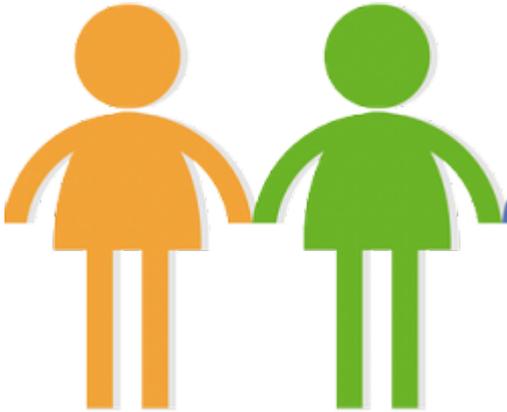


Accountable Care Organizations Want The Rewards But Few Want The Risk



By Chuck Dinerstein — June 13, 2018



Courtesy of Pixabay [1]

Accountable care organizations, are a new organization of healthcare, combining some aspects of insurance and health systems. They are collaborations which are paid a capitated rate, based on risk, and provide all care to these beneficiaries. If they show savings beyond what they are paid, they receive about half as an “incentive.” Savings cannot be achieved at the cost of patient safety and outcomes, so that “quality measures” must be met. For those showing greater costs, losses, what happens is less clear. The federal plan was to have these ACOs move from the safe environment where losses carried no real consequences, to a risk-based approach where there was “skin in the game,” and you might lose money. Oddly enough, few ACOs are moving from phase one where there are only incentives to phase two where money is on the table.

By the numbers

ACOs currently provide coverage for 18% of Medicare Beneficiaries (up from 6% in 2013). In the period to 2016, they received payments totaling over \$2 billion, but those payments are not shared equally; roughly 30% of ACOs earn money, 68% break even. They can be win-win situations for the ACO and the feds, for example, Cleveland Clinic earned \$19 million on \$42 in Medicare savings. Or they can be a win-lose with Medicare seeing financial savings, but the lack of improvement in patient quality scores keeps an ACO from sharing in those savings. They provide care to the entire spectrum of Medicare beneficiaries although percentages vary from 18% of the beneficiaries qualifying because of end-stage renal disease, 14% of beneficiaries qualified by disability, 5.8% of beneficiaries with both Medicare and Medicaid and 19% of beneficiaries qualifying because of age alone. [1]

Their quality scores were 95% in 2016 outperforming fee-for-service providers on 80% of some measures [2] while declining slightly in measures of patient satisfaction. A small subset achieved both significant savings and high quality. These savings were in hospital inpatient care and skilled nursing facility care after discharge. They did have increases in hospital outpatient care and physician payments but were the lowest of all ACOs.

So with all this good news, why are so few ACOs moving into the part of the program where they have downside risk if they spend more than they are allotted? Why are they reluctant to have skin in the game?

ACOs' unique costs and benefits

Patients in ACOs are free to get their care anywhere, unlike other “innovative payment” programs (i.e., Medicare Advantage). A typical patient sees two primaries, five specialists in four different locations; as a result, patients do not always get their care on the ACOs watchful eye, instead opting for convenience or differing expertise all of which may be more expensive; expenses attributed to the ACOs bottom line. And that doesn't even take into account, the snowbirds among the seniors who spend half the year in a different location.

Many of the improvements are system-level changes, coordination of care, use of EHR and greater standardization of screening. Scaling these changes by covering more patients, “lives at risk,” is a way to hedge your bet and this provides the impetus for acquisitions of those patients, through hospital consolidation and purchases of practices with employment of their physicians – all trends we are seeing. And consolidation eventuates in significant financial turmoil as the insurers and the health systems seek leverage against one another, e.g., the fighting between the University of Pittsburg (that controls most care in the western part of Pennsylvania) and Pennsylvania's Highmark (a Blue Cross program).

To Risk or Not to Risk

The 82 ACOs eligible to take on risk were surveyed, 43% responded, and 70% are unwilling to take on risk and will leave the program **if** risk sharing is required. I should say when risk sharing **is** required, which is after their third contract period. Their concerns revolve around the uncertainty of financial projections used in evaluating risk as well as changes in CMS rules governing ACOs, in short, too much risk for the benefit.

ACOs are costly to initiate [3], requiring significant coordination of care not previously provided, but that represent substantial cost reductions, and they need to assess risk, just like insurance companies with divisions of actuaries do. As a result, 80% of ACOs remain in phase 1, all carrot and no stick. At least staying in phase 1 offers them a chance to recoup their investment.

As more and more ACOs reach the limits of phase 1, the choice of risk sharing or leaving the program will become more critical in the survival of this payment approach. Both insurers and hospitals have taken advantage of these risk-sharing programs in their early phases when it was all about the carrot. Their remains a real reluctance to take on the stick, to have real skin in the game. The choices that ACOs and insurance companies make will tell us a great deal about how invested they are in lowering costs for everyone or whether this was an opportunity to raid the

federal cookie jar.

[1] Early patient targets were more complex patients, who cost Medicare more but who, through care coordination and reductions in the need for hospital-based care, can show significant savings. Savings for the walking well are much harder to achieve.

[2] Specifically hospital readmissions; screening for depression with a follow-up plan and screening for falls; pneumococcal vaccinations and use of electronic medical records were better.

[3] Estimates are the initial cost for an ACO is about \$1.8 million for a physician-run program and \$30 million for a mid-size hospital system.

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