Accountable Care Organizations Experience Growth, Challenges

Medicare coordinated-care programs are growing in number and making progress on cost savings and health outcomes, but are facing obstacles including hefty startup costs and arduous regulation requirements, experts say.

Accountable care organizations, or ACOs, are provider-based networks that aim to improve coordination between physicians and services, improve patient outcomes, and reduce spending growth. In these networks, doctors and hospitals share financial and clinical responsibility for providing coordinated services to patients to limit unnecessary care.

They are part of a larger value-based approach to make Medicare payments based on results and outcomes instead of the number of services rendered. Medicare offers several different types of these programs for fee-for-service physicians and hospitals, all of which are voluntary and provide financial rewards for providers.

In an ACO network, the primary doctor would refer a patient to different specialists within the network, similar to an HMO, but specialists and doctors are collectively responsible for that patient’s treatment and outcomes. The CMS established the Medicare shared savings program on Jan. 1, 2012, as required by the Affordable Care Act, and additional ACO programs followed in recent years.

The number of hospitals and doctors entering these networks has grown steadily. The number of networks in the shared savings program, the largest ACO program, increased from 220 in 2013 to 480 in 2017, a 118 percent boost. About 28 million people are covered under these networks.

Joe Damore, vice president of population health management at Premier Inc., a group purchasing organization, said his organization has helped build more than 80 ACO networks, with more on the way.

“We are seeing an incredible increase in physicians and organizations who are interested in being a part of these programs,” Damore told Bloomberg BNA June 6. “But it’s a lot for these organizations to adapt to in order to submit their application successfully to the Centers for Medicare & Medicaid Services (CMS).”

Financial and Quality Improvements A study published in the May 2017 edition of Health Affairs, a health-care journal, which used data from a large ACO in the Partners HealthCare System in Boston, showed some of the program’s first financial and quality results.

ACO participants saw a $14 reduction in Medicare spending per patient each month, a decrease of about 2 percent. Participants in the ACO’s care management plan saw more significant results—a $101 reduction in Medicare spending, or a 6 percent decrease. In care management programs, physicians coordinate with one another to better treat patients with multiple chronic conditions or advanced illnesses. That plan also brought an 8 percent reduction in hospitalization and a 6 percent reduction in emergency department visits.

The study’s lead author is John Hsu, director of the Clinical Economics and Policy Analysis Program at the Mongan Institute Health Policy Center, Massachusetts General Hospital, which is part of the Partners HealthCare System. The study examined a Pioneer ACO—a model with a small number of participants, designed for health-care organizations and providers that were already experienced in coordinating care for patients across care settings.

Coordination “Care management plans play a big role because they help coordinate care and care transitions. They allow smoother transitions for patients coming from inpatient to outpatient services, such as post-acute care, and lower costly hospital readmissions rates,” Allison Brennan, vice president of policy at the National Association of ACOs (NAACOS) in Washington, told Bloomberg BNA June 7. “This is where care managers can play an important role which benefits providers, patients and the Medicare trust fund.”
Corinne Smith, partner at Strasburger & Price, LLP in Austin, Texas, said she sees problems in tracking long-term quality success in the ACO programs.

“While ACOs put a heavy emphasis on care management, wellness and prevention, the long-term and demonstrable effect on patient outcomes is limited,” she told Bloomberg BNA June 9. “People change health plans all the time and it’s very hard to track patient outcomes because they are moving in and out of different ACOs so frequently. Medical records are not transferable and each ACO has its own platform and medical records. The ACO’s ability to create a longitudinal record, a prerequisite for population health, is limited to the period of time during which the patient was in the ACO.”

The study also found that the longer a hospital was in the ACO network, the better its savings. But the savings and quality improvements, while minimal, aren’t unexpected, according to David Muhlenstein, chief research officer at Leavitt Partners LLC, a consulting firm in Salt Lake City.

“Much of what’s happening right now is savings that should have been done,” he told Bloomberg BNA June 2. “Most of the organizations are in the process of getting to where they want to be and are still in the development phase. In general we have seen that ACOs have found it harder than expected and longer to make these changes.”

**Start-Up Costs and Regulatory Burdens** Many hospitals and doctors struggle to find the funding to start up and operate ACO networks and meet the CMS acceptance requirements.

The average cost for annual ACO operations was $1.6 million, according to a 2016 NAACOS survey of ACO participants, a heavy price tag for smaller and struggling hospitals.

“This money has to come from somewhere and it’s not reimbursed up front,” Brennan said. “So coming up with these funds is difficult for a lot of organizations, especially rural ACOs and smaller ones.”

An earlier survey by NAACOS found that the average first-year start-up costs for ACOs in the shared savings program was $2 million and that ACOs would need about $4 million of start-up capital before seeing any chance of recouping the costs. That’s higher than the CMS estimate of $1.8 million, from 2011 draft regulations, but much lower than estimates from other groups, including the American Hospital Association, which had estimated the average costs to be $11.6 million to $28.5 million.

“Funding for things like health IT, data analytics, and care coordinators are the biggest and costliest obstacles,” Brennan said.

“What we are seeing is that it takes a lot of time and money to change how care is delivered,” Muhlenstein said. “This includes hospitals and doctors building new relationships with each other and implementing new technology and communications.”

Brennan said the CMS could better support ACOs by limiting regulatory burdens with physician self-referral law requirements and reducing reporting burdens. She also recommends the CMS increase transparency around certain program methodologies, such as those for setting ACO financial benchmarks, and says the agency could provide more timely, actionable data.

“Medicare typically requires that beneficiaries have a prior inpatient hospital stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient skilled nursing facility care,” Brennan said. “This requirement should be waived for ACOs to allow beneficiaries to receive skilled nursing facility services without first having the 3-day inpatient hospital stay.”

Medicare requires that a physician certify that a patient is confined to their home and meets certain criteria to be eligible to receive home health services under both Medicare Part A and Part B. Brennan also suggested that the CMS “allow the ACO’s beneficiaries to receive home health services without meeting the Medicare homebound requirements.”

**Proposed ACO Improvement Act** While most alterations to the ACO programs can be approved by the CMS, Congress does have legislative power to improve the program. The ACO Improvement Act of 2016 was introduced in the House Sept. 21, 2016, by Rep. Peter Welch (D-Vt.) and Rep. Diane Black (R-Tenn.); it was intended to help strengthen patient-physician relationships in ACO networks and proposed allowing beneficiaries to choose their own physician within the ACO they are assigned.

“To reduce health-care costs and increase quality, we need to change the incentives built into the provider payment system. Promoting ACOs allows us to reward value, not volume. Paying health-care providers based on improvements in patient health rather than the numbers of procedures they perform is the way of the future,” Welch told Bloomberg BNA June 7.

The bill also called for additional care coordination through telehealth and aimed to waive site-of-service requirements for telehealth services.

“Having seen the importance of patient-physician relationships firsthand as a registered nurse, we wrote the bipartisan ACO Improvement Act of 2016 aimed at improving care and reducing service-related costs. It would give healthcare providers regulatory relief to make decisions based on what is best for the patient, not what is best for the system. Providing ACOs with additional tools for coordination puts the most effective care at the forefront of decision-making,” Black told Bloomberg BNA June 7 in a written statement.

Brennan said she expects the bill to be reintroduced in the House sometime this summer.

**ACA Repeal and Medicare Cuts** Muhlenstein said the American Health Care Act, the Republican-backed Affordable Care Act repeal bill that passed the House in May, won’t affect ACOs’ operations or growth because the bill doesn’t touch Medicare reimbursements or alternative payment models. But he also said the growing possibility of cuts to Medicare in the near future could cause a temporary decline in their growth.

“There will be a small slowdown in the next few years in the growth of transitions to ACOs because of...
the uncertainty with Medicare and Medicaid, and possible cuts to them,” he said.

Muhlenstein said cuts to Medicare would improve participation in ACO programs, as hospitals would try to find savings elsewhere.

“Cuts to Medicare would increase participation and adoption of ACO programs,” he said. “When hospitals know that their payments are under threat, that incentivizes them to make these changes. But there would be huge political ramifications,” Muhlenstein said.

Muhlenstein said that once the health-care market becomes more oriented toward a value-based model, participation in ACOs will improve further.

“There’s a belief that’s come over the last 3 years that the system is going to change. In the next few years doctors will be paid more on quality instead of number of services provided. Once that date gets closer, then we’ll see more changes,” he said. “This is a decades-long transition, so we should look at the direction and speed of these changes.”

“There’s a natural evolution that’s going to take several years when it comes to changing how care is given,” Damore said. “This is a great movement across the country, and we still have a lot to learn about what works and doesn’t work.”

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