CATALYST FOR PAYMENT REFORM

Implementing Accountable Care Organizations

Action Brief

WHAT IS AN ACCOUNTABLE CARE ORGANIZATION?

An accountable care organization, or "ACO," is a local provider entity that is responsible for all of the health care and related expenditures for a defined population of patients. The provider entity can take many different forms. The concept was conceived relatively recently,[1] but 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, though the proposed rules for the Medicare Shared Savings Program may temper that activity due to the infrastructure it requires of 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. While fee-for-service payment promotes access to services and protects to some degree against undertreatment, it has significant weaknesses, see box, that make it a prime target for reform.

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

Shared savings and global payment, as discussed on pages 5 and 6, reduce (shared savings) or remove (global payment) the economic incentive for providers to deliver more services or more expensive services.

FEE-FOR-SERVICE …

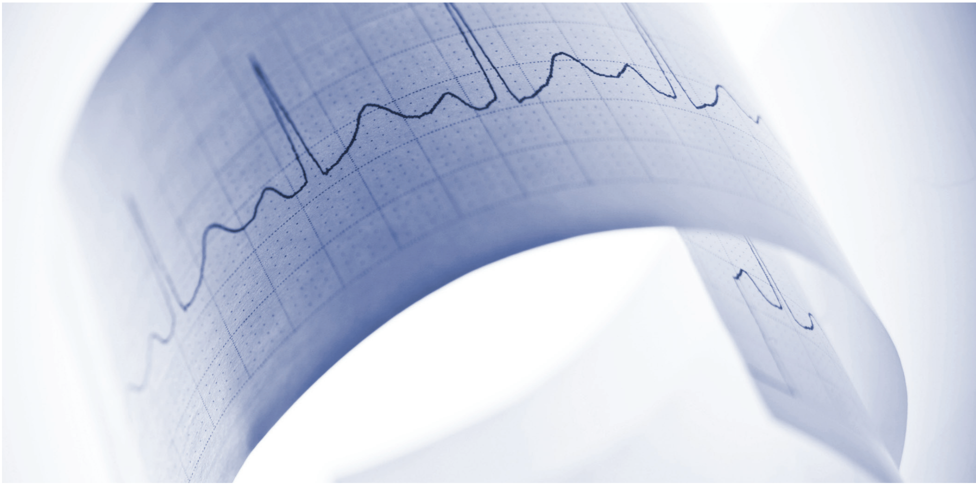
- is inherently inflationary. It creates a strong financial incentive to deliver more care.
- creates a financial incentive to deliver *more costly* care, even if the services are of no or marginal benefit to the patient.
- does not create incentives for, or reward, superior care delivery or outcomes,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

It is widely believed that ACOs need to have a series of operational capabilities in order to succeed:[3]

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;
3. a foundation of effective primary care practices, operating as Patient-Centered Medical Homes;[4]
4. capacity for managing acute and chronically ill patients meeting evidence-based standards;
5. meaningful use of health information technology that supports the integrated and actionable data required to inform care management in ongoing retrospective population analysis and monitoring of fiscal and clinical 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 costs and quality, to 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.

SHARED SAVINGS

Shared Savings is a payment strategy that provides an incentive for the ACO to reduce health care spending for a defined population of patients by offering the ACO a percentage of any net savings it realizes. The ability of the ACO to access 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. The ACO bears no risk, however, if the costs incurred in caring for the ACO population exceed the budget target. Though very few shared-risk arrangements exist today, the Medicare Shared Savings Program proposed rule suggests that ACOs will be expected over time to take on shared risk, in addition to being eligible for shared savings.



HOW DOES AN ACO WORK?[2]

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., a 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 would not necessarily enroll with a specific ACO, unless new health insurance products are structured that way. Rather, employees would be attributed to an ACO based on either a) the ACO affiliation of the PCP selected by the employee (for HMO enrollees) or b) an attribution made by the insurer or TPA based on the past care-seeking behavior of the employee (for PPO enrollees). This could all be done without the employee even knowing that provider is part of an ACO.

ACOs would likely be paid either via a **shared savings**, **shared risk** or **global payment** arrangement. Under both payment strategies the ACO has a budget for its assigned patient population – and needs to have a large enough patient population to reliably do so.[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 for patients with chronic conditions such as heart disease and diabetes.

Shared savings, shared risk and global payment arrangements will adjust payments for the clinical risk of the covered population, removing a possible economic incentive to serve only healthy patients.

SHARED RISK AND GLOBAL PAYMENTS

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 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 adverse financial situation. The insurer can offer the reinsurance or it can be purchased by the provider from another reinsurer.

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

Because the ACO concept is a new one, it can be expected to evolve over time, as payers, providers and policymakers learn which models work best.

- payments are linked to measures of access and quality, protecting against incentives to underserve;
- risk-adjustment models are far improved from what existed 20 years ago;
- 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 have much better health information technology than they did, allowing them to better 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 payment in specific markets in the U.S. produced a pool of organizations and individuals with expertise in how to administer such programs from both from the provider and payer positions.

THERE ARE NO FORMAL EVALUATIONS OF ACOs, PER SE.

There are, however, many commonly cited prototypes of ACOs, including:

- **health systems that own hospitals and employ physicians, e.g.,**
  - Kaiser Permanente health plans
  - Geisinger Health System (PA)
- **multispecialty group practices, e.g.,**
  - Marshfield Clinic (WI)
  - Group Health Cooperative (WA)

Health systems and large group practices are the most cited prototypes. The level of coordination that these entities have achieved has proven difficult to achieve when doctors and hospitals operate independently.

Recent evidence related to ACO-like initiatives includes the following:

- **CMS (Medicare) is conducting a five-year demonstration with 10 physician groups.** By year 3:
  - all 10 had improved quality scores; scores improved by 6-11% on each of four of the five assessed conditions; and,
  - 5 had reduced spending by 2% or more relative to non-participating practices.[6]

(Note: the participating physician groups in the CMS demonstration are large organizations that are *not* representative of physician organizations in the U.S.)

Questions Remain

- **Blue Cross Blue Shield of Massachusetts has implemented global payment arrangements with nine provider groups, representing 25% of network physicians. An evaluation of first-year experience for 2009 revealed:**
  - every group met its budget in 2009;
  - all groups significantly improved quality, including those who were already comparatively high performers; and,
  - quality improvement in the participating medical groups occurred at a faster pace than among those not participating.[7]

WHAT PROBLEMS COULD ACOs PRODUCE?

There is currently great enthusiasm for the potential of ACOs to restrain cost growth and improve quality. There are, however, many challenges and potential problems that its application could produce. These include the following:

- Organization of providers into ACOs in order to accept global payment and manage risk could contribute to further consolidation of the provider marketplace and increased pressure on price, perhaps offsetting the payment incentive for improved efficiency.[8]
- Despite a recent flurry of hospitals acquiring practices, and small practices joining groups, most American physicians continue to operate in small practices and independently are ill-positioned to operate within an ACO.
- Providers operating as an ACO may seek to constrain patient choice of provider in order to maximize their ability to manage to their global payment budget. Consumers have consistently demonstrated an aversion to such a constraint.
- Even if provider networks are not limited, consumers may be distrustful if they know that their providers are managing within a budget.
- Providers may avoid serving expensive patients if payments are not adequately risk-adjusted.
- 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.).

A number of questions remain regarding ACO formation and operation. A few of the most critical include:

1. How will physicians, hospitals and other providers clinically, operationally and financially integrate?
2. How many providers will seek to become ACOs given the high bar for quality reporting set by the proposed rule for the Medicare Shared Savings Program ACOs?
3. How will legal and regulatory barriers, such as anti-trust, anti-kickback and health insurer reserve requirements be addressed with ACOs?
4. How will providers share risk and savings within and outside of the ACO?
5. How will transparency on performance and payment arrangements be ensured so that consumers have what they need to make informed choices?

What steps can a purchaser take?

ACOs seek to address the high costs, suboptimal quality and patient frustration that result from the fragmented health care system.

- PARTICIPATE in state-level discussion and possible regulatory action regarding ACO development. Give attention to the following issues of employer interest (see CPR health plan RFI module on ACOs for more detail):
  - protection of health plans (and employers) against possible monopoly pricing by large ACOs without any meaningful market competition;
  - ensuring that provider financial success is contingent, in part, on performance on access and quality measures to protect against an incentive to undertreat;
  - protection of providers against catastrophic financial loss through risk-adjustment of payment and other means;
  - support testing and/or use of for broad network products (if desired by the employer in response to a consumer preference for a broad choice of provider);
  - support for self-insured employer testing of and/or use of ACOs in their networks (if the employer is self-insured); and,
  - ensure full transparency on clinical performance and financial arrangements to ensure accountability.
- ENCOURAGE your insurer or TPA contracting with ACOs to address the aforementioned concerns , and to offer shared-risk arrangements as appropriate to provide further incentives to providers to contain costs and improve quality.
- SUPPORT employer coalition and insurer efforts to obtain state support for anti-trust protection and other means to ensure competitive health care markets, since provider consolidation to contract on a global risk basis may result in monopoly pricing.
- OFFER an HMO with a network of a provider entity(ies) receiving global payment as an employee option, as such a network will have significant capability to influence cost and quality, as evidenced by CalPERS experience in 2010.[9]
- ANTICIPATE a multi-year transition, and encourage state government and insurers to jointly monitor the development, implementation and operation of ACOs to identify opportunities for improvement and unanticipated consequences, and stay involved.

1. Fisher ES et. al. "Creating Accountable Care Organizations: The Extended Hospital Medical Staff", *Health Affairs*, Vol. 26, pp. w44-w57, December 5, 2007.
2. "Health Policy Brief: Accountable Care Organizations", *Health Affairs*, July 27, 2010.
3. Deloitte Center for Health Solutions, "Accountable Care Organizations: A new model for sustainable innovation", 2010, and Bailit Health Purchasing and Mathematic Policy Research, "Briefing Paper for the Special Commission on the Health Care Payment System: Success Factors for Providers Accepting Global Payments", May 2009.
4. *The Patient-Centered Medical Home: A Purchaser Guide.* Patient Centered Primary Care Collaborative, 2008. See www.pcpcc.net/files/PurchasersGuide/PCPCC_Purchaser_Guide.pdf.
5. ACOs will be required to have at least 5000 Medicare patients.
6. http://tinyurl.com/4oyms5o
7. Personal communication with Deborah Devaux, BCBSMA.
8. Abbleby J. "As more hospital systems consolidate, experts say health-care prices will jump" *Kaiser Health News*, September 25, 2010.
9. Interview with and documentation provided by Juan Davilia, Blue Shield of California and Simmons KJ. "Large Healthcare Purchaser Takes Risky Leap Into ACOs", *HealthLeaders Media*, April 8, 2010, available at www.healthleadersmedia.com/content/QUA-249275/Large-Healthcare-Purchaser-Takes-Risky-Leap-Into-ACOs.