

Action Brief

Implementing Accountable Care Organizations

WHAT IS AN ACCOUNTABLE CARE ORGANIZATION?

An accountable care organization, or "ACO," is a group of physicians and hospitals that share financial and medical responsibility for providing coordinated care, with financial incentives to provide high-quality care and to limit avoidable, unnecessary spending. The provider entity can take many different forms. The concept was conceived of a decade ago,¹ and builds upon past experience with health plans contracting with medical groups on a capitated basis.

The idea received a boost when the 2010 Patient Protection and Affordable Care Act (PPACA) included a new Medicare ACO program beginning in 2012. This prompted frenzied activity among many providers to position themselves to become ACOs, despite the fact that rules for various Medicare ACO programs place significant infrastructure requirements on providers.

WHAT PROBLEMS DOES AN ACO TRY TO SOLVE?

The ACO seeks to address the high costs, suboptimal quality, and patient frustration that result from the currently fragmented health care system.

Much of the current fragmentation in care delivery and the lack of clinical or financial accountability results from the predominant fee-for-service payment system. Fee-for-service payment systems pay providers for each covered medical service or procedure they deliver. While fee-for-service payment promotes access to services and protects, to some degree, against undertreatment, it has significant weaknesses (see callout box to the right) that make it a prime target for reform.

FEE-FOR-SERVICE...

- Is inherently inflationary. It creates a strong financial incentive to deliver more care.
- Creates a financial incentive to deliver more costly care, even if the services are of no or marginal benefit to the patient.
- Does not create incentives for, or reward, superior care delivery or outcomes, nor does it incentivize or reward efficient use of resources or care coordination across providers or settings.
- Has produced shortages of certain services, including primary care, by offering much greater financial rewards for specialty interventional services (e.g., surgery, imaging, testing) than for non-interventional, primarily cognitive, services.

ACOs seek to solve the problems of fee-for-service payment by organizing doctors, hospitals, and other providers to assume shared financial responsibility for a population of patients, typically under a shared-savings or shared-risk payment arrangement, or by global payment.

Shared savings and global payment, as discussed below, reduce (shared savings) or remove (global payment) the perverse economic incentive for providers to deliver more services or more expensive services.

IT IS WIDELY BELIEVED THAT ACOs NEED TO HAVE CERTAIN OPERATIONAL CAPABILITIES IN ORDER TO SUCCEED:

1. **Strong leadership and governance** that will support a clear mission, alignment across ACO provider participants, provider accountability for quality and cost, and resolution of internal disputes;
2. **Partnership between physicians and hospitals** for a team-based approach to care, whether the hospitals fall within the ACO or are contracted externally, including a strong foundation in primary care;
3. **Adequate patient access to emergent, urgent, and routine same day care**, including after hours, through the ACO's defined provider network and through alternative sources like telehealth.
4. **Care coordination**, including the capacity for managing acute and chronically ill patients meeting evidence-based standards;
5. **Meaningful use of health information technology**, such as a shared Electronic Health Record (EHR) that supports the integrated and actionable data required to inform care management in ongoing retrospective population analysis and monitoring of fiscal and clinical quality performance;
6. **Risk assessment** of the population for which the ACO is responsible; and,
7. **Operational capacity to contract** with health plans and providers and align incentives for cost and quality, including the ability to participate in shared savings and shared risk payment arrangements, receive and distribute funds across ACO participants, and potentially, if so delegated by health plans, to administer quality assurance, provider credentialing, and handling of patient complaints.

HOW DOES AN ACO WORK? ⁴

The ACO concept was initially defined to mean a hospital and its naturally occurring referral network, but is now understood to encompass many other organizational forms, including but not limited to:

- a medical group (primary care or multi-specialty);
- an independent physician association (IPA); and,
- an integrated delivery system comprised of doctors, a hospital(s) and potentially other service providers.

To the extent that an ACO is defined more narrowly (e.g., medical group), there is heightened need for the ACO to develop contractual relationships with providers outside of the ACO and to create incentives to coordinate care across settings.

Employees do not necessarily enroll with a specific ACO, unless their coverage options include health insurance products structured that way. Many employees instead are attributed to an ACO based on either a) the ACO affiliation of the primary care physician selected by the employee (for HMO enrollees) or b) an attribution made by the insurer or third-party administrator (TPA) based on the past care-seeking behavior of the employee (for PPO enrollees). This can be done without the employee even knowing that the provider is part of an ACO.

ACOs are paid either via a **shared savings**, **shared risk**, or **global payment** arrangement. Under these payment strategies the ACO has a budget for its assigned patient population.⁵ This creates the incentive to invest in lower cost services, such as primary care, to direct care provision to lower-cost and higher-quality settings, and to coordinate care to prevent avoidable acute and costly service needs, such as for patients with chronic conditions like heart disease and diabetes. Shared savings, shared risk, and global payment arrangements will adjust payments based on the clinical risk of the covered population, removing a possible economic incentive to serve only healthy patients.

SHARED SAVINGS

Shared savings is a payment model that provides an incentive for the ACO to reduce health care spending for a defined patient population by offering the ACO a percentage of any net savings it realizes. The ability of the ACO to share in the savings is additionally linked to reaching certain performance thresholds using access, quality, and/or efficiency measures, and the percentage of earned savings can sometimes increase as performance on the measures rises. However, the ACO bears no financial risk, or downside, if the costs incurred in caring for the ACO population exceed the budget target. Though few shared-risk arrangements exist today (see box below), many ACOs are expected over time to take on shared risk, in addition to being eligible for shared savings.

SHARED RISK

Shared risk arrangements are payment models in which providers share a portion of the savings they achieve (upside) but are also at risk for a portion of spending that exceeds a target (downside). Shared risk can be built on top of fee-for-service payments.

GLOBAL PAYMENT

Global payments are similar to shared savings arrangements except that the ACO bears financial responsibility if costs exceed the budget. Global payments are generally made to provider entities with the financial and operational wherewithal to assume responsibility for managing the health of a population of patients.

Global payment arrangements often require that the provider entity be reinsured and/or purchase “stop loss” insurance in the event that it faces an adverse financial situation. The insurer can offer the reinsurance, or it can be purchased by the provider from another reinsurer.

ACOs VERSUS CAPITATION:

Advocates of ACOs distinguish them from early organizations of providers receiving capitation payments in the following ways:

- Payments are linked to measures of access and quality, protecting against incentives to underserve;
- The accuracy of risk-adjustment models has improved over the last 20 years;
- Providers are protected from assuming excessive risk through minimum enrollment thresholds, the possible option of shared savings arrangements, and use of “risk corridors,” reinsurance, and stop-loss coverage;
- Provider organizations today have more sophisticated health information technology, allowing them to target and monitor their efforts to improve quality and reduce cost;
- Some states have created robust systems to protect against excessive risk-assumption by provider organizations; and,
- Years of experience with capitated payments in specific markets in the U.S. has produced a pool of organizations and individuals with expertise in how to administer such programs from both the provider and payer positions

The number of ACOs in action has grown significantly since the Affordable Care Act spurred their creation in 2010.



EXAMPLES OF ACOs IN ACTION:

Shared savings arrangements have quickly become the most prevalent payment model other than traditional fee-for-service. There are nearly 1,000 ACOs in the marketplace, a combination of 619 Medicare ACOs and 287 commercial ACO arrangements, and 21% of employers are expected to promote ACOs offered by their carriers or contract directly with ACOs in 2018, this number is expected to double by 2020.⁶ Additional recent evidence related to ACO initiatives includes the following:

The CMS Medicare Shared Savings Program (MSSP) is a voluntary program encouraging providers to create ACOs for Medicare Fee-For-Service beneficiaries. The Medicare Shared Savings Program is one of CMS' largest attempts to reform payments.⁷

- The program rewards ACOs that reduce growth in costs while meeting quality benchmarks. After three years, 428 ACOs were participating in the model, covering 9.7 million beneficiaries.
- In performance year 2015, MSSP ACOs generated gross savings of \$429 million. ACOs collectively spent less than their benchmarks to generate savings and received bonus payments from CMS as a result. However, these payments exceeded savings and resulted in a net loss to Medicare of \$73.5 million.⁸
- MSSP has consistently shown high-quality scores in addition to cost savings, calculated on an average across four ACO quality performance measures. In 2016, the aggregate quality score was 93.4%, an increase from 91.0% in 2015 and 86.0% in 2014.⁹

Minnesota Medicaid's ACO payment model, the Integrated Health Partnership (IHP) demonstration project, has seen positive cost and quality results to date.¹⁰

- Reported savings for Minnesota have increased as more providers have joined the demonstration, jumping from \$14.8 million in 2013 to \$76.6 million in 2015. After three years total savings were \$157 million.
- All nine participating providers received a shared savings settlement, ranging from \$388,000 to \$4.7 million, totaling \$23 million.
- Over the three-year period, growth in the total cost of care decreased by 5%, producing savings of \$16.6 million.
- The program also led to an 18% decline in emergency department use and an 8% decline in inpatient hospital use.

The Alternative Quality Contract (AQC) was implemented by Blue Cross Blue Shield of Massachusetts in 2009. The AQC is a global payment model that has since expanded to include 90% of physicians in the Blue Cross HMO network in Massachusetts.

- The AQC improved the quality of patient care and lowered costs in its first four years of operation. The most dramatic quality improvements were in preventive care for children and adults, and management of serious chronic illnesses.
- By year four, the AQC groups had realized 10% in cost savings compared to the control group, mostly concentrated in outpatient care.¹¹

ACOs seek to address the high costs, suboptimal quality, and patient frustration that result from the fragmented health care system. Because the ACO concept is relatively new, it will continue to evolve over time, as payers, providers, and policy makers learn which models work best.



WHAT PROBLEMS DO ACOs PRODUCE?

ACOs have the potential to restrain cost growth and improve quality of care. There are, however, many challenges and potential problems that can occur. These include:

- Organizing providers into ACOs so that they can manage risk or global payment could further consolidate the provider marketplace and raise prices, perhaps offsetting the payment incentive for improved efficiency.¹²
- Consumers may be distrustful if they know that their providers are managing their care within a budget.
- Providers may avoid serving expensive patients if payments are not adequately risk-adjusted.
- Providers may not experience strong enough incentives to cut waste, as they are not held directly accountable for overspending.
- There can be complexities to consider with the use of global payment with self-insured employers. Health care providers may be unable to bear full risk or to find financing instruments (stop-loss or reinsurance) to help them bear risk.
- State insurance agencies may view providers who bear financial risk from self-insured employers as engaging in the business of insurance and regulate them as such (e.g., require them to hold financial reserves).

WHAT STEPS CAN A PURCHASER TAKE TO STAY AHEAD OF THE ACO MOVEMENT?

FAMILIARIZE yourself with CPR's toolkit and movement related to [Standardized Plan ACO Reporting for Customers \(SPARC\)](#).

ASK your current or prospective TPA the request for information (RFI) questions from SPARC.

INCORPORATE the contract provisions from the model contract language and the performance guarantees in SPARC into your greater ASO agreement with your TPA.

REQUIRE your TPA contracting with ACOs to report the results using CPR's Standard Plan ACO Report from SPARC to ensure you receive comprehensive and meaningful information about how their ACOs are performing.

PUSH your TPA to transition its contracted ACOs into shared risk payment arrangements as appropriate to provide further incentives to providers to contain costs and improve quality.

BE AWARE that ACOs can lead to consolidation among health care providers, reduce competition within health care markets, and enable providers with market power to command higher prices.

KEEP ABREAST of how ACOs are performing across the country.

EVALUATE ACOs that impact your population using CPR's Standard Plan ACO Report and share results with other purchasers.

CONSIDER ACOs paired with narrow networks incentives. Narrow network incentives would require that consumers seek care from ACOs to use their insurance coverage, in which case, the ACO would have an easier time managing patient care, may more easily stay within budget, and experience positive patient outcomes.

ABOUT US

Catalyst for Payment Reform (CPR) is an employer-led, national nonprofit on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

References

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Most employers will be impacted via attributed ACO models whether they know it or not. CPR worked with employers to create a standard reporting template that can be used to demand transparency into the performance of your health plan's ACO. The report includes employer-selected quality, cost, and utilization measures.

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