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## **Accountable Care Organizations**

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## Background

### *Provider Payment*

The predominant payment mechanism for health care providers across the United States is fee-for-service (FFS), whereby providers are paid a fee for essentially every individual service they provide. For example, they are paid separately for each lab test, imaging procedure and office visit. In fact often similar activities with relatively subtle distinctions are considered separate services. There are 10 office visit codes based on the complexity of the visit and whether it is a new or established patient. There are several dozen codes for CT scans based on things like the part(s) of the body being scanned and the use of dye. Moreover, payment for any one service may depend on the site in which it is delivered.

Because fees have generally exceeded costs, this system not only incentivizes providers to deliver more services than may be medically efficient, but it also has broader implications in how health care delivery systems are shaped. For example, the FFS system disproportionately incentivizes the provision of those services which are more lucrative. This often means that more procedural services such as diagnostic imaging and surgeries are incentivized greater than the more cognitive, non-procedural services like primary care and psychiatric visits. Additionally, because every service is billed separately, the FFS system leads to a disjointed collection of providers rather than an integrated *system* which can more effectively care for patients both longitudinally and across the care continuum.

There have been various alternatives to FFS that set out to make providers more accountable for the volume of services they deliver. One such alternative is capitation (sometimes referred to as global budgets), whereby providers are paid a fixed amount for each patient on their roster which will cover the cost of care for a given duration (e.g. one year or one month). Capitation spread relatively widely during the 1990s and prompted a major backlash from physicians and patient/consumer advocates. Under capitation, providers are at financial risk for the cost of their patients, thus incenting them to restrict the amount of services patients can get. Also, patients were finding it difficult to get referrals to see specialists.<sup>1</sup> As a result of this backlash, plans moved away from capitation, returning to FFS.

In recent years the rise of health care expenditures, both public and private, has led to a consensus that the FFS system is no longer tenable and must be replaced. However, most stakeholders were wary of any capitated system given the experience of the 1990s. Other reforms to make physicians more accountable have included Pay-for-Performance (P4P) systems, which focus on rewarding good quality but are often built on top of the existing, fragmented FFS system. Out of this context the concept of Accountable Care Organizations (ACOs) was borne which ties a new payment system to a novel organizational structure emphasizing integrated care. The payment system is similar to capitation and P4P whereby providers are held accountable to both cost and quality. The new organization structure entails an integrated network of providers collectively responsible for a set of patients.

### *What is an ACO?*

An ACO is an integrated network of providers (hospitals, physician practices, or both) which contracts with a payer (public or private) to be responsible for the full continuum of care of a defined group of patients. The ACO faces some level of financial accountability for both the cost and quality of care provided.<sup>2</sup>

The ACO model was a major initiative included in the 2010 Patient Protection and Affordable Care Act (ACA). The new federal law stipulated that Medicare would introduce a system that allowed providers to form ACOs and be assigned a group of FFS beneficiaries (i.e. those enrolled in Medicare Parts A and B) for whom they are responsible. This system is known as the Shared Savings Program and works as follows<sup>3-7</sup>:

- ACOs will be assessed based on quality and cost of care provided for their assigned beneficiaries.
  - The quality of care delivered is measured by a set of quality metrics. (See Table 1)
  - The cost is determined by how an ACO's actual per patient cost compared to a calculated benchmark.
- If an ACO achieves high quality as judged by the measures, it would be eligible to receive a percentage of any savings it might have garnered for Medicare by providing care below the cost benchmark.<sup>i</sup>
- In order to become eligible for the Medicare's Shared Savings Program, a network of providers would first have to fulfill certain requirements which would qualify it as an ACO.
  - All of these requirements are intended to make sure the organization is patient-centered and is able to provide integrated care across the continuum.
  - Some of these requirements include a significant health IT infrastructure, utilization of patient experience surveys and patient involvement in ACO governance.

Medicare will support ACOs by providing them with patient cost, utilization, and quality data at the individual and aggregate level.

**Questions to consider:**

1. How can providers use data at an individual level to improve care efficiency? At the aggregate level?

Outside of the ACA and Medicare, many states and private payers are now preparing to implement similar initiatives to promote the formation of ACOs. At least 12 states have passed legislation to promote the formation of ACO-like models for Medicaid and state employee programs. Moreover, all of the major private health plans have begun to introduce ACO-like plans whereby providers are responsible for the full continuum of care, some payment is based on quality and coordination of care, and providers face some risk in managing costs.<sup>8</sup>

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<sup>i</sup> ACOs must demonstrate savings that are deemed significantly significant (i.e. greater than 2%-3.9%, depending on the number of beneficiaries enrolled in the ACO.)<sup>6</sup>

## Sample Case: Medicare's ACO Program

To get a better sense of how ACOs work, let's look at a hypothetical example. A group of providers in Boston, which includes both a hospital and two physician group practices that have existing relationships with the hospital, decides to come together and form an ACO in order to participate in the Medicare Shared Savings Program. Let us say that they call their ACO 'Warren Health Care', and contract with Medicare to provide care for 10,000 beneficiaries<sup>ii</sup> in the Boston area. The beneficiaries are assigned to Warren Health Care based on prior utilization of primary care (e.g. patients who received a significant proportion of their primary care from providers in Warren's network). Knowing that as a group they will be responsible for the quality and cost of care for these 10,000 beneficiaries, Warren invests in electronic health records and prepares their providers to work within an integrated system to better manage the care of their patients. Care management will largely fall under the responsibilities of the primary care providers. Warren also prepares to receive patient-level data on quality and costs monthly from Medicare. Using this data, they implement a system for identifying complex, expensive patients and developing personalized care plans for them.

At the beginning of the contract year, Medicare sets for Warren a cost benchmark of \$400 per patient per month (PMPM). After one year Medicare looks at the quality and cost of care Warren has provided. Let's say that Warren provided care above the quality standards as measured by specific quality metrics, making them eligible to receive 50% of any savings they provided for Medicare. Their costs are added up and found to be \$350 PMPM.

### Questions to consider:

1. How much total bonus payment can Warren Health Care expect to be paid in the form of shared savings for the entire year?
2. How much money has Medicare 'saved' compared to its benchmark?

In this idealized scenario, Warren is happy to have shared in the savings, and patients are happy to have received high quality care, and Medicare is happy to be controlling how much is being spent.

Since the Medicare ACO model makes providers accountable to the cost of care, it is reasonable to worry that the same perverse dynamics of capitation may return—that providers will avoid high cost patients and will restrict access to care. However, there are several measures within the ACO model that mitigate the risk of these perverse incentives. For one, providers are also being judged based on quality, which includes patient perception of care received. Measuring quality in health care is a great challenge, and often patient perception of quality is very different from a physician's perception. In our example above, Warren Health Care's patients might have thought that they were receiving poorer quality care if they received less care than previously, even if Warren's quality score was high. A second aspect of the Medicare ACO program which helps avoid overly restrictive care is that patients have the freedom to seek care from any Medicare provider, including those outside their assigned ACO. Also, there are caps on the amount of shared savings (and losses) an ACO can receive, which limits the incentive to cut costs.

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<sup>ii</sup> The final ACO rule mandates that ACOs must have a minimum of 5,000 beneficiaries assigned to it in order to participate.<sup>6</sup> In this hypothetical example, 10,000 beneficiaries is a large number, but makes the math easier.

## Variations on ACO Models

As mentioned before, the Medicare program is only one model for how ACO contracts work. State and private payers could have important differences in their models, but the basic tenets of an ACO may remain.<sup>9,10</sup> Even within Medicare's program there is variability in contract terms. In some ACO contract models, the ACO faces financial risk if it overshoots its cost benchmark; that is, if the ACO spends more than their benchmark, they must pay a certain portion or all of the excess expenditure back to the payer. ACOs which operate under this model face greater financial risk than the shared savings only model, so they are also typically eligible for greater reward if they contain costs. Because facing this two-sided risk (bonus or penalty) provides stronger incentives to curb costs, Medicare hopes to eventually transition all ACOs to accept this kind of risk.

### Questions to consider:

Although the basic structure of an ACO implies accountability for cost and quality, there are many different ways to hold ACOs accountable for cost and quality.

1. What are some issues regarding measuring quality in healthcare? Think about the differences between process and outcome measures. Also think about patient perception of quality versus provider perception. And what are some perverse incentives associated with basing payment on specific quality measures (e.g. average HbA1c levels)?
2. The determination of cost benchmarks is critical in incenting cost control.
  - i. Benchmarks are set by risk-adjusting for the patient population. Possible adjustments include age, sex, race/ethnicity, health status, and socioeconomic status. Which would you include and why?
  - ii. Benchmarks can be adjusted annually based on local cost growth rates, national growth rates, or a mixture. What are the advantages and disadvantages to using local and national growth rates when setting a given ACO's benchmarks?

## Massachusetts Reform

On the heels of the federal reform, the state government of Massachusetts has also moved to try to replace FFS with alternative payment methodologies, including "global payment", similar to the ACO model where providers are paid a set amount for the full continuum of care for patients. In March 2011, Governor Patrick introduced a bill that would replace FFS with the global payment for all public payments for health care, including Medicaid (MassHealth) and state employee health insurance.

Many private payers have been anticipating these reforms at the state and federal levels and have similarly begun to develop ACO-like contracts with providers. One such example is Blue Cross Blue Shield's Alternative Quality Contracts (AQC), which was introduced in 2009. The AQC is a five-year payment contract available to HMO provider groups whereby they receive global payments. The provider groups are also eligible for significant bonus payments based on quality performance. Preliminary results from this program have shown that the AQC contracts have led to increases in quality and modest reductions in spending.<sup>11</sup> These reductions were mainly due to changes in referral patterns rather than changes in utilization rates. Although

total expenditures for BCBS increased with AQCs when the bonus payments were included, the state's largest insurer expects to realize savings in the future since the increases in the global payments have already been set for the remainder of the contracts and were designed to save money (relative to actuarial estimates of what spending would have been).

**Question to consider:**

1. The AQC has only been applied thus far to patients in HMO plans, where choice is somewhat restricted. What do the early results imply about how well similar ACO contracts might work for patients in Preferred Provider Organizations (PPOs) and even Medicare, where choice is much greater?

**Table 1 – Summary of Proposed Quality Metrics<sup>6</sup>**

<b>Domain</b>	<b>Total Individual Measures</b>	<b>Sample Measures</b>	<b>Domain Weight</b>
Patient/Caregiver Experience	7	<ul style="list-style-type: none"> <li>- Getting timely care, appointments, and information</li> <li>- How well doctors communicate</li> <li>- Access to specialists</li> <li>- Shared decision making</li> <li>- Health status/functional status</li> <li>- Patient’s rating of doctor</li> </ul>	25%
Care Coordination/Patient Safety	6	<ul style="list-style-type: none"> <li>- Falls – screening for risk</li> <li>- percentage of PCPs who qualify for an electronic health record program payment</li> </ul>	25%
Preventative Health	8	<ul style="list-style-type: none"> <li>- Influenza immunization</li> <li>- Adult weight screening and follow-up</li> <li>- Depression screening</li> <li>- Colorectal screening</li> <li>- Mammography screening</li> </ul>	25%
At Risk Population	12	<p>Diabetes</p> <ul style="list-style-type: none"> <li>- HbA1c control (&lt;8%)</li> <li>- LDL (&lt;100)</li> <li>- BP (&lt;140/90)</li> <li>- Tobacco nonuse</li> </ul> <p>Hypertension</p> <ul style="list-style-type: none"> <li>- BP Control</li> </ul> <p>Ischemic Vascular Disease</p> <ul style="list-style-type: none"> <li>- Complete lipid profile and LDL control</li> <li>- Use of aspirin or another antithrombotic</li> </ul> <p>Heart Failure</p> <ul style="list-style-type: none"> <li>- Beta blocker for left ventricular systolic dysfunction</li> </ul> <p>Coronary Artery Disease</p> <ul style="list-style-type: none"> <li>- Drug therapy for lowering LDL-cholesterol</li> </ul>	25%
<b>Total</b>	<b>33</b>		<b>100%</b>

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