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MACRA and Accountable Care Organizations: Is It Working?

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MACRA AND ACCOUNTABLE CARE ORGANIZATIONS: IS IT WORKING?

Abstract: The purpose of this study was to examine how the Medicare Access and CHIP Reauthorization Act (MACRA) has improved health care delivery and to determine its impact on Accountable Care Organization (ACO) goals. ACOs have provided quality care through the reduction in readmission rates, coordinated care, and cost savings. With the passage of the MACRA, it has been estimated that it would further decrease Medicare spending on physician and hospital services. Also, ACOs have had a positive impact on improving health care delivery and have played a significant role in providing exceptional quality of care while also managing to increase the cost savings.

Key words: ACA, ACOs, MACRA, MSSP, quality of care

INTRODUCTION

Over the past few decades, the Federal Government has invested billions of dollars into diverse programs aimed at improving the way healthcare has been delivered, providing efficiency and decreasing cost.[1] In 2011, the Centers for Medicare and Medicaid Services (CMS) finalized new rules under the Patient Protection and Affordable Care Act (ACA) and authorized the use of Accountable Care Organizations (ACOs) to improve the safety and quality of care and reduce healthcare costs. [2]

An ACO which is an organization of health care providers who come together voluntarily to give coordinated care to Medicare beneficiaries with the aim of delivering seamless, high-quality care, while improving quality and lowering costs.[3] The goal of coordinated, high-quality care has been to ensure that patients, especially the terminally ill get

the right care at the right time while avoiding unnecessary duplication of services, preventing medical errors and reducing cost. [3] Participation in an ACO creates incentives for health care providers to work together to treat an individual patient across care settings, with people becoming more involved in their healthcare. [4]

A key driver of ACO growth has been the Medicare Shared Savings Program (MSSP) that offers organizations the opportunity to manage defined patient populations by assuming risk in a shared savings model while delivering quality care. [5] The MSSP has been an alternative payment model that promotes accountability for a patient population, coordinates services for Medicare Fee For Service (FFS) beneficiaries and has encouraged investment in high and efficient services. [6]Also, ACOs in the MSSP has achieved reductions in Medicare FFS expenditures that exceeded the shared-savings bonuses that they were paid. [7] Furthermore, in 2015, 7.3 million Medicare beneficiaries were assigned to 392 ACOs, and 30% of these ACOs received $646 million in shared savings payments. [8]

In 2015, CMS proposed a Quality Payment Program for Medicare payments beginning in 2019 as a result of the passage of the Medicare Access and CHIP Reauthorization Act (MACRA). [9] This proposed provision relied on the altering of Medicare's payment methods that would improve the efficiency and quality of care delivered and lead to system-wide improvements. [1] MACRA has replaced the defective Medicare sustainable growth rate and it has modernized FFS creating a new framework for rewarding physicians for providing higher quality care. MACRA also has established a two-track payment model: The Merit-based Incentives Payment System (MIPS) and the Alternative Payment Models (APMs); to consolidate the existing quality reporting models. [9]

MIPS has been built on the historical context of relativity that characterizes the FFS system and has consolidated multiple existing diverse quality measures into a single unified approach. [10] Providers would receive bonuses or penalties related to performance based on the quality of care, resource use, advance care information, and clinical practice improvement activities. [11] Also, providerscan have several financial incentives to join the APM track; these incentives include lump-sum payments in each year from 2019 to 2024 and higher annual payment rates updates starting in 2026 of 0.75% compared with 0.25% in the MIPS track . [11]

Although progress has been made towards creating integrated and coordinated care, evidence of the efforts of Medicare ACOs on health care spending and quality has been limited and with mixed results. [12]

METHODOLOGY

The purpose of this study was to examine how MACRA has improved health care delivery and to determine its impact on ACOs goals. The primary hypothesis of this review was that MACRA and ACO would increase coordinated quality care and increase cost savings.

The methodology for this study was a literature review which followed a systematic search approach. The review was comprised of primary and secondary data such as; peer-reviewed journals, reliable online articles, and federal agency websites such as Medicare, CMS, the Department of Health and Human Services, and the Department of Justice. The examination was conducted in stages. These stages included defining a search strategy, identifying the inclusion criteria, assessing which articles retrieved were relevant and valid, and extracting the data relevant to the purpose of this study. EBSCO host, PubMed, LexisNexis, Academic Search Premier, and Google Scholar databases were employed to obtain peer-reviewed literature. A free text search using Boolean operators [OR & AND] to combine words was conducted for the databases. The

following keywords were utilized in conducting the literature search: ‘"ACO" and "healthcare reforms" OR "ACA" or "Obamacare" and "MACRA" OR "MIPS" OR "Cost savings" or "care quality" OR "care coordination" OR "reduced readmission rate."

This literature review included 33 articles which were relevant to the purpose of this research. The literature was obtained based on a variety of critical areas which included the effect of MSSP on ACO's, varying cost savings and ACO's, and the reduction in readmission rate. All the references that were utilized in this study were written in English. In order to obtain current research, another inclusion criteria was being published within 2008 and 2018. The search was completed by BA, and CS with validation by AC, who acted as a second reader and confirmed that the references met the research study inclusion and exclusion criteria.

The results were categorized as follows*: Quality of care, ACOs and cost savings, and the Effect of Medicare Shared Savings Program on ACOs.*

RESULTS

Quality of Care

ACO’s and the Reduction in Readmission Rate

According to CMS, 17.5% of Medicare FFS beneficiaries were readmitted within 30 days of discharge, and approximately 75% of those readmissions were preventable. [13] The total cost of preventable readmission across all patients added up to a cost of about $25 billion yearly. [13] In 2014 a study conducted demonstrated how ACO-style care had more of a success rate as compared to traditional care in minimizing hospital readmissions and by shortening the length of stay by 3.9% overall. It was also found that the traditional models had a 3.8% decrease in readmission and a reduction of 2.4% in length of stay as compared to ACO's which had a 6.3% reduction in readmission. Results of the study indicated that ACO's were able to perform better on the quality measures as compared to the cost reductions. [14]

ACOs have presented opportunities for addressing the substantial need for healthcare in rural areas. In 2012, a survey was given regarding ACO's in Rural Health Clinics (RHC) and how unfamiliar they were with the ACO model. It was shown that 48% of those who had taken the survey reported having very little knowledge of ACO's, 58% of those who were knowledgeable of ACO's reported the most frequent benefit was the improvement of patient quality care, and 54% focused on the patient. Furthermore, it was suggested that if RHC's were not provided with the necessary technical assistance and were not valued as ACO partners, then Rural health clinics would not benefit from the improved services that ACO's provide such as the reduction in readmission rates. [15]

Coordinated care has been more than a shared organizational structure and financial incentives, instead required professional skills in the areas of collaboration, communication, and teamwork. [16] The model of coordinated care can also prevent duplicate tests and services, reduce hospitalization, and limit the growth in healthcare cost. [17] Although coordinated care has been challenging, few organizations such as the Central Oregon health council has piloted the ACO

model, and it was found that they had 49% fewer emergency department visits which have saved them about $750,000 in 2011. [18]

ACO's and Cost Savings

The average cost of healthcare in the U.S. has exceeded over $3 trillion and continued to add up. [19] The Congressional Budget Office estimated that ACOs could save Medicare $5.3 billion between 2010 and 2019. [20] In 2012 the Kaiser Foundation analysis of the American population found that 5% of patients consume health care, which averages out to $43,000 annually with two-thirds of the cost being individuals aged 45 and older. [21]

In 2019 providers will receive either penalties or bonuses of up to 4% and will continue to rise incrementally to 9% in the year 2022. [22] By having MACRA in place, it has not only provided stability for physicians but has also provided them with the opportunity to invest in various infrastructure changes that are necessary to improve the quality of care for patients. [23]

While improving the quality of care may be important, the focus of an ACO has been improving value by reducing costs. In 2015 the American Academy of Pediatrics conducted a study based on the cost-quality of care for Partners for Kids which was known as a pediatric ACO that helped in serving the Ohio Medicaid population. [24] Cost grew at a rate of $2.40 per year as compared to $6.47 from the managed care costs and $16.50 from the FFS. It was found that the quality of care had improved significantly between the years 2011-2013 as compared to 2008-2010 and was able to reduce the growth of cost which helped to improve the overall quality and value of care. [24]

Effect of Medicare Shared Savings Program on ACO's

To control cost, CMS has implemented several alternative payment models which have included the shared savings program aimed at reducing cost and have given incentives to providers for quality care delivery. [25] In a study by Delia et al in 2014, analyzed the probability of risks facing CMS and ACO's while under the MSSP. It was found that the probability of an outcome solely depended on the enrollment size of the ACO and that the use of the two models found the probability of a denial for an ACO with 5,000 patients to be around 0.15 and only 5%-7% was saved. [26] Varying the size and savings rate, payments for an ACO can range from $115,000 to $35.3 million. [26] Participating ACO's in the two-sided model can receive a higher amount of shared savings. ACOs that implement either of these models can receive up to 50% or even 60% of the shared savings. [27] It has been found that the expected financial liability to CMS per ACO due solely to normal variation was less than $200,000 in the one-sided model and came up less than 150,000 in the two-sided model. This fact has varied across all ACO sizes. ACOs have also been advantageous through the reduction in the cost of care. MSSP ACO model has been extremely effective in reducing the cost of care, in their first year, 47% had exceeded their cost-savings benchmark and generated $128 million in net savings for the Medicare trust funds. [28] Also, MSSP has also allowed providers to continue to receive FFS payments from Medicare, and if ACO's met the benchmark, they would have the opportunity to receive additional payments. All private payers have been expected to test different methods of payments to ACO's and also have had the opportunity to join independent MSSP affiliated ACO's. [27] In the first three years of this program, the Office of Inspector General found that ACOs reduced spending by about $2.8 billion between 2013 to 2015, and of that amount, the ACOs received $1.3 billion in shared savings payments. [25]

DISCUSSION

The purpose of this study was to examine how MACRA has improved health care delivery and to determine its impact on ACO goals. The findings also support the hypothesis of ACOs having increased cost savings and improving the quality of care.

Results of this review suggested that ACO's have improved value by decreasing cost while also maintaining improvements in quality of care. It was also found that the ACO model is becoming more prevalent due to the high success rate in minimizing hospital readmission along with a reduction in hospital length of stay. Although all hospitals have reduced their readmission rate following the implementation of readmission penalties by Medicare, ACOs have reduced at a more faster rate. [29] Creating this new health care reform has allowed ACOs to egress as a new model for the delivery of cost-effective and high-quality health care. In 2011 CMS sponsored ACO's, allowing the organizations to expand from 23 to over more than 300 ACOs. [30] It has been estimated that ACOs through care coordination would help decrease the cost associated with readmission and this cost reduction could lead to an annual savings of about $1.9 billion. [31]

Coordinated care has prevented duplicated tests and services, reduced hospitalization, improve population health, and limited the growth in healthcare cost. Although coordinated care has been effective in decreasing cost and has improved care outcome, it also has some challenges it must overcome to accomplish its full potential. Interoperability of health IT systems has been a significant challenge, where the exchange of patient information among providers has not been seamless, 41% of hospital medical record administrators with difficulty exchanging records with other healthcare providers and 25% unable to integrate patient information, making a non-

seamless digital exchange for care coordination. [20] In addition, the lack of interoperability and integration of patient information has made care coordination time consuming and less effective.

MACRA has also been estimated to decrease Medicare spending through the implementation of its high-quality measures that would enable physicians to receive financial incentives and bonuses for the quality of care and also penalties for not compiling with the quality measures provided by CMS. Through a three-year contract, ACOs must be able to agree and comply with specific requirements under the track 1 or track 2 models and will have the opportunity to join the track 1 model as part of 2018 to 2020 shared savings program application cycle. [32] This new opportunity is expected to allow providers to join an APM to improve care and potentially earn an incentive payment under the quality payment program. ACOs can share in savings up to a maximum of 50% shared savings rate based on quality performance. [32]

The success of ACOs would solely depend on whether or not the CMS, private payers, physicians, and health system leaders would be able to come together as well as work together. [33] It is prevalent to ensure that the implementation of ACOs provides and maintains a certain level of accountability for those clinicians and health systems participating, while also taking the right measurements to improve the quality of care for patients.

Limitations of this literature review were due to the number of the database accessed, and the search strategy utilized. Moreover, researcher and publication bias may have restricted the articles that were available or reviewed could not be ruled out.

CONCLUSION

ACOs may have a significant potential in the role of improving healthcare. MACRA through the use of ACOs models may enhance the delivery of care provided through improving quality, decreasing cost and reducing hospital readmission rate.

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