. We examined the association between ACO financial performance and ACO provider composition, leadership structure, beneficiary characteristics, risk bearing experience, quality and process improvement capabilities, physician performance management, market competition, CMS-assigned financial benchmark, and ACO contract start date. We examined two outcomes from Medicare ACOs' first performance year: savings per Medicare beneficiary and earning shared savings payments (a dichotomous variable).

Results: When modeling the ACO ability to save and earn shared savings payments, we estimated positive regression coefficients for a greater proportion of primary care providers in the ACO, more practicing physicians on the governing board, physician leadership, active engagement in reducing hospital re-admissions, a greater proportion of disabled Medicare beneficiaries assigned to the ACO, financial incentives offered to physicians, a larger financial benchmark, and greater ACO market penetration. No characteristic of organizational structure was significantly associated with both outcomes of savings per beneficiary and likelihood of achieving shared savings. ACO prior experience with risk-bearing contracts was positively correlated with savings and significantly increased the likelihood of receiving shared savings payments.

Conclusions: In the first year, performance is quite heterogeneous, yet organizational structure does not consistently predict performance. Organizations with large financial benchmarks at baseline have greater opportunities to achieve savings. Findings on prior risk bearing suggest that ACOs learn over time under risk-bearing contracts.

Implications: Given the lack of predictive power for organizational characteristics, CMS should continue to encourage diversity in organizational structures for ACO participants, and provide alternative funding and risk bearing mechanisms to continue to allow a diverse group of organizations to participate.

Level of evidence: III

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1. Introduction

In recent years, there has been a growing interest in using shared savings as a new approach to the financing of health care, departing from fee-for-service payment arrangements. The 2010

Affordable Care Act introduced shared savings payment arrangement as a key component of the accountable care organization (ACO) model and the Centers for Medicare and Medicaid Services (CMS) first tested it in the Medicare Physician Group Practice Demonstration before implementation in ACOs.^{1,2} ACOs are intended to encourage coordination and cooperation among providers through financial incentives for high quality and lowered spending for a defined patient population. The ACO model was instituted through the Pioneer and the Medicare Shared Savings Program (MSSP) in 2012.³ In both cases, ACOs that meet

* Corresponding author.

E-mail addresses: Marietou.H.L.Ouayogode@Dartmouth.edu (M.H. Ouayogodé), Carrie.H.Colla@Dartmouth.edu (C.H. Colla), Valerie.A.Lewis@Dartmouth.edu (V.A. Lewis).

performance standards on quality of care are eligible to share in generated savings as performance-based bonus payments.^{4,5}

There are fundamental differences between the Pioneer and MSSP models. While the MSSP was designed as a permanent program, the Pioneer program started earlier and was intended to evaluate alternative payment models and test care coordination, quality improvement, and healthcare cost reduction in organizations with risk-bearing experience. Moreover, the defined population for which ACOs in these two programs assume risk differs. Unlike MSSPs which accept responsibility for at least 5000 Medicare fee-for-service beneficiaries, most Pioneer ACOs accept risk for at least three times as many beneficiaries (15,000). Therefore, Pioneer ACOs are larger organizations with more physicians and often a more diverse set of providers.⁶ MSSP organizations can operate under either a one-sided risk model, where they can be rewarded financially for lowering health care costs but are not liable for shared losses, or a two-sided model, where they are liable for shared losses if they overspend. The upside-risk-only option is not available to Pioneer ACOs which have five payment arrangement options with varying degrees of shared savings and losses across years. There is both greater risk inherent in the Pioneer program and greater potential for financial reward with higher sharing rates and higher payment caps.

Financial performance data reported by the CMS show that out of 367 Medicare ACOs in the Pioneer and MSSP programs with contract start dates between 2012 and 2014, 193 (53%) ACOs (including 20 Pioneer ACOs) collectively held spending at \$1.17 billion below their total assigned spending benchmarks, while 174 (47%) collectively overspent by a total of \$819 million in the first performance year.^{7–9} Among ACOs realizing savings, 86 (45%) ACOs received a total of \$316 million in bonuses. Despite this wide variation in performance and savings across ACOs, little is known about factors associated with success in the Medicare ACO programs. In creating the ACO programs, the CMS intentionally did not specify necessary organizational forms or necessary capabilities, in part because there is little evidence linking provider characteristics to success under new payment models. As a result, research has shown that Medicare ACO participants are diverse on many levels.^{10–16} ACOs include academic medical centers, physician-hospital organizations, independent practice associations, regional and public hospitals, multispecialty group practices, integrated delivery systems, federally qualified health centers, critical access hospitals, combinations of all of the above organizational structures, or include none of these. The population of beneficiaries in these organizations is equally diverse in terms of demographics and comorbidity patterns.¹² It is not clear whether success in the Medicare ACO programs varies systematically according to organizational characteristics, beneficiary characteristics, ACO capabilities, or even market-level factors.

Prior literature on factors associated with financial performance of ACOs hinged on anecdotal evidence, pairwise correlations, qualitative interviews with ACO leadership for the MSSP program, simulation studies, and research focusing on the Pioneer program.^{5,17–21} Probable factors suggested to influence ACO success include beneficiary characteristics and management (beneficiary turnover, high-need patient targeting, utilization of individual care plans, and beneficiary engagement);^{5,17,18} the use of best practices with evidence-based care and electronic health records;¹⁹ historical spending; and geographical location.^{5,20,21} However, there is a dearth of empirical research confirming or refuting these conjectures. Moreover, organizational structure as well as care management proficiency and clinical integration may influence performance in ACO programs. Understanding how these factors interact with financial performance could inform on what strategies could or could not be changed for current organizations and potential participants. Our research offers a

comprehensive analysis of financial performance data from ACOs first performance year and examines organizational and regional market factors associated with success in achieving savings and earning shared savings payments in the MSSP and Pioneer programs.

2. Conceptual model

We hypothesized that several organizational or market-level factors are associated with financial performance in the ACO programs. We expect infrastructure (e.g. size) to have an effect on the amount of savings per beneficiary and whether the ACO receives shared savings. Smaller ACOs may be more nimble and have greater flexibility to implement change and larger ACOs likely have more support and resources to do so and can spread the fixed costs of some investments (e.g. health technology) over a larger number of patients. However, mid-sized ACOs may be too large to make rapid changes and not have the resources to make productive capital investments: small and large ACO may have an advantage over medium size ACOs. Since primary care providers coordinate care, we expect that a greater proportion of such practitioners in the organization may increase the ACO's ability to realize savings and earn bonuses. Also, empowering physicians in the decision making process with a greater proportion of practicing physicians on the ACO governing board and physician leadership may be favorable to achieving goals of enhancing performance and controlling cost, therefore facilitating savings. Offering financial incentives to physicians (a positive reinforcement) may be important in influencing practice and changing physician behavior so as to generate savings for the organization. ACOs more experienced with risk bearing contracts may be better able to establish core capabilities in coordinating care for the patients they serve,²² and therefore may achieve greater savings.

We anticipate that a stronger emphasis on clinical care activities (e.g. greater quality improvement capabilities such as initiatives to reduce hospital re-admissions) and a higher spending history (i.e. higher financial benchmark) will increase the magnitude of savings and the likelihood of shared saving receipt. Although we anticipate that a larger population of beneficiaries with high-needs (e.g. minorities, disabled, and dual eligible patients) may create additional challenges for the ACO; a larger population of dual eligible beneficiaries, which has shown in an earlier program (i.e. the Physician Group Practice Demonstration) to increase savings,²³ could mean that there is more room for savings.

We also predict that greater integration in the regional market, which may promote less competition as the Medicare ACO programs expand,²⁴ will promote savings and the probability that the ACO gets shared savings payments.

3. Methods

We conducted a cross-sectional study examining Medicare ACOs' financial performance in the first contract year. We described the relationship between ACO performance, size, structure, patient population characteristics, quality improvement capabilities, assigned financial benchmark, and market environment. We used a multivariate linear regression model to examine which ACO-level and regional market factors were associated with savings per beneficiary, our continuous outcome variable. We also used logistic regression to examine potential determinants of whether an ACO earned a shared savings payment from Medicare. For organizations which held spending below their assigned benchmark, shared savings payments are contingent on the ACO's achieving savings in excess of a Minimum Savings Rate (MSR)

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