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ACOs AT MID-LAUNCH: MOVING FORWARD BUT CHALLENGES AHEAD

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Perhaps more than any other delivery system reform associated with the Affordable Care Act (ACA), Accountable Care Organizations (ACOs) have generated enormous interest, spawning new partnerships among a diverse array of providers and payers across the country and reinforcing an existing trend toward delivery system integration. The interest in ACOs reflects a widespread desire for an alternative to a business and clinical environment dominated by uncoordinated fee-for-service (FFS) reimbursement, as well as concerns about unsustainable growth in health care costs.[1] Proponents envision ACOs transforming the organization and delivery of health care but without disrupting beneficiaries, forcing providers into one-size-fits-all approaches or harming existing systems of care. In this essay, I explain the ACO concept, describe the current landscape, and discuss several key challenges to achieving the promise of this new model of care.

WHAT ARE ACOs?

While potentially taking many forms, ACOs are provider-based entities that include primary care physicians and accept organizational responsibility for the quality and cost of care provided to a defined pool of patients. Patients may either be "attributed" to the ACO based on receiving care from the ACO's providers (without signing up) or enrolled more explicitly through an active choice. By moving from pure FFS reimbursement to "shared savings" models that link compensation to objective measures of clinical and financial performance, ACOs shift away from rewarding individual providers for delivering more services regardless of their value. Instead, providers are encouraged to work as a team to deliver high quality care efficiently.[2]

To share in savings, an ACO must first meet quality targets, which generally reflect clinical indicators, care continuity and coordination, and patient satisfaction and access. After meeting quality targets, an ACO may earn a bonus if it has lowered costs relative to its budget target. A "bonus-only" (or "one-sided risk") arrangement does not impose financial penalties if costs exceed budget. With "two-sided risk," ACOs accept financial responsibility for losses but typically receive a higher proportion of any savings to offset the risk of loss. Financial performance reflects costs for all care provided to an ACO's patients, even when received from non-ACO providers.

THE CURRENT INVENTORY OF ACOs

By design, ACOs can adopt flexible arrangements with a limited number of essential features, allowing a diverse range of organizations to form ACOs. As Mark McClellan and Elliott Fisher have noted: "there is no one organizational make-up that will predetermine a successful ACO."[3] This diversity complicates the task of getting a census of ACOs. As of September 2011, Leavitt Partners counted 164 provider entities that either self-identified as an ACO or display the essential characteristics of an ACO. Serving both urban and rural markets in 41 states, these entities include established systems of care as well as organizations newly embarking on coordinated care. Their survey reported that hospitals created 60 percent of the entities, physicians 23 percent, and private insurers 16 percent.[4]

Medicare is actively fostering ACO development through its statutory ACO program established by the ACA and an innovative "Pioneer" program (Figure 1). The statutory Medicare Shared Savings Program (MSSP) permits a variety of payment models, while the Pioneer program is designed to test more advanced models. The first 27 successful applicants under the MSSP were announced in April 2012. Just over half of these organizations are physician led and all but two opted for a one-sided payment option. Another 150 organizations have applied to join the program in July 2012 and a final wave of participants will be selected to start in January 2013. The Pioneer program awarded 32 contracts in January 2012, mainly to hospital-sponsored organizations with significant infrastructure and risk-based contracting experience. In addition, CMS has an "Advanced Payment Model" to help small rural and physician-based ACOs in the MSSP finance start-up costs; five of the initial MSSP participants are taking part in the Advanced Payment Model.

KEY CHALLENGES

ACOs will face important challenges in demonstrating their ability to provide high quality care efficiently. These challenges include improving patient care without some key managed care tools, changing provider culture and care processes, achieving and sustaining the high level of savings needed for economic viability, and assuming prudent levels of risk. From a broader policy

perspective, added challenges arise because developing ACOs may also enhance provider market power, lessen competition, and raise private-sector prices.

Medicare ACOs cannot require patients to enroll, establish differential cost sharing, limit benefits, impose prior authorization, or restrict choice of providers. Comparable rules may apply to commercial ACOs, depending on their benefit plans. These limitations on structural features that restrict beneficiary choice effectively tie the success of ACOs to their ability to re-engineer care processes, complemented by their systems for reporting and analyzing data. Without the full array of managed care tools traditionally used in HMOs to influence patient choice, even highly sophisticated provider systems may not succeed as ACOs, despite years of success working with HMOs.[5]

Newly formed ACOs composed of independent providers face substantially greater challenges because they cannot leverage existing organizational leadership, systems, and financial resources. A critical challenge involves provider culture: because ACO clinical and financial performance is measured at the system level, individual ACO providers must accept being evaluated not only on what they do but also on the actions of others. Additionally, the significant start-up costs and steep learning curve facing new ACOs dictate adopting a realistic, multi-year timeline. Successful ACOs also need a critical mass of Medicare and non-Medicare patients to facilitate engaging providers and spreading the costs of re-engineering care.

Generating sufficient savings initially and over time is yet another challenge for ACOs, especially since savings must be shared with payers. Start-up and operating activities will be costly in the first few years and participating providers will expect meaningful bonus payments, implying a need for significant initial savings in order to be financially viable. Recalibration of future budget targets to incorporate savings from earlier years will require finding additional savings in later years and compounds the challenge of funding bonuses over time. While savings can initially come from "low hanging fruit" such as shifting to lower cost sites of care, diverting inappropriate emergency department visits, limiting unnecessary advanced imaging, and reducing unnecessary hospital admissions and readmissions, achieving added savings in the future may require more fundamental and difficult changes.

ACO financial models that include partial or full capitation pose other challenges by creating potential losses beyond what many providers would have the capital to withstand. Financial responsibility for the cost of over-budget health services means providers may be assuming insurance risk, necessitating establishment of prudent standards for financial reserves. Requirements for ACOs seeking substantial capitation might reflect standards such as those CMS developed for Provider Sponsored Organizations or those the California Department of Managed Health Care applies when providers assume insurance risk.

Finally, anti-trust regulators and others have expressed concerns about the potential for ACOs to increase provider consolidation and market concentration, thereby decreasing meaningful competition and increasing prices to private payers. Indeed, hospitals may create ACOs as a strategy to increase their market power, even though this model of care could reduce their own top-line revenues.[6]

FIGURE 1. MEDICARE ACO OPTIONS

Medicare Shared Savings Program (MSSP)	Pioneer ACOs
• Permanent program • Sites will initially have a minimum contract length of 3 years	• 3-year program, with 2 optional extension years • Targets entities with a track record of managing risk and coordinating care • Designed to establish "proof of ACO concept" and test alternative payment models
• 27 sites selected to start in April 2012 • Additional sites to be added in July 2012 and January 2013	• 32 sites began participation in January 2012
• Includes both one-sided and two-sided payment options	• Mix of payment options, but emphasizes two-sided approaches with more up- and down-side risk than in MSSP, and transitions to partial/full capitation in year 3 and beyond
• Medicare is the only payer	• Multi-payer: sites must derive > 50% of revenue from similar contracts with non-Medicare payers by end of year 2
• Some small rural and physician-owned organizations may qualify for upfront help to finance needed infrastructure investments via the Advanced Payment Model	• Participants are expected to have the necessary management systems in place, including at least 50% of primary care physicians satisfying EHR meaningful use criteria by end of 2012
• Beneficiaries prospectively "attributed" to a specific ACO, usually based on the provider from whom they have received the plurality of their primary care • To assist in care management, ACO notified quarterly of which beneficiaries are attributed to it • Beneficiaries notified of ACO attribution, but remain free to use any provider, retain full FFS benefits, and may decline to have their clinical information shared with the ACO for care management purposes • End-of-year performance assessment based on beneficiary population that actually used the ACO • 33 quality measures used to assess performance and qualification for bonuses	

CONCLUSIONS

ACOs present an important opportunity to create systems of care that change incentives, provide the basis for measuring both financial and clinical performance, and create accountability for the efficient provision of quality care. Medicare, private payers and many provider organizations are moving forward aggressively to implement ACOs. Coordination by CMS, states and private payers will help to minimize obstacles and conflicting requirements, and regulators will need to carefully evaluate the adequacy of rules addressing market power and ACOs assuming insurance risk. Capitalizing on "rapid learning" from initial experience can help refine ACOs and meet the challenges associated with the complex, ambitious transformation from FFS to accountable care. Done well, accountable care holds real promise for improving quality, controlling spending growth, and achieving better value.

ENDNOTES

1 The Commonwealth Fund. "Berwick Not Blue About ACOs Despite Beat Down of Proposed Reg." Washington Health Policy Week in Review. October 17, 2011, http://tinyurl.com/75hsswl.

2 Fisher ES, McClellan MB, Bertko J, et al. "Fostering Accountable Health Care: Moving Forward in Medicare." *Health Affairs*, 28(2):w219-w31. 2009.

3 Engelberg Center for Health Care Reform and the Dartmouth Institute for Health Policy and Clinical Practice. "Accountable Care Organization Learning Network: ACO Toolkit." January 2011. http://tinyurl.com/864syyq.

4 Muhlestein D, Croshaw A, Merrill T, and Peña C. "Growth and Dispersion of Accountable Care Organizations." Leavitt Partners Report, November 2011.

5 Lieberman S. "Pioneer ACOs: Promise and Potential Pitfalls." *Health Affairs* blog, December 29, 2011. http://tinyurl.com/76exo5z.

6 Lieberman SM and Bertko JM. "Building Regulatory Flexibility and Accountability into Accountable Care Organizations and 'Shared Savings.'" *Health Affairs* 30(1):23-31. 2011.