

Accountable Care Organizations in Medicare and the Private Sector: A Status Update

Timely Analysis of Immediate Health Policy Issues

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Why Is Everyone Talking About ACOs?

Many health care providers, policy-makers, and analysts complain about the incentives inherent in the current fee-for-service payment approach, which rewards providers financially for prescribing as many services as possible while driving up health care costs for patients. For many, the holy grail of health policy-making has been to find a model that aligns health care providers' and patients' interests. In the 1980s and '90s, some thought that health maintenance organizations (HMOs) might be such a model, but patients, encouraged by their physicians, eventually objected to HMOs' perceived intrusion into patient care decisions, causing HMOs to back off from some of their earlier approaches and to now fade from prominence.

Two decades later, the next great hope of many has become accountable care organizations (ACOs). Although known primarily as a Medicare program authorized in the Affordable Care Act (ACA), ACO-style payment arrangements have already been adopted by private insurers, even before the Centers for Medicare & Medicaid Services (CMS) issued its final regulations for the program on October 20, 2011.¹ CMS' final regulations for the Medicare Shared Savings Program (MSSP), as it is called, respond to many concerns raised by providers in response to the agency's proposed regulations published in March 2011.²

At the time, many providers that were preparing to become ACOs were dismayed when CMS chose to lay out a program that was more stringent and less generous than CMS' ACO precursor experiment, called the Physician Group Practice Demonstration (PGP demo), which ran from April 2005 through March 2010.³ Shortly after the release of CMS' proposed rules, many prominent health care systems announced that they would not participate in the program being proposed.⁴ (For more details, see "CMS Responds to Provider Concerns about the Medicare Shared Savings Program" later in this paper.)

Having received more than 1,300 comment letters, some with stinging criticism of its proposed regulations, CMS regrouped and made numerous changes in response. Some provider groups and their advisors lauded CMS for "br[inging] ACOs back to life."⁵ With the revised regulation, prospects have increased for a broad test of the ACO concept in Medicare—and with other payers as well.

ACOs consist of networks of providers that are rewarded financially if they can slow the growth in their patients' health care spending while maintaining or improving the quality of the care they deliver. An important difference between HMOs and ACOs is that providers themselves, rather than an often distant insurance company, control the diagnosis and treatment decisions, but exercise this

control under new payment incentives that encourage greater prudence in the use of health services. Furthermore, as with current fee-for-service systems of care, patients retain the freedom to seek additional services from any clinician or facility at any time. And to prevent providers from inappropriately limiting patients' access to services in order to save money, the ACO is monitored through its performance on a suite of quality measures designed to ensure that it is providing recommended services and high-quality care. Performance on these measures also determines providers' financial bonuses. ("What Makes the ACO Concept New?" below describes other features of ACOs.)

This paper provides an overview of ACOs, their origins, and the current status of adoption of this model by both Medicare and private health insurance plans.

When the ACA established the MSSP, ACOs made the leap from being a conceptual idea⁶ tested in only one demonstration⁷ to forming the basis of a national effort poised to transform the way care is delivered.⁸ Beginning in January 2012, CMS will begin accepting applications from providers that are interested in forming ACOs and working to lower their patients' health spending enough to earn annual bonus payments.

Since Medicare is the largest health plan in the United States, this new approach is likely to affect how other

health plans pay providers. Already, many private health insurance plans have entered into contracts with groups of health care providers to serve as ACOs for their plans' privately insured enrollees.⁹ Some HMOs, especially those in California, have been way ahead of fee-for-service Medicare in delegating traditional insurance company functions to provider organizations, and doing so by providing financial rewards for more prudent spending and penalties for overspending. But Medicare's ACO approach may influence many more health plans because it provides a model for an intermediary form of delivery: putting providers in a position somewhere between being paid solely through volume-increasing fee-for-service payments and operating within tightly managed, prospectively defined capitated budgets that place providers at full financial risk for all spending for their enrolled populations.

CMS' new Center for Medicare and Medicaid Innovation, which was also created by the ACA, is testing alternative ACO models in addition to the MSSP.¹⁰ In May 2011, the Innovation Center announced that it will test a new "Pioneer ACO" model, targeted to organizations that already have a track record of managing financial risk and developing systems for being accountable for quality-related performance. Providers interested in being Pioneer ACOs submitted proposals in August, which the Innovation Center has now reviewed; announcements of which applicants will be selected for this experiment are expected shortly. This demonstration program will allow ACOs to earn higher shared savings bonus payments than under the MSSP, but will also put them at risk of paying back higher amounts to CMS if they increase spending above projections. And in the third and final year of the Pioneer ACO experiment, ACOs that meet a specified level of savings will be eligible to move a substantial por-

tion of their payments to a population-based model in which they would receive a dollar amount per beneficiary per month—true capitation—instead of continuing to layer ACO bonus payments on top of traditional fee-for-service reimbursement.¹¹

The Innovation Center will also allow some ACOs participating in the MSSP, including small physician practices and rural community hospitals, to take out loans from CMS to pay for infrastructure investments, such as purchasing electronic health records and hiring nurse care managers.¹² These loans would be deducted from any future shared savings payments the ACO might qualify for from CMS. The Innovation Center is also trying to encourage the development of ACOs through free conferences for executives on core ACO competencies, such as improving care delivery, effectively using health information technology and data, and building capacity to assume and manage financial risk.¹³

Where Did the ACO Concept Come From?

The ACO model has several antecedents. In 2000, Congress passed a law directing CMS to test a model now widely considered to be the ACO model when it authorized the PGP demo.¹⁴ Participating physician groups in the demo were eligible to keep a portion of the savings they generated for Medicare, relative to a projected spending target, and could increase their share of savings depending on how well they improved performance on a set of 32 quality measures. This demonstration ran from April 2005 through March 2010, and involved nine multispecialty group practices and one physician-hospital organization. (For more on this demo, see "Will ACOs Save Money?")¹⁵

The ACO concept also bears resemblance to "provider-sponsored organi-

zations" (PSOs) established in Medicare in the Balanced Budget Act of 1997. In both PSOs and ACOs, CMS contracts directly with providers, not insurers, to take financial responsibility for their patients' health care and essentially function as a health plan. However, to date, only three PSOs have ever been created.¹⁶ ACOs may be less intimidating to set up than PSOs because they do not require providers to immediately abandon fee-for-service reimbursement for fully capitated payments and do not restrict patient choice, and so are less likely to involve the complex insurance-like regulations that contributed to the lack of provider interest in the PSO option.

Dartmouth researcher Elliott Fisher deserves credit for stimulating broad policy interest in the ACO approach by introducing the concept of an "extended hospital medical staff" at a 2006 meeting of the Medicare Payment Advisory Commission (MedPAC).¹⁷ Fisher presented findings showing that Medicare beneficiaries received most of their care from relatively stable sets of local physicians and hospitals; he argued that these providers could be grouped together to form "virtual organizations" that could be held accountable for the cost and quality of the full continuum of care delivered to these patients. In the course of discussion, MedPAC Chair Glenn Hackbarth referred to Fisher's model as an "accountable organization." Fisher apparently liked the term; he adopted it when he published his proposed "accountable care organization" model in *Health Affairs* shortly thereafter.¹⁸ His and others' ACO models have since evolved to require actual organizations, rather than virtual organizations, but the term has stuck.

What Makes the ACO Concept New?

Although private health insurers are now pursuing ACO contracts with

providers, the term ACO was initially developed in the context of Medicare. The new MSSP explicitly relies on ACOs, which CMS has defined as organizations of providers that accept accountability for a population of Medicare beneficiaries, coordinate all of the services received across the care continuum, and encourage investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. Yet this operational definition does not emphasize what makes ACOs different from well-established provider organizations that private health insurance plans (including Medicare Advantage plans) regularly contract with, including multispecialty group practices and independent practice associations (IPAs), using prospective, per-capita payments rather than fee-for-service reimbursement.

The three major characteristics that differentiate ACOs from existing health plan and provider arrangements in various parts of the country — whether they are operating under contracts with private health insurers and/or public payers like Medicare—are the presence of the following central features:

1. **Shared Savings.** In current ACO arrangements, providers generally receive bonuses if their patients' health care costs are below a projected amount based on their own historic spending, regardless of whether the level of their historic spending is high or low. The size of these bonuses depends, in part, on how much savings the ACO produces. Both the MSSP and private ACO contracts have been layering these bonus payments on top of traditional fee-for-service reimbursement, rather than making the leap to capitation (pre-paid fees paid per patient, see glossary for complete definition).
2. **Accountability for Quality.** The ACO's performance on numerous quality metrics is also central to determining whether the ACO is eligible for shared savings and, if so, the amount of shared savings it receives from the sponsoring payer.
3. **Free Choice of Providers by Patients.** Patients assigned to an ACO are still free to continue to seek care from any other provider that accepts their insurance. In short, there is no enrollment and

patients are not “locked in” to seeing particular providers within a designated provider network.

Do ACOs Exist in the Private Sector?

Although CMS has only recently issued final regulations laying out its ACO program for Medicare, private health insurers have already begun to enter into ACO contracts with provider groups.¹⁹ These private ACO contracts are giving patients added incentives to seek care within their plan's provider network, such as by offering reduced premiums for individuals who receive care from providers taking part in such arrangements.²⁰ By contrast, Medicare has so far chosen not to offer such financial incentives to Medicare beneficiaries to stay within their ACO's provider network.

At least eight private health insurance plans have entered into ACO contracts with providers using a *shared risk* payment model, making providers eligible for both bonuses and financial penalties.²¹ Many more (27, by one count) have entered into *shared savings* contracts, which make providers eligible for bonuses, but do not put them at financial risk if they exceed spending

Glossary: Provider Payment Approaches

Fee-for-service – When health insurance plans or payers pay providers a fee for each service performed.

Capitation – A specific per-capita dollar amount paid per patient per month (or per year) to providers, in return for providing whatever quantity of services is needed to meet the health needs of a defined patient population.

Partial capitation – The combination of payment of a preset, prepaid capitated amount and payment based on actual use of services. The term also has been used to characterize two other payment models, which may cause some confusion: (1) providers can accept full financial risk on a limited set of services (i.e., professional services but not institutional services), or (2) providers can accept partial financial risk for all services.

Shared savings – When at least part of a provider's income is dependent on the financial performance of a larger organization (such as a provider organization or a health insurance plan), and the larger entity generates fewer costs than projected in a given time period, providers share in some of these savings. This is also known as “one-sided risk,” although providers actually risk nothing financially.

Shared risk – When financial liabilities are shared among entities. For example, in the MSSP, if an ACO's patients' health care spending is higher than a projected spending amount, the ACO agrees to pay back CMS for a portion of those excess costs. This is also known as “two-sided risk,” since providers are both eligible for bonuses and liable for penalties.

Source: Adapted from Delaware Healthcare Association, “Delaware Healthcare Association Glossary of Health Care Terms and Acronyms,”

(www.deha.org/Glossary/GlossaryS.htm#Top).

targets.²² (See glossary for a description of these and other key terms.)

The private ACO contracts that have been identified so far use shared savings, shared risk, or partial capitation; none have moved all the way to full capitation yet.²³ Meanwhile, CMS is experimenting with all three payment approaches. Its MSSP offers two payment options to ACOs: a shared savings (bonus-only) model and a shared risk model. CMS' Pioneer ACO model starts off as a shared risk model and transitions to a true partial capitation model in the third year.

The private ACO contracts using shared risk include several Blue Cross Blue Shield plans in different states (e.g., Illinois, Massachusetts, New Jersey, North Carolina), Aetna, and Anthem/WellPoint. Some of these insurance companies have taken the unusual step of entering into five-year contracts with their ACO providers;

most other insurers are using shorter periods. Several private ACO contracts are offering providers 50 percent of the savings they generate (the same level of savings offered in the bonus-only option of the MSSP), and intend to transition their private ACO contracts to some form of capitation in coming years, as in the Pioneer ACO model being pursued by CMS' Innovation Center.

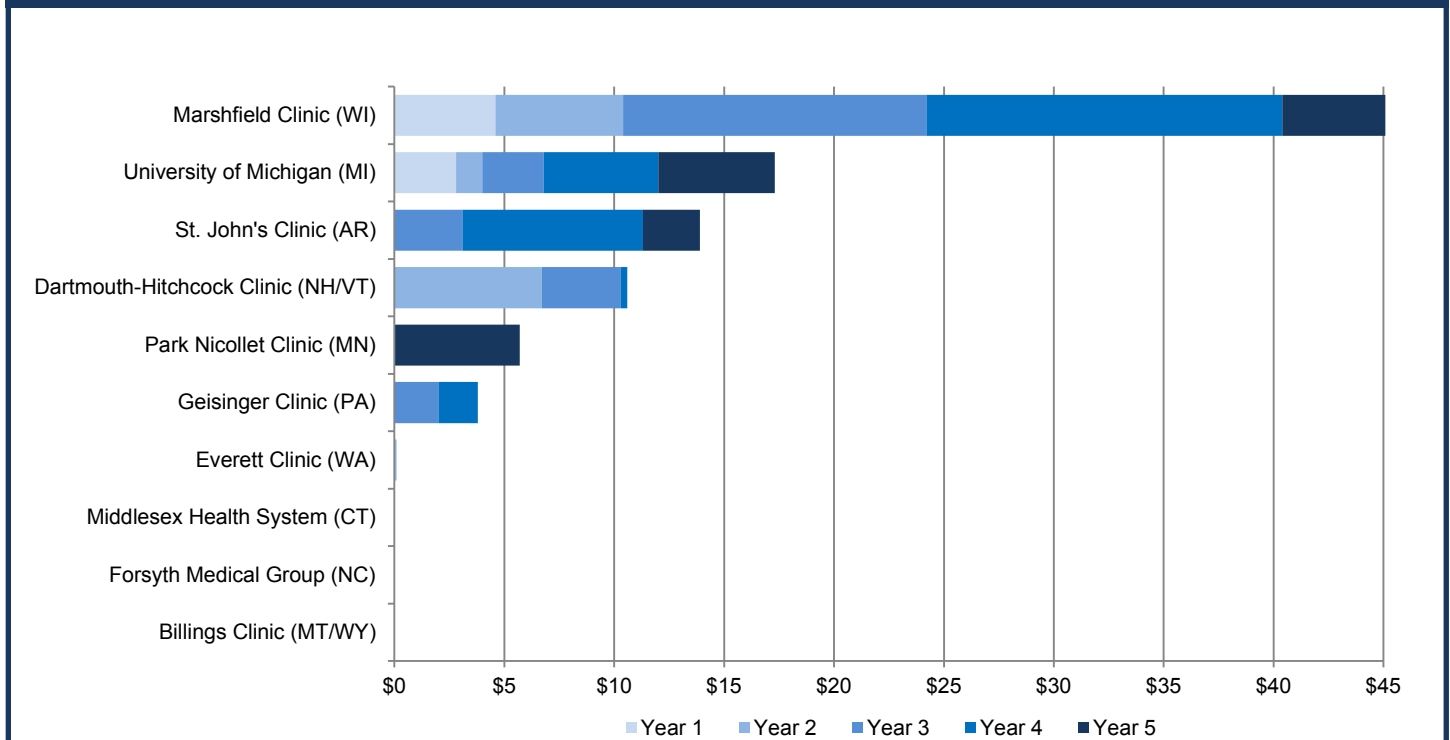
Some health plan representatives and providers question whether full capitation is compatible with the ACO philosophy of allowing patients easy access to providers outside of their provider network; they suggest that full capitation may put providers at too much financial risk with too little control over where patients seek care. In addition, ACOs' relative lack of control over patient choices may make partial capitation more appealing.

Although health care organizations are only beginning to enter into contracts with private insurers to act as ACOs, dozens of major health systems and provider groups have joined learning collaboratives convened by the Premier healthcare alliance and by the Brookings Institution and Dartmouth College to explore what it might take to become an ACO.²⁴ In addition, the National Committee for Quality Assurance has issued proposed ACO capabilities, which will form the basis of a voluntary ACO accreditation program in the fall of 2011.²⁵

Will ACOs Save Money?

The results of the only demonstration that directly tested the ACO concept—CMS' PGP demo—suggest that ACOs will be able to improve the quality of care they deliver (at least as measured by process-oriented clinical quality measures), but will have a harder time generating savings.²⁶

Shared Savings Earned in the PGP Demo (an ACO Precursor) (in millions of dollars)



Source: RTI International, "Physician Group Practice Demonstration: Performance Year 1 - Preliminary Performance Year 5 Summary Results," (www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Summary_Results.pdf).

The PGP demo's independent evaluator has called the savings from the program "small."²⁷ How small? As shown in the previous table, annual shared savings payments to the large medical groups participating in the demo averaged \$5.4 million (among the participants who earned any bonus at all), and ranged from a few hundred thousand dollars to \$16 million for the demo's biggest winner, the Marshfield Clinic. Only two participants lowered health spending enough to receive bonuses in all five years of the demo, and three of the 10 participants received no bonus in any year of the demo.

Another analysis estimated that if new ACOs in the MSSP end up making the same average initial investment that PGP demo participants did—\$1.7 million in their first year—they will need to turn a 20 percent profit to break even over their first three-year ACO contract with Medicare. Given how unrealistic 20 percent operating margins are, these analysts concluded that most organizations will lose money in the first three years under the ACO model.²⁸ Of course, just because ACOs may not turn a profit during their initial three-year contract with Medicare does not mean they would fail to turn a profit during subsequent three-year ACO contracts under the MSSP.

In addition to producing meager savings for participating providers, Medicare also accrued relatively modest savings from the PGP demo. On net, the demonstration—which covered 220,000 Medicare beneficiaries in a select group of large group practices judged by CMS as having the necessary experience, infrastructure, and financial strength to succeed²⁹—saved the Medicare program only \$26.6 million³⁰, or approximately \$121 per beneficiary over five years. Even more disappointing, CMS' independent evaluator questioned whether demo participants generated savings by actu-

ally reducing spending or by merely raising the spending targets they had to work within by more thoroughly recording patients' diagnoses. (Under the risk-adjustment model CMS uses, spending and spending targets are adjusted based on patients' diagnoses.) CMS' evaluator noted in the second-year evaluation that if the illness severity of demo participants' patient panels had increased at the same rate as other providers in the same geographic areas, only one participant would have qualified for a bonus payment, instead of four.³¹

The bottom line is that the PGP demo does not seem to have succeeded in meaningfully reducing spending growth. However, it should not be surprising that the demo did not cause providers to dramatically alter the way they deliver care to achieve large reductions in health care spending. After all, the current fee-for-service payment system penalizes providers for doing what was asked in this demo: namely, to reduce the volume of services providers deliver through better care coordination and greater attention to evidence of what actually benefits patients. Given the initial three-year limit on CMS' commitment to the payment approach used in this demo, it might have been foolhardy for participants to overhaul their business model, including reducing their revenues from hospital admissions, for a temporary pilot being offered by only one payer—even one as important as Medicare.³² In contrast, although MSSP contracts will initially extend only three to four years, ACOs that meet performance standards will be able to renew these contracts, since this is now a fully operational, permanent program, not a one-time demonstration.

The PGP demo has also been criticized for not including strong enough financial incentives to change provider behavior. Some policy analysts and MedPAC have argued that a way

to strengthen incentives is to offer providers the option of taking on financial risk, giving them a more compelling business case for changing the way they deliver care.³³ CMS is now implementing several payment approaches—including offering either shared savings (bonus-only) or shared risk in the MSSP, and shared risk with a transition to partial capitation in the Pioneer ACO demonstration—which should eventually permit an assessment of which payment models are best able to achieve the desired reorientation of clinical practice to improve value for patients and taxpayers.

Will ACOs Improve Health Care Quality for Patients?

A primary objective of the MSSP is to improve the quality of care that providers deliver, and evidence from the PGP demo suggests ACOs will be able to do this. The 10 physician organizations in the demo were able to meet performance benchmarks for the vast majority of the quality measures they were held to, which grew from 10 diabetes measures in the first year to 32 measures covering diabetes, coronary artery disease, congestive heart failure, hypertension, and cancer screening by the fifth year of the demo.

The underlying mechanism driving improvements in care quality in ACOs is the financial bonuses that ACOs can receive if they meet quality and cost benchmarks. This in turn gives providers an incentive to coordinate their patients' care to reduce duplication of services, invest in infrastructure like health information technology, redesign care processes, and practice with greater adherence to clinical evidence of what treatments work best.³⁴ Taken together, these activities may noticeably improve the quality of care received by Medicare beneficiaries—and private insurers' ACO efforts have a similar potential to enhance care for their patients.

CMS Responds to Provider Concerns About the Medicare Shared Savings Program

CMS' proposed rule for the MSSP aroused many concerns among would-be ACOs.¹ Here's a look at some of providers' key complaints, and how CMS addressed them in its final regulations:

Downside risk. The proposed rule would have required ACOs to pay CMS back for a share of their overspending if they exceeded their spending targets (beginning in either in year one or three, depending on which of two payment tracks they chose). Some argued that the ACA did not intend for all Medicare ACOs to be required to bear such financial risk and that the requirement would narrow the pool of potential MSSP applicants.

In the final rule, CMS gives ACOs the option of a bonus-only payment track for their first Medicare ACO contract, although a risk-sharing option is also still offered as an alternative payment track. Subsequent three-year Medicare ACO contracts will require all ACOs to take on financial risk.

Not enough upside. If spending for an ACO's assigned patients is less than what Medicare would have otherwise spent, ACOs get to keep a share of these savings. But in CMS' proposed rule, ACOs would have only been allowed to keep 52.5 percent or 65 percent of these savings, depending on which of the two payment tracks they selected, compared to 80 percent in the PGP demo.² Providers saw this share of savings as not high enough to justify the substantial upfront investments needed to set up an ACO and the requirement that they take on financial risk. The total savings an ACO could earn was capped at 7.5 percent or 10 percent of their Medicare spending, respectively. Further, ACOs in the bonus-only payment track could only keep a share of their savings that exceeded a "minimum savings rate," set at 2 percent to 3.9 percent of their spending target, depending on the size of the ACO's patient panel. Meanwhile, ACOs in the other payment track would have to pass a minimum savings rate threshold of 2 percent before they would be eligible for savings or losses, but could then keep their share of all savings earned—not just the savings above their minimum savings rate (called "first-dollar" sharing). The purpose of having a minimum savings rate is to protect CMS from paying bonuses to ACOs for random, statistical fluctuations in their year-to-year spending levels that might have occurred unrelated to their own activities. Many providers thought the combination of financial risk, minimum savings rates, caps on upside potential savings, and the sharing percentage provided too little potential gains for the financial commitments involved with participation.

CMS' final rule maintains the minimum savings rate thresholds, but now allows ACOs in both payment tracks to retain "first-dollar" savings once their minimum savings rate is met. CMS has also raised the cap on the total savings an ACO can earn, to 10 percent or 15 percent of their overall spending target, but marginally lowered the share of savings that ACOs can keep to 50 percent or 60 percent (depending on which of the two payment tracks the ACO selects).

All-or-nothing quality thresholds for payment, and too many quality measures. CMS had initially proposed assessing ACOs on 65 quality measures, some of which were composite measures made up of several measures. Relatively few of these measures would have been generated using already-submitted claims data; others would have required ACOs to collect new data, often through labor-intensive chart review. Performance on these measures would be used to calculate the size of ACOs' shared savings bonus payments, using an all-or-nothing approach: if for any single quality measure, an ACO didn't meet the minimum performance level (i.e., performing at the 30th percentile or doing something 30 percent of the time, depending on the measure), they would be ineligible for any bonus payments.

In the final rule, CMS cut the number of quality measures it will use in half, to only 33—but many of these measures will still require ACOs to collect new data through medical record review. Also, the approach for determining if ACOs qualify for bonus payments has been relaxed: ACOs can now earn bonus payments if they meet minimum performance targets for 70 percent of the quality measures in each of four domains—a more achievable goal.

Retrospective assignment of patients. To determine which patients an ACO should be held accountable for, CMS proposed identifying beneficiaries that received primary care services from an ACO's primary care physicians at the end of the year, after care had been delivered. But providers prefer to know who they are responsible for at the beginning of the year, to clarify both ACOs' and patients' roles and responsibilities. To facilitate this, CMS would have given providers lists at the beginning of their three-year ACO contracts naming the beneficiaries they were likely to be held accountable for, based on which providers these patients had received primary care from in the past.

CMS has stuck with its approach of prospectively identifying beneficiaries that an ACO is likely to be held accountable for, and then retrospectively assigning them at the end of the year to assess ACOs' actual performance—but it is now calling this approach "preliminary prospective assignment." CMS has made an important change in committing to increase how often it gives ACOs lists of patients they are likely to be held accountable for; that will now be done quarterly, instead of once at the beginning of the ACO's contract.

Not counting specialists' patients in ACOs. To emphasize the crucial role of primary care to the ACO concept, CMS had proposed counting only primary care physicians' patients, not specialists', when determining which patients an ACO is responsible for—even if a specialist provides the plurality of visits a beneficiary receives. This would have prevented the sickest, most expensive patients from benefiting from ACOs' enhanced care coordination, since patients with chronic conditions are often cared for by specialists.³

CMS will now allow some specialists' patients to be included in ACOs, if they are receiving primary care services exclusively from them and not a primary care physician—meaning patients making many visits to specialists and a single one to a primary care physician will be assigned based on that single visit. CMS will also count patients who receive primary care services exclusively from physician assistants, nurse practitioners, and clinical nurse specialists, which should make it easier for ACOs to form in rural areas where physicians are sometimes in short supply.

Unrealistic assumption of stable provider networks. CMS had proposed prohibiting ACOs from adding new provider organizations during their three-year contracts with Medicare, but would have allowed ACOs to add individual physicians working in already-included provider organizations. This would have favored organizations with employed physicians, such as hospitals and large multispecialty group practices, while

constraining associations of separate physician practices such as IPAs.

CMS will now allow both provider organizations and individual clinicians to be added or removed at any time during an ACO's Medicare contract, as long as they notify CMS.

Requires ambitious adoption of EHRs. CMS had proposed requiring 50 percent of an ACO's primary care physicians to be meaningful users of electronic health records by the start of the second year of their Medicare ACO contract—a high bar, when only 10 percent of office-based physicians currently use such advanced software.⁴

CMS is no longer requiring this 50 percent threshold, but is basing bonus payments in part on the percentage of an ACO's primary care physicians that are meaningful users of EHRs.

¹ Meyer, 2011.

² Sebelius, 2009.

³ Longworth DL. "Accountable Care Organizations, the Patient-centered Medical Home, and Health Care Reform: What Does It All Mean?" *Cleveland Clinic Journal of Medicine*, 78(9): 571–582, 2011.

⁴ Hsiao C, Hing E, Socey TC, et al. "Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians: United States, 2009 and Preliminary 2010 State Estimates." U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, 2010, www.cdc.gov/nchs/data/hestat/emr_ehr_09/emr_ehr_09.pdf (accessed October 2011).

More explicit ACO requirements that could lead to improved quality of care include CMS' decision to have ACOs submit written plans explaining how they will promote beneficiary engagement, coordinate care, promote evidence-based medicine, and measure quality. ACOs will also have to include a Medicare beneficiary on their governing board or provide an alternative means of assuring meaningful opportunity for beneficiaries to participate in ACO governance.

Although ACOs have great potential to benefit patients through improved care quality and patient-centeredness, the ACO model's incentive to lower health care spending could lead providers to stint on needed care to save money. However, the backlash against HMOs in the 1990s appears to be causing both public and private plans to build in protections and mechanisms to prevent stinting—not only because withholding needed care is ethically wrong, but because ACOs could fail if patients do not perceive

direct benefits of participating in the program. Health economist Stuart Altman has noted that "[t]he great managed care environment of the 1990s fell apart to a large extent over the fact that the consumer, the patient, felt used."³⁵ To ensure that ACOs do not inappropriately avoid beneficiaries likely to need a lot of services, CMS will monitor ACOs and end their participation in the program if they avoid at-risk beneficiaries who are likely to generate high costs.

Will Quality Measures Protect Patients Against Harm?

ACO proponents think that publicly available quality measures can go a long way towards protecting patients against the kind of stinting on care that patients perceived HMOs as engaging in during the 1990s.

In the MSSP, CMS will monitor ACOs through their reporting on 33 quality measures. ACOs that do not perform at

the 30th percentile or percent (depending on the measure) on at least 70 percent of the measures in each of four domains would not be eligible to share in any savings they generate, and would have one year to improve performance before being terminated from the program. ACOs would be eligible for higher shares of savings if they perform at higher percentiles on these measures.

The measure set proposed by CMS includes clinical process and patient experience-of-care measures, with a few outcome measures. These measures fall into four domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk population measures. There are no efficiency or resource use measures, presumably because the payment model itself provides incentives for ACOs to be cost-conscious.

It is unclear whether quality measures currently are up to one of the tasks assigned them, that is, to ensure that cost savings will not be achieved by

stinting on care. Although the selected quality measures address some areas that have not been given sufficient attention in current volume-based payment systems, such as care coordination and care of at-risk populations, they do not cover the full range of areas that an organization responsible for the entire continuum of care for a population of Medicare beneficiaries should address; for example, appropriate referral to specialized centers outside the ACO, when specialized expertise is needed to treat particular forms of cancer.

As noted earlier, CMS will be requiring ACOs to describe in their applications how they will ensure the delivery of evidence-based medicine, patient engagement in care, care coordination, and quality measurement. Monitoring whether ACOs actually engage in the activities they describe could be used to address quality issues not easily amenable to quality measurement. For example, if an ACO commits to producing referral guidelines that would inform clinicians of the specific conditions that are appropriate to refer to specialized centers of excellence, CMS could monitor the ACO to see whether the guidelines were generated and whether providers are using them.

Will Patients Get to Choose Whether to Participate in an ACO?

In the MSSP, beneficiaries will retain the freedom to seek care from any health care providers they choose. But if a beneficiary obtains the plurality of their primary care from a provider who belongs to an ACO, that beneficiary's total health care spending, along with care quality metrics, will be measured and used to assess whether their provider's ACO is eligible for shared savings bonus payments. ACOs will be sent lists of beneficiaries they are likely to be held accountable for under CMS' assignment algorithm on

a quarterly basis. Then, at the end of the year, CMS will calculate ACOs' shared savings bonus payments based on a re-assessment of where those beneficiaries actually ended up receiving a plurality of their primary care services. CMS calls this approach "preliminary prospective assignment." Beneficiaries cannot opt out of having their data used to measure the performance of their provider's ACO, but they will have the opportunity to decline to allow their clinical information to be shared with the ACO to which they are likely to be assigned, for privacy reasons.

For their part, private ACO contracts suggest that there is not yet a consensus on the best way to attribute patients to an ACO. Some of Aetna's ACO contracts use prospective patient attribution, and others use retrospective attribution. Blue Cross Blue Shield of Illinois uses an approach that it calls "prospective based on retrospective utilization," and Anthem / WellPoint uses a similar hybrid approach. Meanwhile, Blue Cross Blue Shield of Massachusetts uses prospective attribution, while Horizon Blue Cross Blue Shield of New Jersey and Medica Health Plan in Minnesota both use retrospective attribution.³⁶ Within a few years, health plans and provider organizations should have learned some useful lessons about the pros and cons of these different patient attribution approaches.

Will ACOs Address Health Disparities?

Although ACOs will focus on improving adherence to evidence-based medicine in order to improve providers' performance on clinical quality measures, it is unclear whether this focus will ameliorate or exacerbate current health disparities among racial and socioeconomic subgroups. On the one hand, racial minorities may benefit from ACOs' increased attention to

ensuring that patients remain in good health, which could "raise all boats" and thus shrink the current disparities in the receipt of high-quality care among these subgroups.³⁷ On the other hand, ACOs may end up forming in areas that have more resources available to devote to the infrastructure investments necessary to get an ACO up and running—for example, in areas where a higher proportion of the population has private insurance and providers are therefore reimbursed at more generous reimbursement levels. This could lead to an inadvertent exacerbation of health disparities, if racial subgroups are left behind as other populations are targeted by ACOs.

CMS' Medicare ACO regulations include some provisions designed to encourage ACOs to form in areas likely to have fewer resources and lower-income patients. For example, under the final regulations for the MSSP, federally qualified health centers (usually located in underserved areas), rural health centers, and critical access hospitals (located in remote areas) are all allowed to form ACOs.³⁸ The ultimate impact of these provisions, and ACOs more generally, on health disparities remains to be seen.

Will Provider Consolidation into ACOs Raise Prices for Private Insurers?

ACOs are designed to reduce fragmentation and poor coordination between different providers, which could lead to lower health care utilization, but they could also produce higher prices as hospitals and physicians consolidate and become more powerful negotiators.³⁹ This could worsen existing problems: studies exploring why U.S. health care spending far exceeds that of other countries have already found that substantially higher prices—and not the overuse of services such as doctor visits and hospitalizations—is a leading cause of our higher spending.⁴⁰

Because of the concern that newly formed ACOs could use their new-found market power to demand and receive higher payment rates from private insurers, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) issued a proposed statement earlier this spring offering guidance about ACO configurations—in terms of size and provider composition—that are safe from antitrust scrutiny, those that might be problematic, and those that are unacceptable.⁴¹ The proposed statement also called for a mandatory antitrust review for ACOs that met certain thresholds for provider concentration, i.e., if two or more providers participating in an ACO provide a common service to patients from the same Primary Service Area and have a combined market share of 50 percent or more.

The objective of these provisions is to permit ACO configurations that are large enough to truly become accountable for the quality and cost of large populations, but not large enough to be able to demand and receive high prices from private health plans because of their market dominance. The ACO antitrust guidance provides protections against ACOs amassing market power by limiting an ACO's permitted share of providers who would otherwise be competing in its market area.⁴²

Many would-be ACOs opposed mandatory review of ACOs for various reasons, including the argument that it would be bad public policy to change the nature of antitrust enforcement from law enforcement to administration of a regulatory regime. In the final rule, CMS no longer will require receipt of a letter from a reviewing antitrust agency (i.e., DOJ or FTC) confirming that it has no present intent to challenge an ACO on antitrust grounds, but CMS still recommends that prospective ACOs seek a voluntary review by an antitrust agency.

As suggested in comments submit-

ted to CMS, a different antitrust enforcement approach would focus on an ACO's actions, not its size and configuration. One such performance metric that could be used is per capita costs for non-Medicare patients served by a Medicare ACO. If CMS measured ACOs against norms of private per capita health spending, raising prices for private insurers would be self-defeating for ACOs. Some private health plans are already collecting data on costs generated per patient as part of their private ACO contracts with providers, which suggests that reporting this data to CMS might not be administratively burdensome.⁴³ Although it might seem a stretch for CMS to consider the ACO's performance in caring for non-Medicare patients as a major determinant of its participation in a program specific to Medicare beneficiaries, CMS' final rule notes that it has requested that the antitrust agencies conduct a study examining what impact ACOs participating in the MSSP have on the quality and price of health care in private markets. This leaves open the possibility that CMS could change the eligibility criteria for Medicare ACOs in the future to more explicitly consider impact on market competition, using such performance measures.

How Fast Will ACOs Spread?

CMS estimates that the MSSP will generate net savings of up to \$940 million over its first four years, assuming that 50 to 270 ACOs sign up to participate. According to the American Medical Group Association, more than 100 of its member medical groups are well positioned to become ACOs,⁴⁴ and many other providers are likely to be interested in exploring the ACO concept. So far, the reception to CMS' final regulations has been positive. But how many organizations actually apply to CMS to be ACOs is another question.

It remains unsettled whether the primary purpose of the MSSP and companion Pioneer ACO model should be to test the ACO concept to see if it is broadly scalable to diverse providers, whether or not it generates substantial early savings to the government, or whether the goal of the program should be to move as many providers as possible into the program as soon as possible to satisfy political pressures to slow the growth in Medicare spending.⁴⁵

In its final regulations, CMS seems to be adopting the former viewpoint. MedPAC has sided with this view; it has stated to CMS that “it would be a mistake to assess the success of the shared savings program by counting how many ACOs participate in the initial agreement period.”⁴⁶

In the view of Jay Crosson, former executive director of Kaiser Permanente's physician component, the ACO concept is “too vitally important to fail.” He argues that the likely alternative for providers if ACOs do not take root could be blunt, across-the-board cuts to payment rates.⁴⁷ By the end of 2012, we should know how successful CMS' program was in attracting provider interest in the ACO model in Medicare, and how extensively the private sector plans to experiment with this payment model. Within a few years after that, we should have a much stronger evidence base about how to improve quality and reduce costs using ACO-style payment arrangements, given the experiments that Medicare and private sector providers and payers are currently embarking on.

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Notes

¹ Centers for Medicare & Medicaid Services, “42 CFR Part 425, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations,” www.ofr.gov/OFRUpload/OFRData/2011-27461_PI.pdf (accessed October 2011).

² 42 CFR 425, 76 Fed. Reg. 19528 (Apr. 7, 2011). For a summary, see: Federal agencies released several accompanying public statements and notices: (1) a joint proposed statement from the Department of Justice and the Federal Trade Commission on how ACOs can avoid triggering antitrust concerns; (2) a joint notice from CMS and the HHS Office of the Inspector General proposing waiving certain federal laws for ACOs (specifically, the physician self-referral law, the antikickback statute, and the civil monetary penalty law); and (3) an IRS notice soliciting comments on whether nonprofit organizations thinking of forming ACOs need additional guidance on how to do so while maintaining their nonprofit status. (See: Office of the Inspector General. “Accountable Care Organizations,” <http://oig.hhs.gov/compliance/accountable-care-organizations/index.asp>.) In addition, CMS issued a Request for Information in November 2010, which solicited public comments on a variety of issues related to program design (See: CMS. “Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program.” *Federal Register*, 75(221): 70165–66, 2010, www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28996.pdf).

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⁸ U.S. Congress. *Patient Protection and Affordable Care Act*, H.R. 3590. Public Law 111–148. 111th Cong. (March 23, 2010). See Sec. 3022 and Sec. 10307. Note that the version of the health reform bill originally passed by the House in November 2009 used a more cautious approach, directing CMS to

first test ACOs as a Medicare pilot before rolling them out as a permanent program. That bill also authorized ACO pilots in the Medicaid program.

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¹⁰ U.S. Congress. *Patient Protection and Affordable Care Act*, H.R. 3590. Public Law 111–148. 111th Cong., (March 23, 2010). See Sec. 3021 and Sec. 10306.

¹¹ Centers for Medicare & Medicaid Services. “Pioneer Accountable Care Organization (ACO) Model Request for Application,” www.innovations.cms.gov/wp-content/uploads/2011/05/Pioneer-ACO-RFA.pdf (accessed October 2011).

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¹⁶ Devers K and Berenson R. “Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?” Washington: The Urban Institute, October 2009, www.rwjf.org/files/research/acobrieffinal.pdf (accessed October 2011).

¹⁷ Medicare Payment Advisory Commission. (Public meeting transcript, Washington, November 8, 2006.), www.medpac.gov/transcripts/1108_1109_medpac_final.pdf (accessed October 2011).

¹⁸ Fisher, Staiger, Bynum, et al. 2007.

¹⁹ Private-sector ACO contracts differ from Medicare ACO contracts in that private ACO arrangements are typically being implemented in preferred provider organizations (PPOs), which by definition already provide a financial incentive for patients to seek care from a certain network of providers by requiring patients to pay a higher co-pay if they seek care outside of the PPO network. By contrast, nearly all physicians accept Medicare, meaning that fee-for-service Medicare beneficiaries are not charged higher co-pays when they go out of network since there is effectively no such thing as an out-of-network provider in Medicare.

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⁴¹ U.S. Department of Justice and Federal Trade Commission Antitrust Division. “Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program.” *Federal Register*, 76(75): 21894–21902, 2011.

⁴² The DOJ/FTC proposed statement assumes that CMS’ proposed ACO eligibility criteria are consistent with the indicia of “clinical integration” that the agencies have previously set forth for guidance on whether to assess collaborative efforts among otherwise independent providers according to more lenient “rule of reason” analysis rather than strict “per se” treatment. That guidance adopts the position

that “clinical integration” designed to improve quality and efficiency may outweigh the concern that the collaboration will permit the providers to exercise their enhanced market power to raise prices to health plans. Under a “rule of reason” approach, the antitrust enforcement agencies can review particular circumstances to decide whether the objectives of the clinical integration are supported by actual behavior of the collaborating entity, usually an IPA.

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⁴⁴ Crosson FJ. “The Accountable Care Organization: Whatever Its Growing Pains, the Concept Is Too Vitaly Important to Fail.” *Health Affairs*, 30(7): 1250–1255, 2011.

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