

President's Page

Are Accountable Care Organizations sustainable?

In response to the continued increase in healthcare expenditures, the US Department of Health and Human Services, under the umbrella of the Affordable Care Act (2011), created Accountable Care Organizations. This is one step in transitioning from fee-for-service to value-based care. According to the Center for Medicare and Medicaid Services, an ACO is a group of hospitals and/or clinics, physicians and other healthcare providers that align to deliver coordinated, quality care to Medicare patients. Following the directive of the triple aim: better health for individuals, improved population health and decreased healthcare expenditures, an ACO provides the framework for these ideas to be applied.

Although this is a noble concept, it is not a new concept. The history of health care shows that well-known hospital institutions were formed to respond to the needs of the community and many were created by or around physician leaders. Somewhere along the road, control of healthcare expenses has been lost and the system has become fractionated throughout. Coordination has been lost.

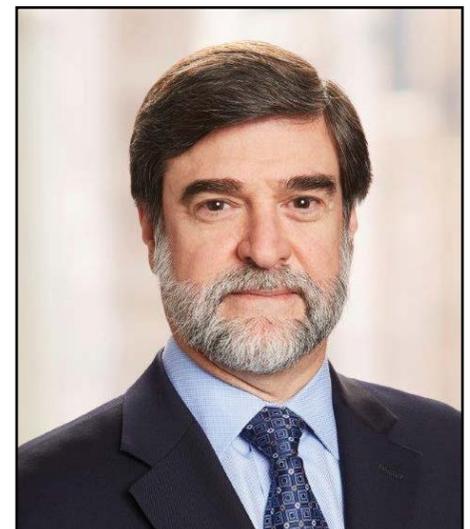
Many ACOs are part of Medicare Shared Savings Program (MSSP).

According to CMS, more than 560 ACOs are operating in 2018, and more than 10.5 million Medicare beneficiaries out of 38 million are in a Shared Savings Program ACO. But not all of these ACOs have generated savings; fewer than one third of them have. Data have shown that physician-owned ACOs have generated more savings than those that are hospital owned. CMS also has recognized that the Shared Savings Program has had increased spending in the last two years. In part, the reason has related to the fact that most ACOs in the Shared Savings Program were not taking risks for increasing costs.

To address this, CMS has proposed a new direction for the ACO Shared Savings Program: Pathway to Success. With this new direction, CMS is trying to control five goals of the program: accountability, competition, engagement, integrity, and quality. This new program increases the risk that ACOs must take, depending on the track they choose. CMS proposes a six-month extension of the current program, but adds accountability and competition with increased risk sharing. In addition, CMS has recognized that the current program has encouraged market

consolidation, resulting in less potential competition and increased costs. CMS authorizes termination of ACOs that show poor financial results. CMS also adds some carrots: expanding telehealth services, providing more beneficiary engagement, and adding language relating to electronic health records. In a way, these changes make the odds of success more attractive for smaller ACOs, which often outperform larger ACOs.

But the many lessons learned have been painful at times. The concept of ACOs may not fit every scenario. Well-known institutions



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that have operated efficiently and provided well-coordinated care have lost money in their first three years in the Shared Savings Program because they exceeded the target benchmarks that CMS expected. Because of this, they had to drop out of the Pioneer ACO Program, demonstrating that a well-run machine may not need many changes. Also, CMS benchmarks were set later in the year, essentially creating a moving target. Systems that start with more excess spending and poor coordination have more room to improve and succeed in this program. That success clearly is related to the CMS benchmark assigned, which is another reason for the proposed changes.

care, better care of the chronically ill, and better control of high-cost patients. They have been able to more accurately target the outcomes and decrease ED visits, improve coordination of services for high-risk populations, decrease hospital admissions and readmissions, improve primary care services, and make transition of care a priority. Smaller ACOs have had more limited resources and capital investments, and more restricted health information exchanges. This has limited their growth but has encouraged them to establish specialty referral networks. However, as with larger ACOs, they have been challenged by the changing CMS benchmarks. Whether you are a small ACO,

Medicare patients — ACOs do not directly get involved with the uninsured population. With the consolidations related to ACOs, options have decreased for this vulnerable population. In addition, the number of hospital closures has increased significantly, affecting mostly rural areas. Most of these closures have been in the South, and most of those have been in Texas. These closures disproportionately affect the uninsured and vulnerable population.

In addition, a value-based system could worsen health disparities. This is what I call the fruit salad: cherry picking and lemon dropping. Physicians treating more complicated patients with chronic illnesses could face a disadvantage in meeting expected quality metrics and thus face higher penalties. As physicians, we need to be aware of these unintended consequences so we can avoid them. As physicians, our job is to deliver care where care is needed.

The future of value-based purchasing is just starting. ACOs have been one of the pilot projects and we have much to learn. But coordination of services has been a key element. The era of increased two-sided risk in ACOs has started. ACOs will need to evolve from their current structure, as the current programs may be unsustainable. Although a perfect healthcare solution may not be possible, our job as leaders and caregivers is to continue to find better solutions to deliver care to all. **DMJ**

ACOs may not fit every scenario. Well-known institutions that have operated efficiently and provided well-coordinated care have lost money in their first three years in the Shared Savings Program because they exceeded the CMS target benchmarks.

Smaller ACOs and physician-led ACOs have been outperforming many larger ACOs. Analysis of these success stories has shown that these groups had a more focused approach and were able to experiment, one goal at a time. They started with better control of their members and services, achieving better coordination of

a physician-led ACO, or a large ACO, the CMS' recalculated yearly benchmarks remain the area that will make ACOs disappear. In a way, you are a victim of your own success.

In all this conversation, where does the poor and the underserved population fall? Remember that this is all about