

In the Spotlight: Accountable Care Organizations In Full Swing

As access to coverage has expanded through the Affordable Care Act (ACA), consumers that previously avoided care are increasingly using the health care system to treat their conditions. While in many ways this is a positive trend that may improve health outcomes, it also calls into question the expense of increased health service use. Accountable Care Organization (ACO) programs are one of the few program types intended to address the cost of care in the ACA. Early in ACA implementation, the Center for Medicare and Medicaid Services (CMS) established the [Medicare Shared Savings Program](#) (MSSP) and [Pioneer ACO program](#) to test the effects of joint payer and provider responsibility for a patient population on the total cost of care and quality for that population. Since these programs were established, the federal government has expanded the two core models by adding the [ACO Investment model](#), [Advance Payment ACO model](#) and [Next Generation ACO model](#). In this *In the Spotlight*, we will review the components, successes and challenges of these ACO programs as a means to reduce the cost of health care.

Medicare ACOs: An Overview

ACOs are provider-led organizations that may include physician group practices, networks of individual practices, and hospitals, who all work together to coordinate and manage the care of a patient population. To participate in one of the various ACO programs with Medicare, ACOs sign a contract with the federal government to take financial and clinical responsibility for a defined population of Medicare patients. To meet program goals, the government provides data to ACO providers about their patient population, including where they go for care and clinical information. ACOs are expected to analyze the data to influence care delivery and improve health outcomes. ACOs are also expected to manage patients' medical expenses by coordinating service use across different providers and encouraging use of low cost settings for care, where appropriate.

The federal government uses payment incentives to shift responsibility for patients to ACO providers. While individual claims incurred by the ACOs' patients are often still paid per-service¹, ACOs may be eligible for additional payments. Notably, if an ACO demonstrates that it saved money for its patient population while improving quality on defined Medicare metrics, then it is eligible to share in those savings with the federal government. In some models, savings are paid in advance. Savings are determined by comparing the total cost for each patient to a benchmark. The percentage of savings that the ACO is eligible for depends on the program (and the "Track" they choose in the Medicare Shared Savings Program). Many programs also put ACOs at risk to repay the government if their patient population is *more* expensive than the benchmark. In theory, if the ACO is effectively coordinating and managing the care of its population, expensive or excessive service use or low quality care would be avoided and ACOs could avoid repaying any funds.

¹ ACOs in the Next Generation ACO pilot may opt for flat monthly payments for its patient population, from which the ACO would be responsible for directly paying claims. Source: <https://innovation.cms.gov/Files/fact-sheet/nextgenaco-comparefactsheet.pdf>.

Medicare ACO Model Overview

Program Name	Description and Program Goals	Shared Savings/Losses
Medicare Shared Savings Program (est. 2012)	<ul style="list-style-type: none"> Goals: Test use of shared savings to incentivize ACOs to offer better care and offer better care coordination so that government sees lower health care costs. Providers in ACO receive fee-for-service payments for services. Total costs for a defined population are added over the year and compared to a benchmark to determine savings or losses. ACOs in the new Track 3 may also access a waiver for 3-day hospital stay requirements and the government is considering flexibility on telehealth restrictions for these ACOs. 	<p>ACOs may be eligible to receive % of savings or losses incurred for the defined population based on the "Track" they enter in contract. The "Track" that an ACO enters equates with the level of risk the ACO is responsible for. The greater the Track number, the greater the risk on the ACO:</p> <ul style="list-style-type: none"> Track 1: ACOs may receive up to 50% Shared savings only (<i>drops to 40% if ACO continues Track 1 for more than 1 contract term</i>) Track 2: Available to more experienced ACOs. ACOs may receive or be responsible for up to 60% shared savings and losses. (Future)Track 3: Available to more experienced ACOs. ACOs may receive or be responsible for up to 75% shared savings and losses.
Pioneer ACO Program (est. 2012)	<ul style="list-style-type: none"> Goals: Test risk sharing incentives for experienced ACOs to determine whether ACOs can provide better care coordination, improve outcomes and lower costs. Original contract period from 2012-2014, allows for optional years through 2016. No certainty of whether model will be continued. 	<p>Offers five payment arrangements, which share savings and losses of up to 60-75%. Originally created to complement MSSP by offering greater risk sharing between ACO and government.</p>
Advance Payment ACOs (MSSP Pilot, est. 2012)	<ul style="list-style-type: none"> Goals: Adding new ACOs to MSSP to make program more appealing, and to generate savings to Medicare more quickly. Type of MSSP in which ACOs receives payments from government before it begins patient care. 	<p>ACOs receive three types of payments:</p> <ul style="list-style-type: none"> Upfront, fixed payment Upfront, variable payment based on number of enrollees Monthly payments varying by size of ACO <p><i>If ACO does not earn sufficient savings to cover costs of advance payments, government will recoup this amount</i></p>
ACO Investment Model (MSSP Pilot, est. 2015)	<ul style="list-style-type: none"> Goals: Test use of prepaid shared savings in rural and underserved areas and encourage MSSP ACOs to transition to greater financial risk. Will use a two-pronged approach to make MSSP payments more appealing to ACOs depending on how long ACO has contracted with the government. 	<ul style="list-style-type: none"> ACOs that began in 2012-2014 receive three types of payments like those described in Advance Payment ACOs ACOs beginning 2015 or later receive two types of payment: <ul style="list-style-type: none"> Upfront, variable payment based on number of enrollees Monthly payments varying by size of ACO <p><i>If ACO does not earn sufficient savings to cover costs of advance payments, government will recoup this amount</i></p>
Next Generation ACO Program (Pilot, exp. 2016)	<ul style="list-style-type: none"> Goals: Test whether even stronger financial incentives, patient engagement and care management tools can improve health outcomes and lower expenses in ACOs. 	<p>Offers the option of two risk arrangements:</p> <ul style="list-style-type: none"> Risk Arrangement A offers shared savings and losses of up to 80% Risk Arrangement B offers shared savings and losses

- Allows ACOs to contract with government for different payment types to care for the population, ranging from fee-for-service to full capitation.

of up to 100%. First dollar shared savings and losses.

Early Successes and Challenges

During the first two performance years, Pioneer ACOs are reported to have saved \$384 million.² According to a performance evaluation of the first two years of implementation, savings were increasingly concentrated among a small number of ACOs. In year 1, three ACOs accounted for 27% of savings, and in year 2, three ACOs accounted for 70% of savings. However, roughly one-third of the ACOs demonstrated statistically significant savings both performance years.³ The report credited much of the ACO's medical expense savings in Pioneer ACO program to keeping patients from being admitted to the hospital for acute care. Quality performance showed Pioneer ACOs improved in a number of measures over market trends. These metrics include hospital admissions for certain disease types, and physician follow-up post-hospital discharge. Due to savings realized and quality improvements, the federal government approved an [expansion of the Pioneer ACO program](#) in April 2015.

The Medicare Shared Savings Program is reported to have experienced some cost savings as well. According to an August 2015 [government announcement](#), total net savings in 2014 performance of MSSP was \$465 million and improved on 27 of 33 required quality metrics based on ACOs that reported quality in 2013 and 2014. The results were not based on uniform savings by all participating ACOs; of the (over 100) ACOs that began in 2012, CMS reports that 37% generated shared savings, while 19% of the (over 120) ACOs beginning in 2014 achieved savings.

Despite the apparent success of these programs, many challenges and limitations surround the government's ACO programs and ACOs generally as a means to realize sustainable cost savings:

1. Initial participants in the ACO programs were likely among the most integrated health systems in the nation, so activities like data-driven care coordination were already performed by these provider groups. Providers' capacity to perform effective care coordination and analytics varies significantly nationwide, and may require significant investment to improve smaller providers' capacity to make ACOs successful.
2. The ACOs' ability to achieve savings or responsibility for losses is based on how the government calculates its benchmark payment. Scholars have reported limitations with the government's methodology for calculating its benchmarks, as benchmarks should take into account regional cost and quality variation among other factors.⁴
3. Another fundamental concern is whether an ACO is best equipped to control care and take responsibility for a defined patient population. Since many of the ACO programs allow members to see any participating Medicare provider, ACOs may not have sufficient ability to control where consumers go for care. On the other hand, ACOs could take a very active role to refer patients within the ACO, which may drive further financial incentives for providers to consolidate.

² L&M Policy Research. "[Pioneer ACO Evaluation Findings from Performance Years One and Two](#)." March 2015.

³ L&M Policy Research. "[Pioneer ACO Evaluation Findings from Performance Years One and Two](#)." March 2015.

⁴ McClellan, Mark, et al. [Health Policy Issue Brief: How to Improve the Medicare Accountable Care Organization \(ACO\) Program](#). The Brookings Institution. June 2014.

BCBSNC Views

BCBSNC recognizes the need for flexibility so that all payers and providers may implement innovative payment mechanisms to address the ever-increasing cost of health care. BCBSNC commends the government for working with industry to develop payment best practices for alternative payment models through forums like CMS' [Health Care Payment Learning and Action Network](#). BCBSNC is taking action to change the paradigm on health care costs by implementing payment reform through a number of different programs, including ACO relationships across North Carolina. BCBSNC has seen early success with ACOs delivering better health outcomes and medical savings. At the same time, BCBSNC has learned that the change toward alternative care delivery and payment models is complex and will not be achieved overnight. BCBSNC also believes that ACOs are not the only solution to solving the health care system's cost problem. ACOs should be coupled with other actions by payers, providers and even consumers to more fully address the whole scope of the cost problem.

For More Information

Center for Medicare and Medicaid Innovation: Accountable Care Organization General Information:
<http://innovation.cms.gov/initiatives/aco/>

Kaiser Health News: Accountable Care Organizations, Explained: <http://khn.org/news/aco-accountable-care-organization-faq/>

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