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Accountable Care Organizations (ACO's): Still Evolving

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A New Business Model

In March of 2011, a key part of the new federal health-care law started taking shape as the government outlined rules in a 429 page proposal for how doctors, hospitals and other healthcare providers could organize into voluntary entities to better deliver healthcare while reducing Medicare costs and improving care.

These entities, known as Accountable Care Organizations (ACO's), would tightly coordinate care of Medicare patients across the continuum of care and benefit financially if their resultant costs were lower than expected. If patient costs were greater than anticipated, then the ACO would potentially be responsible.

ACO's were designed to change the incentives that influence how doctors and hospitals operate, in essence, a new business model for practicing medicine. Today, most hospitals and doctors get paid more by delivering higher volume, not necessarily better, health care that leads to over-utilization (the average senior on Medicare sees two physicians and five specialists; thirteen on average for those with chronic illnesses). ACO's will attempt to reward providers for holding down costs and meeting certain quality measures, such as reducing hospital readmissions or emergency room visits. ACO's will seek to replicate the models of care at the Mayo Clinic in Rochester, Minnesota and Geisinger Health System in Pennsylvania where hospitals and doctors coordinate their efforts within the same organization.

The Initial Proposal

Obama administration officials said better coordination of care could reduce medical mistakes and hospital re-admissions, and produce Medicare savings of as much as $960 million over three years. These savings are an important step as the first of the 77 million Baby Boomers turn 65 in 2011 and qualify for Medicare. Enrollment will grow from 48 million in 2010 to 64 million in 2020 and 81 million in 2030, according to Medicare actuaries (See Figure 1). That 33 million increase in the next 20 years compares with 13 million in the last 20. This demographic burst combined with rising health care costs has created an unfunded liability of ~$25 trillion over the lifetime of those now in the program as workers and as retirees. On its current trajectory, Medicare is expected to grow to 6.7% of GDP in 20 years from 3.7% today.

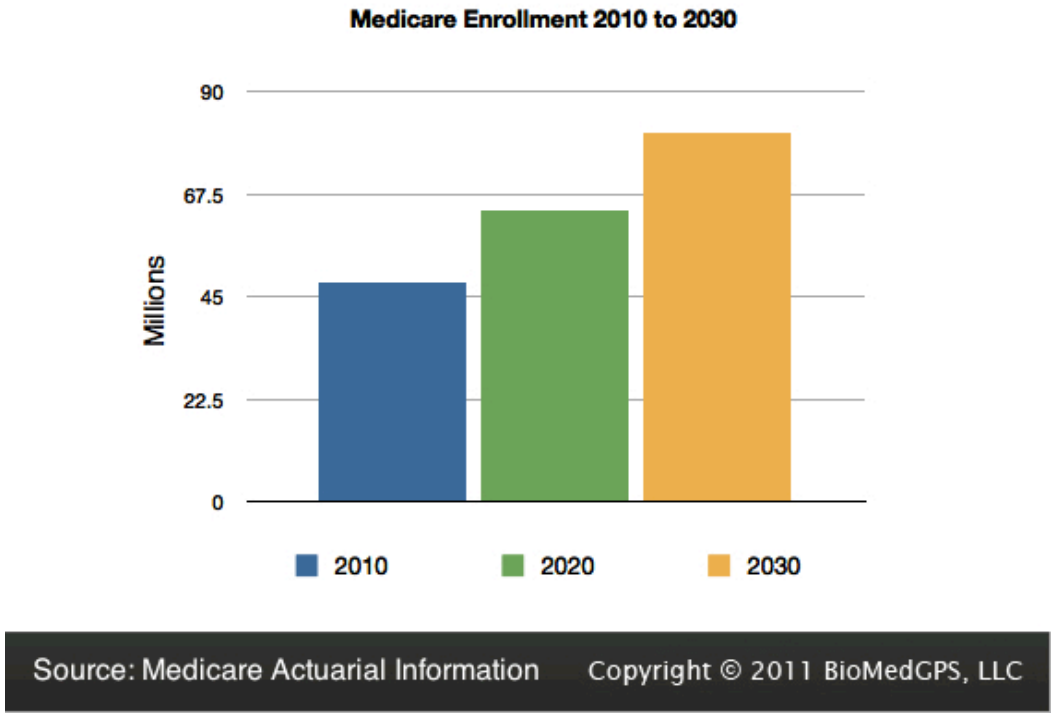

Figure 1: Medicare Enrollment 2010 to 2030

ACO's, expected to launch in January of 2012, are expected to involve partnerships among primary-care doctors, hospitals and specialists. The initial proposal suggested two ways for providers to be paid:

- Track 1: An ACO could receive bonuses for the first two years of a three-year contract if it meets quality measurements and saves money. In the third year, the ACO would share in the downside should their patients wind up costing more
- Track 2: Providers would be put at risk for losses in the beginning of a contract, in exchange for higher bonuses should they save money and improve care. This option was expected to be selected by sophisticated medical groups that already have systems in place to coordinate care.

Provider Push-Back

After reviewing and digesting the proposal, hospitals and doctors wasted little time in pushing back against the initiative. Health care providers said the rules were too onerous and the financial incentives too weak, and they threatened to participate only if the program underwent a major revamp. Hospitals and doctors complained that the regulations were overly prescriptive with detailed requirements such as 65 quality measures. They also felt that the ACO design could

mean steep start-up costs. The Centers for Medicare & Medicaid (CMS) estimated that average start-up and first-year operating costs at approximately $1.8 million per ACO. The American Hospital Association projected the cost to likely be more than two to three times higher – between $5.3 to $12 million – depending on hospital size. The Institute for Health Technology Transformation reported that it could cost $7.5 to $11.3 million for a 200-bed hospital or $1 to $11.7 million for a 200-physician practice, depending on variations due to technology usage. In addition, the hospitals and doctors said the proposed structure could make it difficult to achieve the programs objectives since an ACO would not know the identity of the beneficiaries until after they were enrolled. Finally, a requirement that 50% of primary care physicians were needed to demonstrate meaningful use of electronic health records by their second year was viewed as a sure way to curtail interest in the program.

In June, an ACO poll by KMPG and others confirmed that 39% of senior executives at hospitals, health systems and payer organizations didn't know what their organization's position was on shared savings participation and another 25% said they will watch-and-wait and not meet the January, 1, 2012 effective date as proposed by CMS. Fifteen percent expected to file later and only 17% said they would participate and meet the deadline.

The Pioneer ACO Model

Also in June, CMS clarified the Pioneer ACO Model. Separate from the Medicare Shared Savings Program, the CMS Innovation Center has offered the Pioneer ACO model for more experienced organizations and providers who already coordinate across multiple settings so they can reap the rewards earlier than Shared Savings participants. The goal is to test how experienced organizations coordinate care with private payers to improve outcomes of Medicare beneficiaries – those practices may later be included in the Shared Savings Program. CMS mentioned the potential benefits of participating in the Pioneer ACO model, including a longer three-year commitment period with the option to extend to five years and additional rewards – based on additional risk – as compared to the Shared Services Program. ACO's participating in the Pioneer Model can not participate later in the Shared Services Program. The CMS draft indicated that patient choice will likely remain intact for the ACO-aligned population. The draft further indicated that ACO's will likely be able to place caps on certain chronically ill patients. Finally, baseline expenditures will likely change with each performance year and be recalculated – and indication that CMS recognizes population changes from year to year.

Banner Health, Arizona's largest health system, could be the first ACO under the Pioneer ACO program. CMS confirmed acceptance of Banner's application as the first in the ACO experiment on a government level. Iowa Health System (IHS), a regional health system that includes eight hospitals and 450+ physicians, is a finalist in the Pioneer ACO program. The VP and Chief Medical Officer at IHS stated that "the biggest challenge (in creating an ACO) is to be staying ahead of the changes in the payment system. We live in a fee-for-service, volume-based system,

which is driving behaviors……we will be working with two systems until the whole healthcare system converts to value-based purchasing. It's a challenge to do the right thing and stay financially solvent until then".

Bundled Payments for Care Improvement Initiative

In August, the Department of Health and Human Services (HHS) announced that doctors, hospitals and other health care providers can apply to participate in a new pilot program known as Bundled Payments for Care Improvement Initiative. Made possible by the Affordable Care Act, it will align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for service separately. Bundled payments will provide doctors and hospitals with an additional incentive to coordinate and improve the quality of care and save money for Medicare. Over the past five years, more and more physicians have been employed directly by hospitals and bundled payments may support that trend.

Potential Barriers

Also in August, professors from Harvard and Berkeley voiced their skepticism of the touted cost benefits of ACO's and their formation. Harvard economists wrote that "the viability of ACO's will depend on the receptiveness of physicians to capitated payments — some specialists will see their incomes fall and are unlikely to take these cuts quietly. While their concerns may not resonate with patients, they might if providers claim that valuable care is being withheld. Designers of ACO's are thereby keenly interested in measuring ACO performance and patient satisfaction, but current quality measures only capture truly negligent care." Berkeley Law professors reported that "legal barriers could stall ACO formation and development, including self referrals, competition, and tax rules, particularly among safety-net providers".

Pilot Site Results

Despite the negativism, several ACO pilot sites (Monarch Healthcare in Irvine, CA; Healthcare Partners in Torrance, CA; Tucson Medical Center in AZ) confirmed that they were in the implementation stage. California, in particular, was proving to be a fertile area for the ACO experiment. The University of California San Francisco, two Catholic Healthcare West facilities, and California Pacific Medical Center were partnering with Blue Shield of California with savings and care goals as primary objectives. In a previous partnership between Blue Shield, Hill Physicians and Catholic Healthcare West, the care collaborative model produced $15.5 million in savings in 2010. In addition, the partnership resulted in a 15% decrease in length of stay. With aligned incentives, Blue Shield, Hill Physicians and Catholic Healthcare West sought long-term strategies aimed at improving quality and efficiency. The goal was to stabilize healthcare premiums, which are estimated to double in California in the coming years. Leaders from the hospitals admitted that the accountable care payment model required a cultural change away

from payment based on services and volume. Instead, alternative revenues need to come from cost savings and reduced waste.

In September, a survey of more than 200 provider organizations conducted by Beacon Partners confirmed that only 15% of hospital executives said they were "very familiar" with ACO's as proposed; 25% were "not familiar" with them at all. The survey also found that 48% don't know how an ACO will impact their organization, or whether it will improve patient care. However, despite the unfamiliarity, 92% of respondents already were in the planning/development phases of an ACO, with about 30% in the operational phase. The survey authors questioned whether the healthcare sector will be fully prepared for ACO reform in 2012.

ACO Policy

In early October, CMS sent the Medicare Shared Savings/Accountable Care Organizations final rule to the Office of Management and Budget — one of the last stops before publication in the Federal Register. The final rule was expected to include drastic changes based on the review of over 1,300 comments as well as significant backlash from professional physician organizations and leading hospitals.

In late October, the Obama administration publicly bowed to industry concerns and made it easier for doctors and hospitals to participate in the ACO program. The administration made several concessions to the health industry including:

- Providers will be able to participate in an ACO and share in savings with Medicare without the risk of losing money. ACO's will be able to start sharing in the savings earlier rather than letting Medicare retain all the monies initially
- The number of quality measures that ACO's will have to meet to qualify for performance bonuses was reduced from 65 to 33
- At formation, the ACO's will also be told which Medicare beneficiaries are likely to be a part of their system
- The use of electronic health records as a requirement of participation was eliminated community health centers and rural health clinics will be permitted to lead ACO's
- CMS relaxed the timetable for the launch of the ACO's with groups allowed to apply throughout 2012

To further entice members, CMS confirmed that it will provide physician-owned and rural providers early access to some of the expected savings – about $170 million – so they can use the monies to start ACO's.

In conjunction, the Justice Department and Federal Trade Commission released their final policy statement on ACO's and antitrust issues. The new policy eliminated the mandatory review for a new ACO. But CMS encouraged provider groups to voluntarily seek a Justice Department opinion. The policy also puts the responsibility for gathering market share data on the government versus the providers.

In addition, CMS released its 2012 applications for its Shared Savings Program. Interested ACO's were given the option of start dates on either April 1, 2012 or July 1, 2012.

Many hospital association and professional physician groups gave the relaxed guidelines an enthusiastic response and applauded the revisions as an easier-to-swallow version of the ACO program. However, insurers and employer groups complained that the new guidelines watered down antitrust provisions designed to prevent coordination among providers from driving up medical prices. Overall, the reduced quality measures were seen as less burdensome and the adjusted cost savings as better motivators to join ACO's. The final regulations seemed to create a balance between driving care coordination around patient quality outcomes to reduce costs, while not overburdening organizations with significant new infrastructure investments. Academic centers seemed to approve of the new ACO regulations but admitted that the requirements would still be difficult to meet.

Moving Forward

Industry executives asked "how many ACO's" and "how fast will ACO's spread"? CMS estimates that between 50 to 270 ACO's will either be formed and/or sign up to participate over the next three years (affecting the care of only 2 million of the 47 million Medicare beneficiaries), generating a net savings of $940 million during the first four years through Shared Savings (versus initial estimates of $960 million over three years).

However, skepticism remains that the ACO movement will catch on as quickly as intended. According to a report by the Robert Wood Johnson Foundation, it is unclear if the Shared Savings Program (and the Pioneer ACO) model is intended to test the ACO concept for large-scale implementation, to see whether it generates sustainable governmental savings, or to move as many providers as possible to ACO's to curb Medicare spending. Others have argued that it would be a mistake to assess the success of the program by counting how many ACO's participate in the initial agreement period. Health insurers remain concerned that the trend of provider consolidation will drive up medical prices resulting in additional cost-shifting to families and employers with private coverage. They claim that the anticipated savings of $940 million over four years pales in comparison to the $2 trillion Medicare anticipates spending during the period.

As 2011 concludes, many in the healthcare industry agree that the delay and the resultant disappointment caused by the proposed rules in March not only wasted time but stifled the growth of ACO's. It may take some time to regain that lost momentum. ACO proponents, however, remain confident that the new entities will proliferate and be expanded for both Medicare beneficiaries and privately insured patients.

Time will tell about the degree of success that ACO's will achieve – and whether they will enhance healthcare delivery, improve care and cut costs as envisioned. In the meantime:

- Some form of integration – whether government sponsored ACO's or not – is clearly on the horizon; Physicians are partnering with hospitals and health plans, payers are experimenting with bundled payment plans
- Large hospital systems and academic medical centers may benefit most from an ACO model; however, hospitals will need to "integrate" without losing money in the medium to long term
- Medical device manufacturers who market physician preference products may benefit least; bundled payments will continue to erode prices
- Device manufacturers will need to demonstrate — more than ever — the value of their products by either improving patient outcomes cost effectively, improving hospital processes/efficiencies, or minimizing error rates

As the health care industry responds to economic, regulatory and political uncertainties, in a rapidly changing environment, maintaining the status quo will be a losing strategy. All health care constituents – including device companies – will need to think about competition and collaboration in different ways and experiment with different business models in order to be successful.

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