

The Impact of Accountable Care Origins and Future of Accountable Care Organizations

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EXECUTIVE SUMMARY

Accountable Care Organizations (ACOs) represent a changing dynamic in the American health care system where providers will increasingly be paid to effectively manage the health of populations rather than based on the volume of services they provide. An ACO is formed when a group of health care providers (physicians, hospitals, non-physician providers, etc.) come together and collectively agree to become responsible for the financial and quality outcomes for a defined population. The changing payment models shift financial risk from payers (such as insurance companies or employers) toward providers. In doing so, providers are strongly incentivized to change how they are delivering care with the goal of decreasing spending while improving quality measures and patient satisfaction. Accountable care models have been adopted by Medicare, state Medicaid plans, and commercial health insurers. These initiatives have led to an increase in the number of ACOs from fewer than 100 to well over 700 in the past five years. ACOs now exist in all 50 states and provide care for more than 23 million people.

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INTRODUCTION

The fragmented and misaligned state of the U.S. health care system has become a catalyst for payment and delivery system reforms. Traditional fee-for-service (FFS) payment structures incentivize high volume rather than high quality care, and lead to the suboptimal provision of medical services across the disjointed provider landscape. Despite various attempts to improve care delivery, health care costs continue to rise. The Accountable Care Organization (ACO) model seeks to reverse these trends by promoting a simultaneous restructure of the payment and delivery systems to incentivize higher quality, lower cost care.

This paper provides an overview of the accountable care movement; describes the structural classification of ACOs and various accountable care payment contracts; and provides a high-level trend analysis of where the ACO movement is heading.

ORIGINS OF THE ACO MOVEMENT

The goal to improve the patient care experience, improve the health of populations, and reduce the per capita costs of health care is a major driving force for health system delivery and payment reforms.

ACOs accept financial accountability for the health care needs of a population.

Previous attempts to reform care delivery have seen mixed success. The Health Maintenance Organizations (HMOs) of the late 1980s and 1990s were originally enacted as an FFS alternative. The HMO “managed care” approach brought a wide range of health care services into a single organization, with the idea to coordinate care as

well as reduce costs by offering lower premiums to patients who stayed within an HMO network.¹ Despite widespread adoption and some success at reducing costs, HMOs failed to create lasting delivery system reform. Under the pressure of financial risk, many organizations reduced patient access to certain services, resulting in consumer backlash. As a result, many of

the managed care systems floundered and only a few successful organizations maintain that model today. The unintended consequences of managed care expose the difficulty associated with reforming payment and delivery systems in tandem. The HMO era also revealed that health information technology was inadequate to help providers manage patient populations.

The Medicare Physician Group Practice Demonstration (PGP) pilot program was the Centers for Medicare & Medicaid Services’ (CMS) first attempt at moving risk directly toward providers while using traditional FFS billing, and is the forerunner to the ACO model.² From 2005 to 2010, the PGP created incentives for 10 provider groups to coordinate care administered to Medicare FFS beneficiaries. Providers were awarded bonus payments for improving cost efficiency and for their performance on 32 care quality measures, similar to the model currently ascribed ACOs. Some PGP organizations achieved both cost and quality success,² but results were mixed.

The most recent reform attempt to achieve the triple aim is the accountable care model. The term “Accountable Care Organization” was originally coined by Dr. Elliott Fisher during a 2006 public meeting with the Medicare Payment Advisory Committee (MedPAC).³ Dr. Fisher and others argued that in order to significantly improve quality and costs, accountability for a patient’s care should be shared among all providers along the health care continuum.^{4,5} By moving away from strict FFS payment arrangements toward more accountable, value-based reimbursements, providers can be incentivized to more efficiently improve the cost and quality of care. Realizing that reform through accountable care was inevitable, providers and payers began to develop commercial ACOs.

In December 2008, the Congressional Budget Office (CBO) included the idea of bonus-eligible organizations (BEOs), based on ACO principles, in their budget options book.⁶ Following modestly favorable scoring by the CBO, the ACO model was included in the Medicare program by section 3022 of the Patient Protection and Affordable Care Act (ACA) of 2010. ACOs have since become a leading payment and

delivery reform model at CMS, as they embody the tenets of the triple aim, an aspiration promoted by then Acting Administrator Don Berwick, that the U.S. health care system should be structured to improve the patient care experience, improve the health of populations, and reduce the per capita costs of health care.⁷

Medicare launched the Pioneer ACO program in January 2012 and the Medicare Shared Savings Program (MSSP) in April 2012. The current ACO market is comprised of both commercial and public ACOs, and continues to grow as more provider groups ascribe to value-based, accountable care.⁸

WHAT IS AN ACO?

Many definitions describe accountable care as a provider-led model that emphasizes cost and quality outcomes.⁹ At an organizational level, entities pursuing accountable care adopt financial accountability for the health care needs of a population, and manage the care of that population across the health care continuum. ACOs also coordinate care among providers and utilize emerging health information technology to improve cost and quality. However, accountable care can be simplified to an outcome-driven delivery and payment system reform effort that emphasizes improved outcomes and reduced costs.

A more comprehensive definition based on literature reviews, organizational analysis and interviews with ACOs and ACO-type entities has expanded the accountable care definition to include three necessary components: 1) goals to reduce costs and improve health care quality, 2) process-level mechanisms to help achieve desired outcomes, and 3) a structural realignment to enable process-level change.¹⁰ The last two components for a successful ACO model, process mechanisms and structural realignment, are essential to achieving the first component, the goal to improve costs, patient experience and population health outcomes. In order to achieve accountable care, providers must apply each of these concepts to their organization practice.

Structural Alignment

An effective way to drive behavioral change is to create incentives. Within the ACO model, providers change behavior based on the acknowledgment that they are responsible for cost and quality outcomes of a population. Financial responsibility of a patient population incentivizes providers to change care practices to promote wellness, and thus maximizes the opportunity of achieving reduced costs and improved care quality.¹⁰

In accountable care, providers enter into a contractual obligation or other risk-based agreement with an insurer to take on financial risk associated with the care and outcomes of a defined patient population. While the amount of risk can range from mere incentive payments to upside-only bonus agreements and to even more comprehensive bundling and full capitation contracts, ultimately, an ACO's financial structure encourages the provision of lower cost, higher quality care.¹¹

Two common approaches for promoting financial accountability are either a shared savings or a partial or full capitation agreement. In a shared savings model, ACOs are rewarded for spending below projected costs by sharing in a portion of the savings earned. ACOs may also participate in shared risk, wherein they take on financial penalties for spending above projections. Generally, shared savings contracts begin with one-side-only risk and gradually move toward two-sided risk as entities gain more experience in accountable care. Capitation models differ in that the organization bears full upside and downside risk for spending below or above a negotiated capitation rate.

Together, the providers manage the provision of the entirety of care provided to a population of patients and are thus able to promote better overall health outcomes.

Most Medicare ACOs to date have only assumed one-sided financial risk, without taking the opportunity to transition into a two-sided risk model. Some Pioneer ACOs have moved to population-based, partially capitated payments. However, the private sector has generally offered a broader range of ACO payment models.

Accountable care contracts also associate financial accountability with the attainment of or improvement on a predefined set of care quality measures. Both government and commercial payment arrangements include quality measures as a factor in their financial agreements.

Process-Level Care Management

Refining care delivery also requires behavioral change, particularly by the providers who are actually delivering care. To modify the care delivery process to be more patient-centric, ACOs redirect their care management mechanisms to: 1) oversee the clinical provision of care, 2) coordinate that care across the health services spectrum, and 3) effectively manage population health by implementing appropriate health information technology (HIT).¹⁰

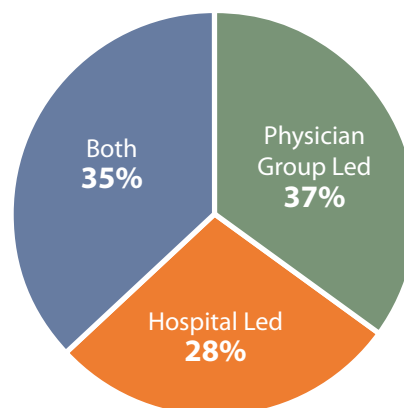
Care coordination allows providers to assist patients in health management by directing them to appropriate care settings along the continuum of care. Together, the providers manage the provision of the entirety of care provided to a population of patients and are thus able to promote better overall health outcomes. As care coordination requires that entities have the ability to identify the care needs of individuals, track the care received and not received by patients, and prepare for future risks, ACOs often invest in health information technology such as electronic medical records, health information exchanges and patient management software.¹⁰

TYPES OF ACOS

Though accountable care entities have similar objectives, there is considerable variation across the market in terms of ACO organizational structure, ownership, and patient care focus. Not only can the ACO landscape be broken down into government and commercial-sponsored organizations, but it can also be classified by provider-types, ranging from small provider groups to large, multi-state integrated delivery systems. Well-capitalized health systems with control over much of the care spectrum were the early adopters of the ACO model. However, growth of physician-sponsored programs has begun to outpace hospital-sponsored ACOs (see Figure 1).

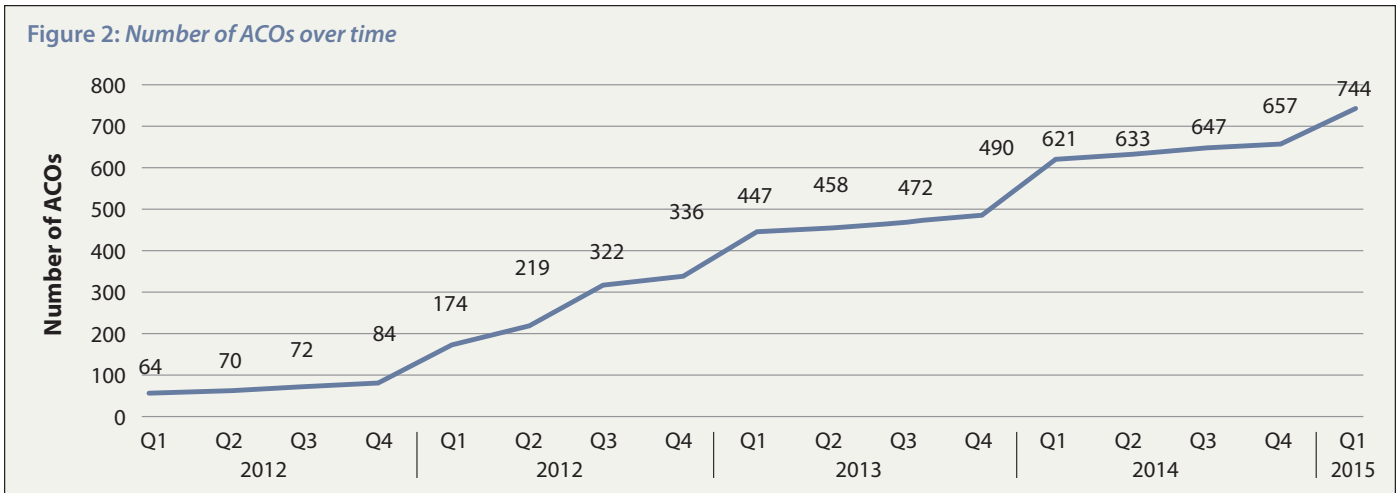
ACOs can be further classified into six categories based on the number and leadership structure of parties involved in the ACO, the services provided directly by the ACO, and the services provided through contracted entities (see Table 1).¹² ACOs can range from an “Independent Physician Group” that only directly provides outpatient care, to a larger, “Full-Spectrum Integrated” ACO that directly provides all core medical services, from ambulatory to inpatient and to post-acute settings.¹² Using this taxonomy to identify different ACO types can help providers learn from like-entities by distinguishing structural commonalities between different organizations, and by highlighting common approaches to managing patient care. Further research using this taxonomy can also help ACOs and researchers alike better understand performance to date of these different accountable care arrangements and the factors most critical for success.

Figure 1: Percent of ACOs by Provider Type



Source: Leavitt Partners, 2015.

Figure 2: Number of ACOs over time



Source: Leavitt Partners, 2015.

Table 1: ACO Taxonomy

ACO Type	Description
Independent Physician Group	A single organization that directly provides outpatient care.
Physician Group Alliance	Multiple organizations that directly provide outpatient care.
Expanded Physician Group	Directly provides outpatient care and contracts for inpatient care.
Independent Hospital	A single organization that directly provides inpatient care.
Hospital Alliance	Multiple organizations with at least one that directly provides inpatient care.
Full-Spectrum Integrated	All services provided directly by the ACO. May include one or multiple organizations.

TYPES OF ACO CONTRACTS

While the types of organizations that are entering into accountable care are numerous, accountable care entities may also enter into a variety of payment contracts. A common approach to discussing ACO contracts is by classifying them by payer. CMS, through Medicare, state Medicaid agencies and commercial payers represent the major payer participants involved in accountable care.

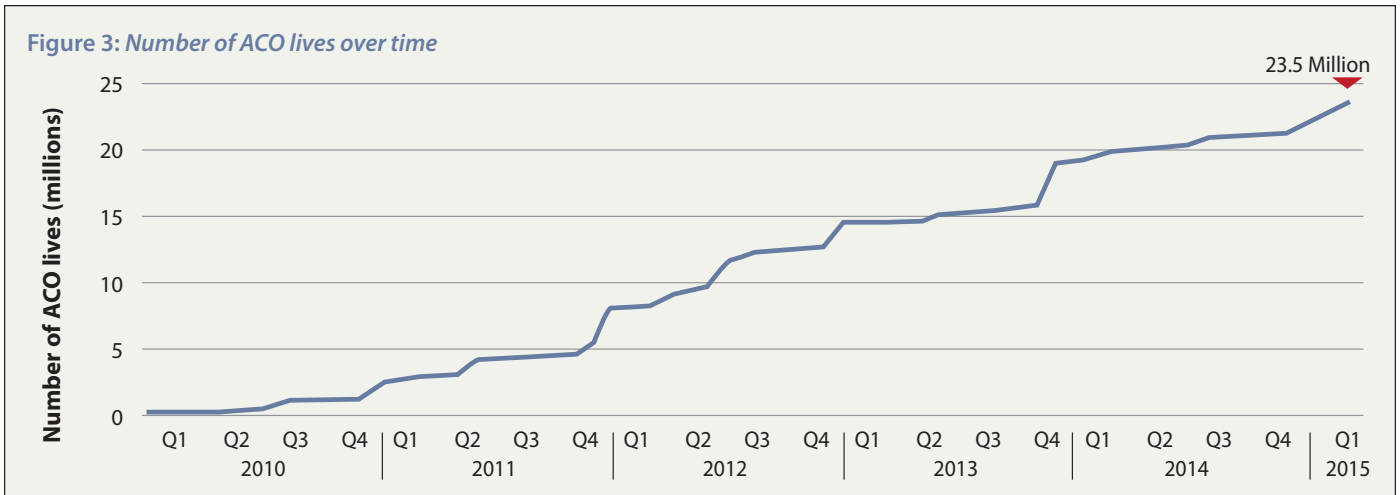
CMS: Pioneer, MSSP, and Advanced Payment ACOs

Medicare currently houses the first government-sponsored ACO initiatives, the Pioneer program, which commenced in January 2012, and the Medicare Shared Savings Program, which began in April 2012.

The original 32 Pioneer ACOs were selected to participate based on prior population health management and risk-bearing experience, and thus have become a testing ground for accountable care policies.¹³ The MSSP initiative is less stringent than the Pioneer program, and is intended for any organization wishing to pursue accountable care.¹⁴ As an open-enrollment program, the MSSP currently has 404 participating ACOs, with 89 new organizations announced to begin in 2015. There are currently 19 Pioneer ACOs; nearly a third of these organizations have left the program as a result of dissatisfaction with program requirements and less favorable results than expected. Medicare ACOs collectively serve 7.8 million beneficiaries. Both Pioneer and MSSP ACO models are based on a shared savings payment policy, though Pioneer contracts have higher levels of risk sharing, and all CMS ACOs are paid based on performance on 33 clinical care quality measures.¹⁶ The Advance Payment ACO Model is an initiative for rural providers participating in the MSSP that may not have the proper capital up-front to invest in care coordination infrastructure. The 35 Advance Payment ACOs receive additional up-front and monthly payments from CMS determined by their historically assigned beneficiaries and based on their expected shared savings.¹⁷ HHS has recently announced a new program called the Next Generation ACO Model which will allow providers to accept full risk for the patients they serve.¹⁸

* On October 31, CMS finalized changes to the quality measures used for the MSSP. In the proposed rule, the total number of measures was to be raised to 37, but the number will stay constant at 33. However, eight of the measures will be modified or replaced. ACOs will only be evaluated on reporting the new measures for the first two years.¹⁵

Figure 3: Number of ACO lives over time



Source: Leavitt Partners, 2015.

Medicaid ACOs

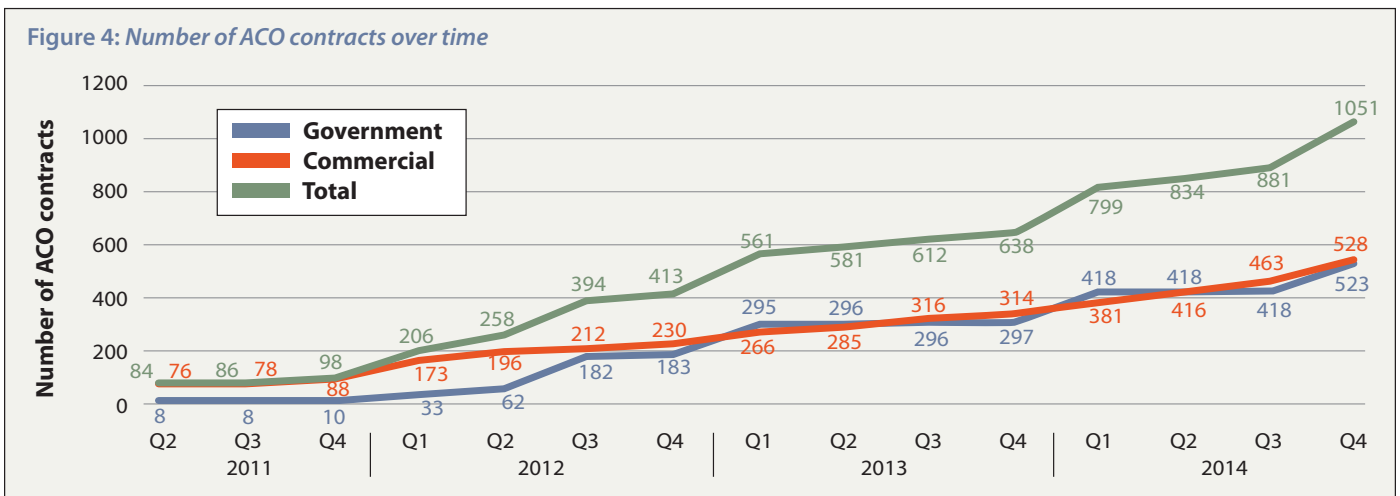
While Medicare ACOs ascribe to detailed payment and performance structures outlined by CMS, Medicaid ACOs are implemented by states and thus vary on a state-by-state basis.¹⁹ Current Medicaid ACO models include Colorado, Utah, Oregon, New Jersey, Arkansas, Maine, Iowa, Minnesota, Vermont and Illinois, although Massachusetts, Missouri, Alabama, Ohio, New York, and Washington have also announced emerging ACO-like programs or pilot programs.²⁰ Because each program is implemented by the state, Medicaid ACOs comprise a variety of payment structures. For instance, Colorado’s Accountable Care Collaborative (ACC) is based on an FFS payment structure but providers receive additional reimbursement for coordinating patient services. Utah’s Medicaid ACO program is

instead administered with capitated payments. Implementation of Medicaid expansion may induce more states to create Medicaid ACOs. As state-based organizations, the growth in Medicaid ACOs will have a large impact on the number of ACO-covered lives.

Commercial ACOs

Comprising the first wave of ACO activity, commercial ACO contracts are the most diverse. Without the restraints of CMS program structures, commercial ACOs are generally not held to the same financial requirements, quality metrics or reporting timeline as Medicare ACOs. While government contracts still make up the highest number of ACOs, the rate of growth for commercial contracts is increasing and already covers more individual beneficiaries than CMS programs.⁸

Figure 4: Number of ACO contracts over time



Source: Leavitt Partners, 2015.

Currently, the largest commercial payers are Cigna, Aetna and Anthem, though many other commercial payers are beginning to add more ACO contracts as the model proliferates. UnitedHealthcare and Humana are among the payers that are beginning to contract multiple accountable care payment arrangements across the country. As Medicare ACOs improve care coordination strategies, some have opted to adopt a commercial contract in tandem with a government contract, and vice versa. ACOs adding multiple types of accountable care payment arrangements are contributing to the growth and significance of the ACO movement.

CURRENT TRENDS

The success of the accountable care model can be assessed by analyzing the growth of the movement, and the quality and financial results of current ACOs. Although the accountable care model is relatively nascent, continued growth and moderate financial and quality successes suggest the potential for accountable care to fundamentally modify the United States' health care delivery system.

Growth

Since 2010, the size of the ACO market has steadily increased, not only in total number of accountable care entities, but also in covered accountable care lives and total number of ACO contracts (see figures 2-4).⁸ Though the rate of growth has slowed in recent years, the continual pervasion of ACOs into the health care market represents, at least in the short-term, a substantial movement toward delivery and payment system reform.

As of January 2015, there are approximately 744 accountable care entities, 404 of which have government contracts, 217 have commercial contracts, and 103 have both commercial and government contracts.⁸ The remaining 20 ACOs have not specified the details of their accountable care contracts. In aggregate, these ACOs cover over 20 million lives as a part of their accountable care payment arrangements.⁸

Early drivers of the growth of the movement can be attributed to a combination of conscientious acknowledgment of the need to improve care delivery and a desire to seek first-mover advantage in new types of contracts. Some commercial initiatives moved toward accountable care because they believe it represents a better care delivery process. Others sought to prepare for inevitable future risk-bearing. Many early adopters have also indicated that the prospect of increasing market share and maintaining a competitive edge was a strategic incentive for pursuing the accountable care model. As the MSSP has recently announced that 89 more ACOs will become a part of the market in 2015,²¹ these tenets for initial accountable care adoption still resonate with providers today.

Quality and Financial Results

Further growth of the accountable care movement, however, is dependent on the success of current ACOs. CMS has recently released first-year financial and quality results for the MSSP ACOs as well as preliminary second-year data for Pioneer ACOs.²² Some commercial ACOs have also released quality and financial results, though such data is more difficult to compare due to inconsistencies in payment arrangement types and quality metrics.

As of November 2014, Medicare ACOs in both the Pioneer and MSSP initiatives have together generated \$877 million in savings, \$460 million of which has been returned to the ACOs as part of their shared savings contract.²³ While the cost savings are generally positive, savings are inconsistent among participants.²⁴ A recently released CMS report indicates that only 22 percent of MSSP ACOs qualified for shared savings payments in year one of the program.²⁵ Thus, the amount of savings generated through Medicare ACOs has only been realized for a minority of participating organizations; a majority of Medicare ACOs have either shared in losses or have neither shared in savings nor losses.²⁰

While savings generation is varied, overall, Medicare ACOs continue to improve on quality scores year over year, and have maintained a higher average performance than other Medicare FFS providers on corresponding measures.²⁶ Committed to the same 33 quality measures, Pioneer ACOs improved on 28 measures from year one to year two of program participation while MSSP ACOs improved on 30 measures from their benchmark year and first performance year results.¹⁷ As hospital readmissions is an obvious cost-saver, Medicare ACOs as a group performed highest on reducing readmissions.²⁷

Analysis by both the Brookings Institution and Leavitt Partners indicate that while the majority of ACOs are able to realize quality improvements, reducing costs is more difficult.^{27, 28} Furthermore, there is little correlation between shared savings and quality improvement in both the Pioneer and MSSP programs. In MSSP performance year one for instance, ACO-improved quality and earned-shared savings were minimally correlated.²⁷

Overall, ACOs are more likely to see quality improvements than generate shared savings in their first years of ACO participation. As entities gain more experience in accountable care, they will be more likely to earn shared savings in the long term.

CONCLUSION

In less than five years, accountable care has transformed from an academic idea to a tangible model that has been implemented across the nation. Accountable care represents a fundamental restructuring of the fragmented U.S. health care delivery system to promote the triple aim of improved patient care experiences, outcomes, and clinical costs of care. By realigning financial structures and redirecting care delivery process mechanisms to be more patient-centered, accountable care organizations give providers more accountability in the care of their patients, with the ultimate goal of promoting whole population wellness by addressing individual needs.

Both commercial and public ACOs have seen success at reducing costs and improving quality, which will encourage more ACOs to enter the market in the near future. New proposals to amend the Medicare ACO program and sustained market growth indicate that the ACO will continue to exist as a viable payment model. The number of ACOs is projected to grow in the coming years. The success of these ACOs and their ability to move the health care system to one that is more keenly focused on value-based care will depend on understanding the markers for success to date and continuing to develop innovative models that focus on improved quality and reduced costs.

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The Impact of Accountable Care

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Origins and Future of Accountable Care Organizations

Part 2:

Physician Participation in Accountable Care Organizations

Part 3:

Hospital Involvement with Accountable Care Organizations

Part 4:

Health Insurers and the Accountable Care Movement

Part 5:

Employer Perspectives on Accountable Care

Part 6:

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