

REVIEW ARTICLE

The Economics of Medicare Accountable Care Organizations

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BACKGROUND: Accountable care organizations (ACOs) have been created to improve patient care, enhance population health, and reduce costs. Medicare in particular has focused on ACOs as a primary device to improve quality and reduce costs.

OBJECTIVE: To examine whether the current Medicare ACOs are likely to be successful.

DISCUSSION: Patients receiving care in ACOs have little incentive to use low-cost quality providers. Furthermore, the start-up costs of ACOs for providers are high, contributing to the minimal financial success of ACOs. We review issues such as reducing readmissions, palliative care, and the difficulty in coordinating care, which are major cost drivers. There are mixed incentives facing hospital-controlled ACOs, whereas physician-controlled ACOs could play hospitals against each other to obtain high quality and cost reductions. This discussion also considers whether the current structure of ACOs is likely to be successful.

CONCLUSION: The question remains whether Medicare ACOs can achieve the Triple Aim of “improving the experience of care, improving the health of populations, and reducing per capita costs of health care.” Care coordination in ACOs and information technology are proving more complicated and expensive to implement than anticipated. Even if ACOs can decrease healthcare costs and increase quality, it is unclear if the current incentives system can achieve these objectives. A better public policy may be to implement a system that encompasses the best practices of successful private integrated systems rather than promoting ACOs.

KEY WORDS: accountable care organizations, antitrust issues, best practices, care coordination, care quality, healthcare costs, incentives, integrated systems, Medicare, Triple Aim

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The US healthcare system is broken financially and quality-wise. The present financing system is not sustainable; nearly 20% of the US gross domestic product is spent on healthcare.¹ The United States spends by far more on healthcare than any other country, but its outcomes are not better, and universal access is lacking. In fact, the United States spends more on healthcare than the next-highest 10 countries combined.² Various measures show that the United States is nowhere near the top of the World Health Organization’s (WHO) health measures categories such as infant mortality and life expectancy.³

A major issue is whether the United States is getting its money’s worth. The costs of many healthcare procedures are much greater than the benefits, and some procedures provide little or no benefit to patients. For example, Ezekiel Emanuel argues that there may be overemphasis on extending life rather than improving the quality of life.⁴ As quoted by Donald Berwick, Michael Porter and Elizabeth Teisberg assert that “value is added by care that produces the best outcomes at the lowest cost over time.”^{5,6} Moreover, the present healthcare system is fragmented,

especially in terms of patient care coordination. Many patients see various types of physicians, but there is little communication among the providers. More than 10 years ago, in *Crossing the Quality Chasm*, the Institute of Medicine stated, “In its current form, habits, and environment, American health care is incapable of providing the public with the quality of care it expects and deserves.”⁷

Donald Berwick, former Administrator of the Centers for Medicare & Medicaid Services (CMS), stated that the United States is “still struggling to make highly reliable and safe health care a norm rather than an exception.”⁵ In fact, the United States has tried many organizational forms in the past 80 years, from the Committee of Medical Care’s Prepaid Group Practices, the Nixon era of HMOs and PPOs, and President Clinton’s Accountable Health Plans. Since then, the federal government and private providers have developed a new scheme to help coordinate care and control costs—accountable care organizations (ACOs). In this article, we examine whether Medicare ACOs are an adequate solution or rather the newest experiment in the attempt to solve our healthcare crisis.

Methods

We conducted a comprehensive review of the literature through a search of MEDLINE/PubMed and Google

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KEY POINTS

- The United States spends much more on healthcare than any other country, without necessarily improving the quality of care or patient outcomes.
- The goal of accountable care organizations (ACOs), which were instituted by the ACA in 2010, was to reduce costs and improve patient care.
- This article presents the mixed results seen with the current Medicare ACOs and the many hurdles confronted by these organizations.
- To reduce costs and improve care quality, ACOs need to enhance collaboration to decrease the use of unnecessary services.
- Consolidations of insurance companies and providers increases market power and the consequent ability to raise prices for healthcare services.
- The payment system used in ACOs should be reorganized and cross-subsidization minimized.
- Overall, the results seen with current ACOs have been mixed, with some studies showing reduced hospitalizations and shorter hospital stays than in traditional care.
- However, others contend that reduced hospitalizations can also mean subpar patient care.
- Overall, some private integrated systems have so far been more successful than Medicare ACOs in achieving high-quality care and cost reduction.
- Adopting the best practices of these integrated systems may be more beneficial than investing more resources in Medicare ACOs.

Scholar, using the term “accountable care organizations.” Internet searches using Google and a search of various *Fierce* publications related to the healthcare industry were also conducted, as well as a review of CMS’s website.

Discussion

Accountable Care Organizations

CMS has defined Medicare ACOs as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.”⁸ The concept of ACOs is based on the concept of the Triple Aim—“improving the experience of care, improving the health of populations, and reducing per capita costs of health care.”⁵ In some cases there may be a trade-off between these aims; for example, new technology can improve outcomes but increase costs. In other cases, these aims can work together to decrease the use of unnecessary services, which can

reduce costs and increase quality. As Greaney noted, “ACOs may take a variety of organizational forms, including integrated delivery systems, primary care or multispecialty medical groups, hospital-based systems, and even contractual or virtual networks of physicians, such as independent practice associations.”⁹ Moreover, a variety of reimbursement systems exist, such as 1-sided shared savings, 2-sided shared savings, and bundled, partial capitation, and global payments.¹⁰

Most ACOs are at an early stage of development and generally follow the traditional payment model, with the fee-for-service approach still prevalent.¹¹

Under Medicare ACO plans, patients are assigned to doctors based on which primary care physician provides the most care to the patient. Although not all ACOs are for Medicare patients, this article focuses on Medicare ACOs, because of the emphasis Medicare places on ACOs as a tool to control cost and improve quality.

Overall, the goal of ACOs is to establish a healthcare system that solves the principal agent problem—a system that aligns the interests of patients and providers.¹² The system should allow providers to control diagnosis and treatment decisions under new payment incentives that spur greater efficiency in resource use.¹² ACOs give physicians more flexibility than HMOs. The HMO system is fraught with issues such as prior authorizations, a limited network of specialists to whom providers can refer patients, and other bureaucratic requirements, all of which increase physicians’ administrative costs.¹³ ACOs typically do not require preapprovals. An ACO that operates under global risk would presumably have the necessary infrastructure to determine what care is appropriate. In some cases, preapproval may be required.

Providers’ Risks and Incentives

It is difficult for many physicians to change their habits. ACOs are designed to give incentives to physicians and hospitals to decrease costs by sharing in the cost-savings; however, providers risk being penalized if they do not decrease costs or do not meet certain quality standards.

Under ACOs, incentives vary for different types of physicians. The incentives for primary care physicians are to share in the cost-savings and improve quality, whereas specialists want to be part of the referral network.¹⁴ Specialists who are concerned about efficiency are likely to join an ACO. Nevertheless, savings largely accrue to primary care physicians, thereby increasing their incentives for efficiency. One mechanism to encourage cost-consciousness is bundling payments, which involves establishing a set price for an entire procedure or treatment. Bundling of rates should encourage coordinated care because, if everyone is sharing the reimbursement, they also should share the responsibility, and thus

coordinate the care. Bundled care will shift the financial risk to providers, to encourage more efficient care delivery. An advantage of bundling in an ACO is evident from a statement by a chief of orthopedic surgery, noting, “Before, I had no incentive to get costs down. Now I do.”¹⁵ Specifically, this surgeon stopped using costly antibiotic cement in favor of the standard version, because there was no evidence that the more expensive cement reduced the incidence of infections.¹⁵ Such benefits of adopting best practices also have been achieved by providers who are not part of an ACO. For example, the Mayo Clinic uses benchmarking and standardization to save resources and improve patient outcomes.¹⁶

ACOs are associated with considerable start-up costs. Tom Scully, former CMS Administrator, estimates start-up costs to be at least \$30 million in a midsized market.¹⁷ The estimated cost of starting and operating a physician ACO in the first year was more than the CMS estimate of \$1.8 million.¹⁸ The current CMS rules for Medicare ACOs provide too much risk and too little reward. In 2014, 90% of surveyed ACOs were concerned about return on investment, compared with only 14% in 2013.¹⁹ So, even if physicians are in a 1-sided ACO that does not penalize them for not meeting established standards, they still risk not getting a return on their start-up investment. Moreover, a considerable amount of time may elapse before costs actually decrease, making it difficult to obtain rapid return on an ACO investment.

In addition, there are potential liability risks if something goes wrong. These risks include failure to access patients’ medical records and inadequate engagement of the patient or family member in shared decision-making in cases where 1 of the parties has power of attorney, guardianship, or healthcare power of attorney. In such situations, providers could be sued by the party that was not consulted. Administrators can be held liable, and ACOs could be accused of corporate negligence.²⁰

Patient Incentives

Unlike HMOs, ACOs are designed to increase quality of care without limiting patients’ choices. With the possible exception of a hospital ACO, Medicare beneficiaries can obtain care from any provider that accepts Medicare. Therefore, Medicare patients have few incentives to use the most effective provider. To be successful, ACOs need to change patients’ behavior through incentives. Much has been written about price transparencies that make consumers aware of the price being charged for services, but price transparency may lead to even higher costs, because consumers may perceive that a higher price indicates superior quality.^{21,22}

It will likely be difficult for ACOs to decrease costs when patients can choose high-cost providers without

incurring substantial penalties. This is the case for some Medicare beneficiaries who have supplemental insurance under traditional Medicare. For beneficiaries in Medicare Advantage plans, there are often incentives to use certain providers, presumably low-cost, high-quality ones. This also means that gains from ACOs in those insurance plans should be smaller. Although patients need protection against catastrophic health-related expenses, the system must ensure that supplemental insurance does not offset all patient cost-sharing.²³

Policies to incentivize patients are available, such as reference pricing, which have been successful in achieving cost-savings. Reference pricing is when payers guarantee quality care at a set (reference) price for each service. Any charge by a provider above the reference price is paid out of pocket by the consumer. CalPERS instituted reference pricing for various surgeries, which saved \$5.5 million during a 2-year period.²⁴

Previous Studies

Coordinated care is one of the goals of ACOs. Previous experiments to achieve goals similar to those of ACOs have not been successful. The acquisition of physician practices has not promoted coordination, improved quality, contained costs, or integrated clinical care.²⁵ Effective care coordination among multiple providers has long remained an elusive goal. In 2002, CMS funded 15 demonstration programs of care coordination, only 3 of which reduced patient costs and hospital admissions. Even in those 3 sites there was no net savings for Medicare after deducting fees for care coordination.²⁶ The Congressional Budget Office found “insufficient evidence that disease management programs for Medicare can even pay for themselves, concluding that any reduction in the cost of care is tempered by implementation costs. Such programs sometimes improve patients’ functional status but do not save money.”²⁶

The shared-savings approach of ACOs parallels that of the 2005-2010 Medicare Physician Group Practice Demonstration.²⁶ All 10 participating groups attained prespecified benchmarks on most quality measures, but only 5 groups generated any savings, and only 2 generated enough savings to qualify for bonuses in all 5 years.²⁶ Previous reviews of pay-for-performance programs suggest, at best, mixed results.²⁷

Mixed Results of ACOs

Early results for ACOs are mixed. A 2014 study demonstrated that ACO-style care had more success than traditional care in reducing avoidable hospital admissions and shortening hospital stays.²⁸ ACOs also have superior numbers for other indications of efficiency. Specifically, ACOs had a 6.3% reduction in hospital re-

admissions and a 3.9% reduction in length of stay, whereas traditional models had reductions of 3.8% in readmissions and 2.4% in length of stay.²⁹ However, some experts argue that some readmissions reflect better quality, in particular after surgery and in cancer care.³⁰

In general, ACOs have performed better on quality measures than on cost reductions. For example, Pioneer ACOs improved on 28 of the 33 quality measures in the first year.³¹ However, the cost results were mixed for the first 2 years. In the first year, they ranged from a 7% decrease to a 5% increase; in the second year, they ranged from a 5.4% decrease to a 5.6% increase.³² CMS's Physician Group Practice Demonstration saved Medicare \$26.6 million, or \$121 per beneficiary, over 5 years.³³

Eleven Pioneer ACOs earned shared-savings. The average quality score for Pioneer organizations increased from 71.8% to 85.2%, and Pioneer and Medicare Shared Savings programs saved more than \$800 million over 2 years.³⁴ Bundling was implemented, with estimated cost-savings of 5.4% over 10 years.³⁵ Given the investments to create ACOs, and the learning period to change physician behavior, these mixed and modest results are not surprising.

The Pioneer ACO program has serious problems. As of September 2014, 10 of the original 32 Pioneer ACOs had left the program.³⁶ Of these 32 ACOs, 18 reported gross savings in the first year, but 14 posted losses. Some former participating ACOs claimed that "CMS doesn't seem to have a handle on what the Pioneer ACOs need."³⁷ They complained that 19 of the 31 (1 measure is a composite measure of 2 individual components) quality measures were established without an anchoring methodology, reflecting a lack of data and excessively strict rules and benchmarks.³⁸

Moreover, there is fear that the federal government may take most of the cost-savings of ACOs. Some ACOs may switch to Medicare Advantage. In the first year of ACOs, 54 of the 114 Medicare Shared Savings programs had lower costs than projected, but only 29 qualified for shared-savings.³⁹ The fact that just 1 in 4 ACOs qualifies for a bonus is troublesome. For example, Duke University Hospital cut the costs of treating congestive heart failure by 40% but stopped the program, because it lost money under the Medicare fee schedule.⁴⁰ Given the costly investments of physicians and other providers, and the learning required to change behavior patterns, more flexibility is clearly needed.

Initially, ACOs have focused largely on the highest-risk, most complex patients and on reducing readmissions. These patients utilize most of the healthcare resources and have the most inefficient care. After all, the highest-cost 1% and 5% of patients account for approximately 22% and 50%, respectively, of total healthcare costs.⁴¹ This could

lead to a reduction in duplicative care, prevention of defensive medicine, and increase in high-quality interventions.¹³

Subsequently, less costly patients could be targeted by ACOs. For example, efforts could be undertaken to change the habits of surgeons and develop protocols for specific illnesses, such as cancer or renal disease; patients with end-stage renal disease represent 1% of enrollees but 7% of costs.⁴² Some ACOs already are dedicated specifically to patients with cancer or with other chronic diseases.

Challenges of Coordinating Care

ACOs face many issues, which will be addressed in the next few sections. Coordination of care becomes more difficult when patients go to physicians outside the ACO. Each year, Medicare fee-for-service beneficiaries see, on average, 2 primary care providers and 5 specialists across 4 sites of care.²⁶ Hence, a primary care physician who treats 257 Medicare patients would need to interact with up to 229 physicians, practicing in 117 care sites.²⁶ Patients who have multiple chronic conditions use even more providers and have a lower percentage of visits to their assigned primary care physicians than do other patients. Approximately 20% of Medicare beneficiaries who have at least 5 chronic conditions usually seek care from specialists and refer themselves to these experts.²⁶

Physicians will be challenged to coordinate care for such patients unless ACOs can drastically reduce the number of eligible providers patients can choose. This is important, because a small number of chronically ill patients account for most of Medicare's spending.²⁶ For example, Empire Blue and Mount Sinai developed a personal healthcare strategy for patients with complex chronic conditions, who constitute 1% of patients but 21% of costs.⁴³ Therefore, the opportunity for a primary care physician to coordinate their care may be lost. This limits the ability of ACOs to affect a huge portion of Medicare spending. At the end of the year, patients in traditional Medicare plans are attributed to the ACO that provided the majority of their primary care.

How is it possible to coordinate care if the provider does not know who is in his or her network? Care coordination also becomes more difficult with snowbirds (ie, patients who spend a substantial part of the year in different geographic locations). Although innovations such as minute clinics and other retail healthcare providers have decreased the cost of some healthcare services, they may increase the difficulty of coordinating care, because patients are seeing someone other than their primary care physician for primary services.

For Medicare Advantage HMOs, patient care coordination is not an issue, because beneficiaries must select a primary care provider. In 2015, approximately 31% of Medicare subscribers participated in Medicare Advan-

tage.⁴⁴ For the majority of health insurance subscribers, care coordination remains an issue. Primary care will play a critical role in ACOs. There are shortages of primary care physicians, and uneven geographic distribution of these providers. Physician shortages may be alleviated by use of nonphysician providers.

Some ACOs have included nonclinical integrators, or patient navigators, who arrange follow-up visits, connect patients to local care services, and schedule appointments. This frees clinical time to provide medical services. “Lay patient navigators can help offset up to approximately 25% of case managers’ non-clinical tasks, increasing efficiency allowing them to work at the top of their licenses.”⁴⁵ They have reduced emergency department visits and readmissions.⁴⁵ Adding patient navigators would initially add costs to the system. However, a systematic review of substitution of other providers for physicians has shown negative results, including reductions in productivity, patient volume, and practice income.²⁶

Economic theory suggests that greater reliance on lower-cost physician “extenders” is appropriate to increase efficiency and reduce costs.¹⁶ For primary care doctors to coordinate care will require them to reduce the time they spend on direct patient care. It was estimated that primary care physicians in a patient-centered medical home would need to work an additional 3.2 weeks each year to coordinate care for patients treated by specialists for 7 chronic conditions.²⁶

Readmission Issues

Medicare penalizes hospitals for high readmission rates. Thus, ACOs have been concentrating on reducing readmissions. Such reduction efforts focus on educating patients who are most likely to return to the hospital. The primary strategy is to make patients partners in their own care. Such a strategy can save substantial resources. For example, on average, a readmission in Wisconsin hospitals costs \$9600.⁴⁶ Wisconsin hospitals have successfully reduced readmissions by 22%, exceeding CMS’s goal of 20%. As a result of these actions, 63% of Wisconsin hospitals will not face readmission penalties, and no hospital in the state will be penalized more than 1%.⁴⁷

Some have claimed that hospitals are unfairly punished for factors beyond their control. Specifically, readmission rates are higher for patients who are unmarried, those from poor neighborhoods, or those who have severe health conditions.⁴⁸ Also, safety-net and large teaching hospitals are more likely to be penalized.⁴⁹ The high percentage of hospitals penalized (approximately 66%) indicates that the benchmark is not realistic. Thus, some adjustments in penalties are appropriate for hospitals in areas with a high percentage of patients at high risk for readmission.

As noted earlier, evidence exists that readmissions

related to surgery and cancer do not reflect low quality of care.³⁰ Some markers of quality, such as volume of patients, are associated with higher readmission rates. Moreover, the top 4% of cancer centers—the recognized leaders in cancer treatment—have higher readmission rates than other centers.³⁰

Adjustments to penalties should take into consideration socioeconomic factors and other issues. For example, it may be appropriate to weigh penalties according to the timing of readmissions (ie, higher penalties for the readmission within the first few days than for 4 weeks after discharge) and to give hospitals credit for low mortality rates, which may be associated with higher readmission rates.⁵⁰ A recent study shows that longer stays in the hospital decrease the cost and incidence of readmissions.⁵¹ Longer stays may be an option for those with a high risk of readmission. It may be beneficial for hospitals to look at patients’ recuperation progress and not release patients until they are fully recovered. Although this will increase short-term costs, the overall costs should be reduced.

Antitrust Issues

Antitrust laws must ensure that ACOs foster, not hinder, competition in the healthcare markets. ACOs encourage mergers and consolidations, and provider organizations wish to be large enough to absorb the risk of forming ACOs. They may also desire additional market power to be able to raise prices. It has been claimed that an “ACO is nothing more than a collaboration of competing providers.”⁵² The Federal Trade Commission has various antitrust concerns. Consolidations of insurance companies, hospitals, and physician practices are occurring, which increase market power and the consequent ability to raise prices, which could derail cost containment. A study from Robert Wood Johnson showed that hospital mergers result in price increases of 5% to 40%.⁵³

Critics have complained that the net effect of dueling monopolies (ie, insurers and hospitals) is that insurers pass on higher cost to consumers, employers, and government. However, the 2010 Affordable Care Act mandates that insurers spend at least 80% of premiums on healthcare benefits and quality-improvement activities. Insurers also must receive state approval to increase premiums. These requirements may suggest harder bargaining in the future, but thus far there has been little pressure for insurers to negotiate hard, so they just pass along the higher costs.⁵³ Thus, a balance is needed that encourages the efficient integration of providers while preventing the formation of anticompetitive monopolies or oligopolies.

Other Issues Facing ACOs

Historically, hospitals have provided considerable charity care, and the government has allowed for

cross-subsidization to cover the losses. The current reimbursement system set by CMS allows hospitals to charge higher prices than surgery centers or physician offices for the same procedure. In a Medicare ACO system aimed at reducing costs, such cross-subsidization leads to higher prices. We believe that the government should reimburse hospitals directly for the charity care and should implement reference pricing for services.

Another way to help achieve the Triple Aim in ACOs is to set up a system of focused factories, a system advocated by Regina Herzlinger⁵⁴ and Michael Porter and Elizabeth Teisberg.⁶ Focused factories deliver highly specialized care for certain types of conditions such as diabetes, cancer, or heart-related disorders. Such institutions can achieve better outcomes at lower costs.⁶ This was the concept of specialty hospitals, but the construction of new specialty hospitals was banned in favor of continuing the practice of cross-subsidization.⁵⁵

End-of-life care is fragmented, which leads to preventable hospitalizations and less palliative care. In fact, additional palliative care should probably be provided, because it reduces the length, number, and duration of hospital readmissions and visits to the intensive care unit and the emergency department.⁵⁶ Providing more palliative care may improve overall care and decrease costs. However, few providers are trained in palliative care.⁵⁷ In 2011, Medicare spent \$554 billion overall, of which approximately \$170 billion (or 28%) was spent on the last 6 months of patients' lives.⁵⁸ Clearly, such spending is a primary candidate for examination by ACOs.

Another issue is whether hospitals or physicians should control the ACO. A hospital-controlled ACO might be hesitant to reduce admissions or visits to the emergency department because it derives revenue from services provided therein. Moreover, physician-controlled ACOs could use whatever leverage they have to obtain the greatest value from the hospitals.⁵⁹ Indeed, hospital mergers in part may reflect the concern that physician-controlled ACOs could exercise leverage against hospitals. Another way to control healthcare costs is to keep people healthy. Healthier people use fewer healthcare resources. Finally, ACOs would seem to entail some regulatory costs.

Current Implications

The question of whether ACOs can achieve the Triple Aim remains unanswered. Care coordination and information technology are proving more complicated and expensive to implement than anticipated. Evidence suggests that ACOs have had greater success in meeting quality targets than in cutting costs.^{31,32,35}

Even if ACOs can decrease costs and increase quality, is the incentive system in place to do so? We believe that

the present system lacks appropriate incentives, which perhaps could be provided. Many patients are assigned to Medicare ACOs post hoc instead of ex ante. Many providers are unsure of which patients are in their ACO. This makes coordination of care more difficult. How can providers coordinate patient services if they do not know which patients are in their network? Also, bundling payments could help achieve the Triple Aim by giving physicians the incentive to control costs. Of course, global risk-bearing itself encourages cost consciousness, but bundling payment is a useful adjunct.

Furthermore, Medicare patients need incentives to use low-cost, high-quality providers. Price transparencies are important in any market but have been difficult to achieve in the healthcare market. However, the cost incurred in delivering price transparencies may be wasted, because patients will not shop for lower prices if they lack incentives to do so. Moreover, if consumers perceive that higher prices indicate higher quality, price transparencies will have the opposite effect of increasing costs.

Reference pricing is needed to incentivize consumers to use low-cost, high-quality providers. It is ironic that patients are not accountable in an ACO, because many times it is they, not the clinicians, who cause bad outcomes and high costs, often because of poor lifestyle or lack of adherence to medication or physicians' orders. The consequences include hospital readmission and visits to the emergency department, which contribute to excessive healthcare costs.

ACOs raise various antitrust issues. Although ACOs support the consolidation of hospitals, such mergers traditionally have led to higher prices (because of increased market power) but not to lower costs (as a result of culture conflicts and lack of synergy). The United States has a history of failed hospital mergers.⁶⁰ For Medicare ACOs to be successful, palliative care must be expanded, which could result in lower costs and better quality of life for terminally ill patients.

ACOs should promote low-cost alternatives to hospital care. It has been shown⁵⁵ that ambulatory surgery centers and specialty centers can provide the same services at a lower cost, more efficiently, and possibly with better outcomes than hospitals. Hospitals need to treat the most complicated cases, but to change the function of hospitals, the payment system must be reorganized. No longer should considerable cross-subsidization exist in the healthcare market.

Conclusion

The current Medicare ACOs have some positive aspects, but also many flaws, which could lead to a failure to achieve the Triple Aim. Modifications to correct these problems could be helpful, along with the benefits

of learning and experience. In fact, CMS has recently unveiled a new group of next-generation ACOs. Several private integrated systems have been successful, suggesting that instead of experimenting further with ACOs, it may be more beneficial to try to duplicate these successes and implement a policy that encompasses the best practices of these integrated modalities. ■

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STAKEHOLDER PERSPECTIVE

Time to Reexamine Accountable Care Organizations?

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The lackluster outcomes seen with accountable care organizations (ACOs) suggest that this nascent development may not be ready for prime time. Several aspects related to the concept and operations of the ACO model have been deemed “experimental.”

PHYSICIANS: The trek toward value-based care appears long and arduous. The American Medical Association's 2014 benchmark survey (conducted before the 2015 slower pace in ACO growth) showed that 23.7% of physicians were part of a medical home, 28.6% were part of a Medicare ACO, but almost 25% were unaware of whether they were part of either.¹ More than 50% of physicians were using advanced practice models, but few reported that their practices had eliminated the fee-for-service payment model.¹ The Centers for Medicare & Medicaid Services (CMS) is continually tweaking benchmarks and methodologies for Medicare's Shared

Savings Program to spur growth beyond the 434 ACOs that were included as of January 2016.²

Blackstone and Fuhr appropriately identify structural deficiencies in ACOs that reveal difficulties in meeting the dual objectives of quality improvements and cost containment.³ ACOs were introduced by the Affordable Care Act (ACA) of 2010, but they have now become essentially private-sector initiatives, with CMS remaining in a regulatory role.⁴ The academic literature has yet to grasp the ACO movement; therefore, many related publications come from press releases, health trade journals, newsletters, and popular media. Blackstone and Fuhr, however, rely on more credible sources, yet many of their points deserve future health services research to move beyond the “wait and see” perspective they take.

A recent article in *Kaiser Health News* noted that pushing physicians and hospitals to collaborate for effi-

STAKEHOLDER PERSPECTIVE *Continued*

ciency resulted in greater costs in nearly 50% of the ACOs.⁵ In fact, the ACO experiment showed a net loss of nearly \$3 million to Medicare.⁵ In August 2015, Navigant Center for Healthcare Research and Policy Analysis also said that 3 of 4 ACOs did not save Medicare money, and there were no shared savings to their providers.⁶ Overall, of the original 32 ACOs that participated in the Pioneer program, 12 dropped out because they could not adjust to the risks.⁶ Other factors suggest that only modest reductions have occurred in the use of low-value services in the ACOs.⁷

PAYERS: ACOs arose in a highly contested political environment and involved an experimental direction and a steep learning curve. Moving away from the fee-for-service reimbursement model demands a more precise definition of “value” for our plethora of medical interventions than is currently available. The merger and acquisition fervor among the largest health insurers, hospital systems, physician groups, pharmacy benefit managers, and retail chain pharmacies is moving large-scale national and regional corporate systems into a financially successful model. Although the ownership and control of ACOs have not been a topic of public policy, the reality is that ACOs will likely not go away even if the ACA is reversed.⁸

Rather, there is a general realization today that financing healthcare in America is rapidly and consistently moving toward “value-based care,” and the forces for such an approach are formidable.⁹ This direction must be an evolutionary, protracted process with the goals of measuring outcomes and achieving accountable care on a much larger scale.⁹ On the one hand, some of the criticism by Blackstone and Fuhr about ACOs is not surprising⁴; several of their critiques were indeed anticipated with the enactment of the ACA, assuming that ACOs could fail along the way, so successful models must be carefully scrutinized as “best practices” and for how they win patient satisfaction in the marketplace. On the other hand, as a nation we must accept a fundamental value in healthcare, whereby “winning” is defined as more than a mere financial success. We must also invoke measures to demonstrate quality as well as true community health advances, as is now called for through “accountable care communities.”^{10,11}

POLICYMAKERS: My own past review of the ACO development relied mainly on healthcare trade magazines and the popular press, because of the absence of academic studies at the time.¹² I commend Blackstone and Fuhr on their forthright discussion.³ Based on the available literature, it is apparent that various facets of

our health system transformation are happening in different places, at different paces, and in different ways. The United States must bring together healthcare leadership to collaboratively promote “societal learning-curve” sharing, to harness advances in the private sector for widespread dissemination. Larger systems must help the array of public providers who are serving underserved populations, including public hospitals, community health centers, and state and county public health departments.¹³

A beginning step for ACOs is to adjust their model for socioeconomic status so that when quality standards fail because of a medical group or a hospital’s financial distress, they will not punish patients and exacerbate disparities across communities. This is a key issue for physicians’ performance. Blackstone and Fuhr’s suggestions are well-taken, but not all their suggestions, as well as others, will likely be addressed. ■

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