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RESEARCH BRIEF NO. 2 | MARCH 2015

Accountable Care Organizations: Still a Lot to Learn About Best Practices

Many experts believe that to achieve meaningful health care reform in our country, it is necessary to shift away from a fee-for-service (FFS) payment system that rewards volume instead of value. Under a FFS system, providers get paid a set amount for each procedure or service performed, regardless of the quality of care provided or the outcome for the patient.

An Accountable Care Organization is a broad spectrum of health care providers who agree to be held accountable for health care spending, quality of care and outcomes for a defined population of patients.[1] ACOs coordinate care across multiple levels and providers, making sure patients get the care they need while aiming to eliminate waste and inefficiency.

The design of ACOs includes financial incentives for improved care coordination, better quality of care and outcomes, and cost savings, so that payments to ACOs reward quality and efficiency rather than the volume of services provided. In order to be eligible for enhanced payments, ACOs must demonstrate that they improve the quality of care. This helps prevent ACOs from trying to meet budget constraints by skimping on quality or denying care that people need.[2]

SUMMARY

Health care delivery reform designed to create value and improve the quality of care have long been a concern for payers, providers and consumers.

Accountable Care Organizations (ACOs) center on a new way to pay health care providers, foster closer alignment of providers across the care spectrum and incentivize higher quality of care for patients. As such, the system provides incentives for providers to organize so as to provide more integrated care. But change is hard, and the evidence shows that ACOs in practice don't always align with the goals.

Why are ACOs Different than Current Delivery Systems?

ACOs have three distinct features that set them apart from other provider contracting arrangements and health care delivery models: shared savings, accountability for quality, and patient freedom of choice in providers.[3]

- **Shared savings agreement between providers and payers:** Providers generally receive a bonus if they keep patient costs below a projected amount based on historic spending, regardless of whether their spending is historically high or low; subject to the next requirement to also hit quality targets.
- **Providers are held accountable for the quality of care given to beneficiaries:** Providers must meet quality benchmarks in addition to spending targets to be eligible for shared savings and bonus payments.
- **Freedom of provider choice:** Consumers retain freedom of choice to see the provider they like—including providers outside the ACO and are not "locked in" to seeking care from certain providers or within a designated network of providers.

What Value Problems do ACOs Address?

ACOs aim to address the highly disjointed, poorly coordinated and expensive care that is characteristic of the American health care system by providing financial incentives for coordination across providers, thereby improving quality and lowering costs.[4]

What Does the Evidence Say?

While ACOs hold the potential of more integrated, continuous care and the possibility of slowing health care spending, it is important to keep certain considerations in mind. ACOs are a relatively new development and, while data on results are still forthcoming, several areas of concern have emerged that warrant a close examination. As with all policies of this type, the devil is in the details and it appears we still have a lot to learn about fine tuning the shared-savings arrangements and use of quality metrics.

At a 2015 panel discussion hosted by the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice,[5] officials from the Centers for Medicare & Medicaid Services (CMS) reported significant cost savings achieved by ACOs, and largely positive responses from the recipients of ACO care. The consensus among the expert panelists was that the keys to success include strong clinical leadership, a culture of collaboration between leadership and physicians, communication and transparency among providers, a redesign of common practices, and effective information technology and analytics.

Medicare Demonstration

Medicare ran a Physician Group Practice Demonstration (PGP) from 2005-2010, after Congress passed a law in 2000 allowing for the creation of a new delivery model with the aim of improving health outcomes and controlling costs.[6] This early example of a pay-for-performance measure "created incentives for physician groups to coordinate the overall care delivered to Medicare patients, rewarded them for improving the quality and cost efficiency of health care services, and created a framework to collaborate with providers to the advantage of Medicare beneficiaries."[7] Ten physician groups were chosen to participate based on technical review panel findings, organizational structure, operational feasibility, geographic location, and a demonstration implementation strategy. This demonstration also allowed CMS to test new incentives in diverse clinical and organizational environments including freestanding multi-specialty physician group practices, faculty group practices, physician groups that are part of integrated health care systems, and physician network organizations.

During this project, physician groups were allowed to keep a portion of the savings they produced for Medicare relative to a spending target, if they met certain quality measures.[8] Specifically, the ten participating provider groups were able to keep up to 80% of the savings with the other 20% going to the Medicare trust fund.[9,10] In order to be eligible for savings, physician groups had to produce savings for Medicare Parts A and B totaling more than 2% of their spending target. The threshold was established to ensure that savings were not just a result of random variation and instead represented an accurate reflection of real practice changes.[11]

The quality and savings results varied over the course of the five year program. By the end of the fifth year, all ten provider groups reached the benchmark for 30 of the 32 quality metrics and seven of the ten met all 32 performance benchmarks.[12,13] Four groups also earned bonus payments totaling $29.4 million based on savings of $36.2 million they produced for Medicare.[14]

Massachusetts Example

Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract (AQC), established in 2009, is the earliest example of what is now known as an ACO. This model combined incentives for providers to improve quality and reduce spending by "negotiating a multi-year series of global budget targets with a set of providers. Both providers and insurers would share savings or loses if medical expenses were below or above the target. In addition, a substantial incentive payment was offered."[15] A 2013 evaluation of the ACQ in Massachusetts from the Robert Wood Johnson Foundation found that the AQC initiative improved cost savings.

Savings were greater in the second year of the program, with medical savings 2.8 percent less than the projected savings for that year.[17] Results also showed substantial improvements in quality of care.

California Example

The state of California has the most ACOs in the country.[18] According to the Berkeley Forum for Improving California's Health Care Delivery System, ACOs in California have helped improve quality of care and may have reduced costs. A 2014 report released by the Berkeley Forum compared medical groups with ACO contracts to medical groups without ACO contracts based on various measures of quality and patient satisfaction. ACO patients had consistently higher satisfaction scores than consumers in non-ACO plans. Although there is little data about the full cost-savings of the programs, "preliminary evidence from an ACO contract in Sacramento found savings of $20 million, with no increase in health insurance premiums for California's CalPERS enrollees. The study also addressed the concern that as ACOs grow in size they may exert pressure to increase prices."

The same report recognizes six factors that are associated with a "successful" ACO including: sufficient size to spread costs; developing new models of caring for complex/high-risk patients; expanding use of electronic health records, developing effective partnerships with post-acute care providers and specialists; motivating patients and families to become more engaged in their care; and using standardized and transparent quality of care data for the purposes of public reporting and internal quality improvement.

Potential Impacts on Consumers

Concerns about Provider Consolidation Could Increase Costs

Perhaps the most pressing concern related to ACOs is the potential increase in market power that may result due to vertical integration of provider organizations. Although this trend began before the development of ACOs, the formation of ACOs plays squarely into concerns that increased market power might result in higher prices.

Care Coordination Could be Hampered

Aside from the very real concern that ACOs might increase health care costs if accompanied by increased provider market power, there are other consumer considerations that might arise due to the design and incentives built into ACOs.

ACO providers could be tempted to skimp on care for their patients in an attempt to lower the health spending of the organization to qualify for bonus payments.[19] ACO physicians might also be reluctant to make outside referrals, as that means less impact on patient outcomes.[20] Additionally, providers might try to avoid seeing patients they deem more expensive, again in an effort to meet savings targets.[21]

ACO proponents argue that quality metrics provide protection against these unintended consequences, but this has not been demonstrated in results from past examples.[22]

Network Adequacy

In some private payer ACO agreements, the payer could require the beneficiary to pick an ACO through which they will receive care.[23] This could prevent consumers from seeking care from providers outside the ACO.[24] While not necessarily a bad arrangement, this would make it important for consumers to have access to adequate providers within the ACO and to have strong protections for situations in which care from an outside provider was needed. If consumers perceive ACOs as limiting their choice of providers, even if this is not the case, they could become distrustful of the model in general.[25]

Consumers should be notified if they see a provider who is part of an ACO. This notification should explain what an ACO is and how their quality information and health care spending data will be used.

Conclusion

The ACO could be an improvement over the current fee-for-service system which focuses on volume. Better record keeping, communication and compensatory practices are the foundation of the ACO model, which could help create a health care system focused on high-quality care at lower cost to consumers.

Notes

1. Catalyst for Payment Reform, *Action Brief: Implementing Accountable Care Organizations*, San Francisco, Calif. *http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_ACO.pdf*
2. National Committee of Quality Assurance, *ACO Factsheet*, *http://www.ncqa.org/Portals/0/Public%20Policy/2013%20PDFS/ACO%20Fact%20sheet.pdf*.
3. Berenson, Robert A., and Rachel A. Burton, *Accountable Care Organizations in Medicare and the Private Sector: A Status Update,* Urban Institute (2011).
4. Catalyst for Payment Reform
5. *https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition*
6. Berenson (2011)
7. Memo from CMS*, Medicare Physician Group Practice Demonstration, Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration* (July 2011).
8. Berenson (2011)
9. The physician groups that participated in the PGP demonstration were Billings Clinic, MT; Dartmouth-Hitchcock Clinic, NH; The Everett Clinic, WA; Forsyth Medical Group, NC; Geisinger Health System, PA; Marshfield Clinic, WI; Middlesex Health System, CT; Park Nicollet Health Services, MI; St. John's Health System, MI; and University of Michigan Faculty Group Practice, MI. *https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf*
10. Ibid.
11. Iglehart, John K, "Assessing an ACO Prototype–Medicare's Physician Group Practice Demonstration," *New England Journal of Medicine, Vol. 364, No. 3 (2011).*
12. The seven groups that met all the quality benchmarks in year five were: Billings Clinic, Everett Clinic, Forsyth medical Group, Geisinger Health System, Middlesex Health System, Park Nicollet Health Services, and St. John's Health System.
13. CMS, *Medicare Physician Group Practice Demonstration* (July, 2011).
14. Ibid.
15. Wilson, Katy, *Private Sector Approaches to Health Care Cost Containment: A Closer Look*, Robert Wood Johnson Foundation, Princeton, N.J. (Nov. 5, 2013).
16. Ibid.
17. This is in comparison of the control group without ACQ program.
18. *http://berkeleyhealth careforum.berkeley.edu/wpcontent/uploads/BerkeleyForumACOExpBrief3_feb16.pdf*
19. Berenson (2011)
20. Catalyst for Payment Reform
21. Ibid.
22. Ibid.
23. Families USA, *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know*, Washington, D.C. (February 2012).
24. Ibid.
25. Catalyst for Payment Reform

Stephanie Cohen, policy analyst, was the primary author of this research synopsis, with early input from Consumers Union analysts Victoria Burack and Laurie Sobel. Lynn Quincy, director, provided substantive review. Supported by generous grants from the Atlantic Philanthropies and the Robert Wood Johnson Foundation.

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Support provided by the Robert Wood Johnson Foundation