CMS Perspective:

ACO Investment Model (AIM)

Final Evaluation Report

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For information on the model and to download the independent evaluation report discussed in this document, please visit
https://innovation.cms.gov/innovation-models/aco-investment-model

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Accountable Care Organizations (ACOs) have grown in prevalence across the country over the past five years as a means for providers to reduce spending for fee-for-service Medicare patients while preserving or enhancing their quality of care. Some providers are well equipped to organize as ACOs, whereas others that are smaller or in rural or underserved areas may need additional financial or administrative support before they are ready to become part of an ACO. Forming an ACO often requires significant investments in strategic planning, health information technology solutions, and hiring care coordinators or other staff.

The ACO Investment Model (AIM) was an initiative developed by the Center for Medicare & Medicaid Innovation (Innovation Center) designed for ACOs in the Medicare Shared Savings Program (SSP) that ran from 2015 through 2018. AIM distributed an average of $2 million per ACO in up-front and monthly payments known as "pre-paid shared savings" to encourage new ACOs to form in rural and underserved areas (known as AIM Test 1 ACOs) and to encourage smaller existing SSP ACOs to transition to greater financial risk (known as AIM Test 2 ACOs). AIM funds were recouped from earned shared savings. AIM Test 1 ACOs committed to a three-year Shared Savings Program participation agreement, during which they were subject to recoupment without needing to repay any outstanding funds if they did not renew participation. AIM Test 2 ACOs were required to repay any outstanding funds if they did not continue participating in the Shared Savings Program.

AIM funds were mainly used by the ACOs to hire more clinical staff, upgrade health information technology, support data analysis, and perform ACO management. Over two years, the model provided a total of $96.2 million in up-front funds to AIM ACOs, which could be spent into a third year. Through the 2018 performance year, $52.1 million (54.2 percent) in AIM funds have been recouped by CMS. An additional $13.2 million (13.7 percent) may still be recouped, and $30.9 million (32.1 percent) will not be recouped from ACOs that disbanded without being required to repay outstanding AIM funds.

In each of the three independent evaluation reports of AIM, AIM funds showed promise in stimulating AIM Test 1 ACOs to form in rural or underserved areas while also reducing Medicare spending and maintaining quality. Forty-one AIM Test 1 ACOs started AIM in January 2016, and approximately 75 percent of their beneficiaries resided in rural areas across the country, which is a significantly greater proportion of rural population than is otherwise served by the Shared Savings Program.

AIM Test 1 ACOs appeared to demonstrate that up-front payments to SSP ACOs in rural or underserved areas can lower Medicare spending with no signs of decrements in quality of care. Across three performance years, total spending among the 41 AIM Test 1 ACOs newly established in primarily rural or underserved areas amounted to $526.4 million in significantly lower spending relative to other fee-for-service beneficiaries in their markets, or $381.5 million (2.5 percent) in savings to the Medicare program after subtracting their earned shared savings and all AIM payments made to ACOs.

Since AIM Test 1 ACOs were formed in areas underserved by ACOs, it was not known whether they would perform at the same level as their peer ACOs. The evaluation compared the performance of AIM Test 1 ACOs to other non-AIM SSP ACOs of similar size that started the Shared Savings Program at the same time with upside-only financial risk and found reductions in total Medicare spending of similar magnitude as the comparison to other fee-for-service beneficiaries. Moreover, measures of patient or caregiver experience and ACO-level quality indicators were not meaningfully different between beneficiaries in AIM Test 1 ACOs and their peer ACOs.

There was also no single factor that explained the AIM Test 1 ACOs' pattern of reductions in spending all three years, although the presence of a management company seemed to be related to spending reductions in the first two years when ACOs were actively receiving AIM funds but not in the third year when ACOs were spending their remaining funds. It's possible that these companies were able to provide insight when AIM ACOs formed about which potential infrastructure investments would most likely reduce beneficiary spending. Most AIM ACOs worked with management companies to perform ACO administration activities and data analytics, generally reporting that they were beneficial for forming and operating the ACO.

By contrast, it is difficult to draw conclusions for AIM Test 2 ACOs about whether AIM payments were associated with movement to greater financial risk and reductions in Medicare spending or improvements in quality because of the small number of AIM Test 2 ACOs and the variation in results between them. Six AIM Test 2 ACOs started AIM in April 2015 or January 2016. Two AIM Test 2 ACOs ceased participating in the Shared Savings Program at the end of 2015, leaving four AIM Test 2 ACOs evaluated in each of three performance years. All AIM ACOs began the model under upside-only financial risk, and two of the AIM Test 2 ACOs transitioned to a two-sided financial risk track on or before it was time to renew their Shared Savings Program participation agreement. AIM Test 2 ACOs were only compared to similar non-AIM SSP ACOs since they began AIM as existing SSP ACOs. None of the AIM Test 2 ACOs had consistently lower or higher spending across performance years relative to their peer ACOs, while quality of care appeared no better or worse.

AIM formally concluded at the end of 2018, when AIM ACOs could no longer spend their AIM funds and most AIM Test 1 ACOs had completed their three-year participation requirement. Among the 29 AIM ACOs ending their participation the following year, many were affiliated with management companies and roughly half of their providers joined other SSP ACOs.

Lessons from AIM have allowed CMS to continue creating opportunities for rural ACOs to proliferate. CMS recently announced an ACO Transformation Track in the Community Health Access and Rural Transformation (CHART) Model. CHART resembles AIM by providing up-front payments to help rural ACOs participate in the Shared Savings Program and builds on AIM by giving ACOs a longer participation agreement period to transition to two-sided financial risk.