Evidence that ACOs Don't Cut Costs

Submitted to the Health Care Financing Task Force by the Board of Directors of the Minnesota Chapter of Physicians for a National Health Program

November 24, 2015

In our October 24 letter to task force members, we called your attention to research demonstrating that "value-based purchasing" (VBP) worsens health disparities. It has that effect because it links inaccurate measures of cost and quality with financial rewards and penalties. In our view, this effect, although unintended, is so serious it warrants not endorsing VBP, or at most limiting its use to pilot tests.

If VBP had been shown to lower costs or improve quality, this might be a difficult decision. But VBP has not been shown to lower total costs, and its effects on quality have been mixed. In this letter, we present the evidence supporting our conclusion that accountable care organizations (ACOs) do not lower costs.

We focus on the ACO for these reasons:

- It is a widely cited example of an entity capable of accepting value-based payments;
- it is the most important of the cost containment provisions in the Affordable Care Act;
- it is the centerpiece of the Minnesota Accountable Health model that DHS described in its application for the State Innovation Model (SIM) grant; [1]and
- it has appeared repeatedly on task force agendas.

The available evidence indicates ACOs have no impact on total medical costs. Moreover, a small body of evidence and commonsense thinking indicates ACOs incur substantial costs to pay for ACO-related services, and that providers pay the bulk of those costs (as opposed to insurers). If ACOs cannot cut medical costs, but do add substantially to provider costs, and if providers can pass their additional costs on to other payers, that would mean ACOs are raising total health care costs. If, on the other hand, ACOs are not able to pass on their additional costs, then the appropriate conclusion is that the ACO experiment is not sustainable and will generate increasing resistance from providers.

Evidence on the ACO's ability to cut costs

In a recent op-ed for the *Wall Street Journal*, Ezekiel Emanuel and Topher Spiro expressed disappointment in the performance of ACOs. "The results so far are less than encouraging," they wrote. The authors were so concerned about the poor performance of

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[1] See summary of the SIM grant here http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home

ACOs they urged the Obama administration to shift its focus from ACOs to bundled payments.[2]

The authors' gloomy assessment of ACOs was apparently based on analyses of the performance of the Pioneer and Medicare Shared Savings Program (MSSP) ACOs. It may also have been based on the performance of the Physician Group Practice Demonstration (which ran from 2005 to 2010). That demonstration was widely seen as a test of the ACO concept.[3]

Analyses of the two CMS ACO programs and the Physician Group Practice Demonstration (PGPD) are the only reliable sources of evidence on the ability of ACOs to cut costs, and even those reports are incomplete because they contain no information on what it cost the providers to set up and run their ACOs. For reasons we discuss below, reports on private-sector ACOs are unreliable, incomplete or both.

The latest assessment of CMS's ACO programs appeared in a report published by *Kaiser Health News*. In an article dated September 15, 2015, Jordan Rau and Jenny Gold added up all the Medicare savings and Medicare bonus payments to Pioneer and MSSP ACOs in 2013, and concluded: "After paying bonuses to the strong performers, the ACO program resulted in a net loss of nearly $3 million to the Medicare trust fund, government records show."[4]

This conclusion that the two Medicare ACO programs are saving no money is consistent with a report published by CMS's Chief Actuary last spring indicating that, after taking into account CMS's bonus payments to ACOs, the MSSP program raised Medicare costs by .2 percent in 2012 while the Pioneer ACO program lowered Medicare spending by .2 percent in 2012 and .5 percent in 2013.[5]

A paper published by CMS employees about the Pioneer ACO program in May of this year claimed to find small savings for the Pioneer ACOs during their first two years (which would have been consistent with CMS's reports). [6] However, the paper

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[2] Ezekiel Emanuel and Topher Spiro, "The coming shock in health-care cost increases," *Wall Street Journal*, July 7, 2015, http://www.wsj.com/articles/SB11301772451238044816904581084584272004382.

[3] John Iglehart, "Assessing an ACO prototype – Medicare's Physician Group Practice Demonstration," *New England Journal of Medicine*, 2011;364:198-200, http://www.nejm.org/doi/full/10.1056/NEJMp1013896

[4] "Medicare yet to save money through heralded medical payment model," *Kaiser Health News*, September 14, 2015, http://khn.org/news/medicare-yet-to-save-money-through-heralded-medical-payment-model/

[5] Here is how the Chief Actuary put it: "Total Pioneer aligned FFS Part A and Part B claims costs were approximately 1.2 percent below the combined expenditure benchmark in 2012 and 1.3 percent below benchmark in 2013; these results exceeded the combined shared savings payments (net of shared losses) of approximately 1.0 percent of benchmark in 2012 and 0.8 percent in 2013. By comparison, the MSSP beneficiaries in the program's first performance period (covering April 2012 through calendar year 2013) exhibited total spending that was only 0.5 percent below the combined benchmark, or slightly less than the offsetting cost of resulting shared savings payments (net of shared losses) that represented about 0.7 percent of the combined benchmark." (Paul Spitalnic, ASA, MAAA Chief Actuary, Certification of Pioneer Model Savings, April 10, 2015, p. 4 https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Pioneer-Certification-2015-04-10.pdf

[6] David J. Nyweide et al., "Association of Accountable Care Organizations vs traditional Medicare fee-for-service with spending, utilization, patient experience," *Journal of the American Medical Association*, 2015;313:2152-2161.

studied a simulation of the Pioneer program, not the actual program, and as Mark McClellan, former FDA commissioner and CMS administrator, observed in an accompanying editorial, it failed to take into account CMS's bonus payments to the ACOs and the costs incurred by ACOs.[7]

The PGP Demonstration produced equally discouraging results. The ten group practices that were part of the PGP Demonstration (which included Park Nicollet Health Services) were able to cut Medicare spending by a grand total of 1.7 percent over the five years that the program ran (2005 to 2010), but when the cost of the bonus payments to the PGPs was subtracted, the total savings came to .3 percent.[8]

A paper by Colla et al. published in 2012 reported similarly very small savings for the PGP demo (for Medicare dual eligibles but not for the non-dual-eligibles).[9] But the paper failed to include the shared-savings payments made by CMS to the PGPs. Had those payments been included, the paper may not have found savings even for the dual eligibles.

None of the analyses described above sought to determine the cost to providers of setting up and administering ACOs. According to the staff of the Medicare Payment Advisory Commission, that cost is approximately 1 to 2 percent of the Medicare payments ACOs receive.[10] If the Medicare ACOs are breaking even from Medicare's perspective, but are costing ACOs money, we must conclude ACOs are raising total health care costs, providers are absorbing significant losses, or some combination of those effects is occurring. The high cost of running an ACO is probably why 13 of the 32 original Pioneer ACOs have dropped out of the Pioneer ACO program.

Reports on private-sector ACOs are not reliable

Reports on private-sector ACOs – ACOs established by insurance companies – are nearly always unreliable. They suffer from one or several of these defects:

- They say nothing about cost, and instead report only changes in utilization rates (typically use rates of emergency and inpatient services);
- They make no effort to measure the cost to providers and insurers of setting up and running the ACO;

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[7] Mark McClellan, "Accountable Care Organizations and evidence-based payment reform," *Journal of the American Medical Association*, 2015;313:2128-2130, http://jama.jamanetwork.com/article.aspx?articleid=2290607

[8] Here is how the report put it: "Expressed as a percentage, the [PGP] demonstration saved Medicare .3% of the claims amounts." RTI International, *Evaluation of the Medicare Physician Group Practice Demonstration, Final Report*, September, 2012, p. 64, https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PhysicianGroupPracticeFinalReport.pdf. See also Table 5-13, p. 65.

[9] C.H. Colla et. al. "Spending differences associated with the Medicare Physician Group Practice Demonstration," *New England Journal of Medicine*, 2012; 308:1015-1023.

[10] At the November 7, 2013 meeting of the Medicare Payment Advisory Commission, a staff member told the commission: "The ACOs we spoke with confirmed that the cost of running the ACO was about one to two percent…." (See. p. 164 of the transcript of that meeting http://www.medpac.gov/documents/default-library/11_13_transcript.pdf?sfvrsn=0).

- They offer little or no information on the methodology used to derive their conclusions.

Two papers cited by DHS in its application to the federal government for the SIM grant illustrate these defects. Both papers were about entities set up by Blue Cross Blue Shield that the authors claimed were similar to ACOs.

DHS stated in the SIM grant application:

> A study published in the August 2012 edition of *Health Affairs* details the impact of Blue Cross Blue Shield of Massachusetts' global budgets on 11 provider organizations in Massachusetts. The study found that contract participation over two years led to a savings of 2.8% (1.9% in the first year and 3.3% in the second) compared to a control group.[11]

In fact, the study also reported that non-medical payments to providers (described as "surplus sharing, quality bonuses, and infrastructure support") "probably" exceeded the savings in medical spending. The authors concluded: "Our findings do not imply that overall spending fell."[12] Oddly, even though the authors of this paper had access to Blue Cross Blue Shield data, they failed to report exactly how much BCBS paid out in shared-savings payments etc. Had they done that, they could have reported by exactly how much BCBS's ACO raised total spending. The authors made no attempt to determine what the ACO experiment cost the participating providers.

DHS also stated in the grant application:

> A second study published in *Health Affairs* in September 2012 reviewed a partnership between Blue Shield of California and health care providers using an annual global budget for total expected spending and shared risk and savings among partners for providing health care to certain members of the California Public Employees' Retirement System [Calpers] in Sacramento. The study found that the ACO model showed early success based on … effectiveness in controlling costs. Cost growth was held to approximately three percent, based in part on declines in inpatient lengths-of-stay and thirty-day readmission rates. [13]

The ACO described in this paper was set up to serve a single powerful customer – Calpers – and any savings reaped by Calpers may have simply confirmed the well-known fact that large buyers of health insurance (and of many other goods and services) get larger discounts than small buyers. In any event, this paper failed to describe its

[11] This statement appears at page 17 here: http://mn.gov/health-reform/images/SIM%20Grant%20-%20Project%20Narrative.pdf. The footnote that followed this statement reads: "Song, Z., Safran, D.G., Landon, B. E., et. al. (2012). The Alternative Quality Contract Based on a Global Budget, Lowered Medical Spending and Improved Quality. Health Affairs. 2012, 31, No. 8. doi: 10.1377/hlthaff.2012.0327."

[12] Song et al., op cit., p. 1891.

[13] This statement appears at page 17 here http://mn.gov/health-reform/images/SIM%20Grant%20-%20Project%20Narrative.pdf. This footnote that followed the statement reads: "Markovich, P. (2012). A Global Budget Pilot Project Among Provider Partners and Blue Shield of California Led to Savings in First Two Years. Health Affairs. 31, No. 9 doi: 10.1377/hlthaff.2012.0358."

methodology, and it failed to include in its calculation of savings the ACO-related costs to Blue Cross Blue Shield and participating providers. According to another analysis of this ACO by the Commonwealth Fund, the cost to just the physicians for just electronic medical records was $60 million over four years, but the physicians received only $4 million in shared savings during the first two years of the experiment.[14]

Conclusions

Imagine that a drug company released a paper claiming that its hypertension drug would save $10 billion dollars if the 70 million American adults with hypertension took their drug, but the paper failed to take into account the $10 billion cost of dispensing their drug to all those patients. Would anyone accept the claim that the drug can cut US medical costs by $10 billion? The answer is obviously no. But ACO researchers and proponents routinely make the same error with respect to provider costs, and often insurer costs as well, and, astonishingly, get away with it. Analysts pretend, in effect, that ACOs are free and, therefore, any reduction in medical costs achieved by ACOs is pure gravy.

The research on ACOs hints at the possibility that when providers deliver more services to very sick patients, the patients' health improves, sometimes so substantially that the reduced medical costs of those patients exceeds the cost of the additional services. Providing additional services for chronically ill patients, such as patient education and better monitoring of patients, is often called "disease management." We urge the task force to focus on proven disease management services for the sick and to avoid recommending ACOs or any other derivative VBP concept that links provider payment to performance on cost or quality measures.

Focusing on disease management for the sick rather than on unspecified services for an entire population of "attributed patients" will focus resources where they can do the most good. And not punishing or rewarding providers based on crude measures of the effects of disease management will avoid worsening disparities among racial and income groups.

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[14] Alexander Cohen et al., *Hill Physicians Medical Group: A Market-Driven Approach to Accountable Care for Commercially Insured Patients*, Commonwealth Fund, October 2014, http://www.commonwealthfund.org/~/media/files/publications/case-study/2014/oct/1770_cohen_hill_physicians_aco_case_study.pdf.