

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

Timely Analysis of Immediate Health Policy Issues

November 2011

Robert A. Berenson, Rachel A. Burton

## 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. After the backlash against health maintenance organizations (HMOs) as the solution, 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. Generally, 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's the Status of ACO Implementation?

When the ACA established the Medicare Shared Savings Program (MSSP), ACOs made the leap from being a conceptual idea tested in only one demonstration to forming the basis of a national effort poised to transform the way care is delivered. 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.

CMS' final regulations for the MSSP respond to many concerns raised by providers in response to the agency's proposed regulations published in March 2011. 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. Shortly after the release of CMS' proposed rules, many prominent health care systems announced that they would not participate in the program being proposed.

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 of providers' specific complaints included CMS' proposal to:

- require ACOs to pay back CMS if the ACO ended up speeding the growth in their health care spending instead of slowing it down;
- tie bonuses to performance on a whopping 65 quality measures;
- identify the beneficiaries that ACOs would be held accountable for at the end of the year, after care had been delivered, instead of the beginning;
- not count specialists' patients in ACOs;
- prohibit ACOs from adding new provider organizations during their three-year contracts; and
- require 50 percent of an ACO's



primary care physicians to be meaningful users of electronic health records. (For a fuller discussion of the extent to which CMS addressed these issues in its final regulations, see the full-length version of this issue brief.)

Upon learning of the concessions CMS made in its final rules, some provider groups and their advisors lauded CMS for “bringing ACOs back to life.” With the revised regulation, prospects have increased for a broad test of the ACO concept in Medicare—and with other payers as well.

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. 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. It will also allow them to move a substantial portion of their payments to a partial capitation payment model, instead of continuing to layer ACO bonus payments on top of traditional fee-for-service reimbursement.

## 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. 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. 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 targets.

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.

## 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. 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 succeed—saved the Medicare program only \$26.6 million, or approximately \$121 per beneficiary over five years.

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 PGP 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. 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.

## Will Provider Consolidation into ACOs Raise Prices for Private Insurers?

Because of the concern that newly formed ACOs could use their newfound 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. 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. 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.

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. CMS' final rule notes 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. 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 into the program as soon as possible to satisfy political pressures to slow the growth in Medicare spending.

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."

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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## About the Authors and Acknowledgments

Robert A. Berenson, M.D., is an institute fellow and Rachel A. Burton, M.P.P., is a research associate at the Urban Institute. The authors thank Judy Feder and Kelly Devers for their helpful comments and suggestions. This research was funded by the Robert Wood Johnson Foundation.

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