



Key Points

- Attribution, or the assignment of patients to a particular ACO, should be considered carefully. There is potential for positive or negative selection depending on the method chosen and how populations are enrolled in these programs.
- Risk adjustment methods are important tools to help mitigate selection concerns.
- Financial and utilization targets against which savings will be measured should be set and adjusted to ensure a fair assessment, balancing past performance with high performance standards.
- Comprehensive databases from multiple sources are critical to performance metrics and financial targets.

Additional Resources

American Academy of Actuaries, Fact Sheet: Medicare Shared Savings Program and the Pioneer ACO Program, http://www.actuary.org/files/ACO_Fact_Sheet_FINAL_121912.pdf

An Actuarial Perspective on Accountable Care Organizations

The Affordable Care Act (ACA) and regulations implementing it incorporate a concept that some health reform proponents have advocated for several years: an Accountable Care Organization (ACO). There are now hundreds of ACOs across the country in both the public and private sector. An ACO is a group of health care providers, such as physicians and hospitals, that work together to manage and coordinate care for a group of patients—across the entire spectrum of care for those patients—and accept responsibility for the quality and cost of that care. The ACO structure is intended to encourage more integrated care for patients, resulting in quality improvements and reduced costs. Under many arrangements, including the new Pioneer ACO program and Medicare Shared Savings program (MSSP),¹ if an ACO achieves a benchmark level of cost savings while maintaining a measurably high quality level, the ACO shares in the cost savings.

The ACO concept and other approaches, such as patient-centered medical homes (PCMHs), are being researched and piloted by health care providers. To succeed in achieving their financial goals, these programs need to focus on measurement and certain key actuarial issues. The American Academy of Actuaries' Health Care Quality Work Group has developed this issue brief to provide an actuarial overview of ACOs and outline a number of issues that stakeholders should evaluate as ACOs are implemented.

¹Final rule to implement Section 3022 of ACA related to ACOs: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>.

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This brief outlines the financial considerations necessary to develop successful ACOs. Although sections of the brief refer to the ACOs as defined by the ACA and its related regulations, it also is intended to be a broader examination of the ACO concept across the public and private sectors. It is not intended to be an in-depth review or to be limited to the Pioneer or MSSP specifically.

The brief addresses the following key points:

- Attribution, or the assignment of patients to a particular ACO, should be considered carefully. There are risks closely connected to various population characteristics. There is potential for positive or negative selection depending on the method chosen and how populations are enrolled in these programs.
- An ACO can assume varying degrees of financial responsibility and risk:
 - Shared savings with bonus-only methods usually rely on fee-for-service (FFS) payment and may not remove incentives for overutilization.
 - At the opposite end of the spectrum, global payments provide significant financial incentives to avoid overutilization but, unless the ACO is structured to assume the full financial risk of a population, introduce solvency concerns.
 - Other payment options are available that strike more of a balance between shared savings and global payments.
- It is also important to create an incentive structure for individual providers within the ACO that can influence behavior and practice patterns.
- Risk-adjustment methods are important tools to help mitigate selection concerns related to an ACO arrangement. Reinsurance also can help an

ACO manage its financial risk.

- ACOs taking on significant amounts of risk should be subject to financial requirements—for example, a modified risk-based capital (RBC) approach after adjustment for the differences between accountability for internal expenses versus external claims payments.
- Financial and utilization targets against which savings will be measured should be set and adjusted to ensure a fair assessment, balancing past performance with high performance standards.
- Comprehensive databases from multiple sources—for example, past claims experience, electronic medical records (EMRs), and disease registry data—are critical to performance metrics and financial targets.
- The payment methodology between the ACO and payer, such as Medicare or commercial health plans, should be developed as a multiyear strategy. The payment strategy within the ACO—that is, how the ACO organization pays each provider—is equally important.
- Regulators and other stakeholders should balance broader marketplace implications, considering the effect on affordability, local prices, payment reform, and delivery efficiencies.

Background

With health care spending accounting for an increasing portion of the gross domestic product (GDP), attention has been focused on “bending the cost curve” in health care spending. Slowing the growth of spending could require fundamental changes in the way health care providers are paid. Instead of paying providers for each service such as an office visit (i.e., FFS)—without consideration of the quality or efficacy of the services—payment could

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be based on the performance or value (that is, reflecting a combination of high quality outcomes and lower costs) across a continuum of care for a patient.

There have been a variety of initiatives over the years to improve the quality and affordability of the health system by building on existing provider organizations or networks of providers. In the 1990s, for example, provider-based integrated delivery systems and carrier-based health maintenance organizations (HMOs) were developed across the country. Technical advances in the past few decades—such as improved analytic and measurement tools and improved health information technology support for care coordination—have made the implementation of such organizations more practical even as increasing health care costs have made the need for controlling health care costs more urgent.

Redesigning the financing model with new forms of reimbursement and incentives that increase alignment and accountability will be more successful if provider organizations also change internal incentive structures to fit the new reimbursement forms. Without changing the delivery of care and the relationship of providers across the continuum of care, an ACO could run into problems similar to those that occurred with earlier versions of managed care. This structural change might include redesigning the resources available to patients and providers to fit the new design of care delivery.²

While the focus of this issue brief is ACOs, it is worth noting that many of the considerations presented also apply to PCMHs, which are designed to support the primary care physician (PCP) in taking the lead role in coordinating care for patients.³

In recent years, a number of initiatives/pilot programs have been established. While under federal statute ACOs are now defined within the Pioneer and MSSP programs, hundreds of organizations identify themselves as ACOs, including:

- Advanced Primary Care Practice Demonstration—previously the Medicare Physician Group Practice (PGP) demonstration projects—by the Centers for Medicare & Medicaid Services (CMS);
- ACO pilot programs, including existing organized systems such as large California physicians' groups, Premier's Accountable Care Collaboratives, and the Brookings-Dartmouth ACO pilots;
- Alternative networks available in several states for Medicare Advantage plans;
- Alternative networks available in several states offered through commercially insured or self-insured employer plans;
- Pay-for-performance programs;
- Pilot programs for quality improvement, complication reduction, and unbundling;
- Many PCMH pilots across the country.

In addition, there are a number of federal pilots underway, including various payments incentives, the Comprehensive Primary Care Initiative, Health Care Innovation awards, and bundled payments.

Recent Developments

Until now, ACO-like programs typically have required members to enroll prospectively in the ACO, at which time they would be assigned a PCP and the patient would be required to get referrals to specialists. While this framework is not uncommon in the private sector, the ACA regulations offer both a retrospective and prospective method in which the ACO and physicians are linked based on their existing level of connectivity. To illustrate, an assignment methodology attributes patients to a particular physician or physician group based on number of visits or charges to that physician during the past year.

Traditionally, payments to an ACO-like program from a health plan (or other payer) could be based on FFS, bundled payments, or even partial or global payment, depending on the

² For more information, see the Brookings-Dartmouth ACO Toolkit: <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>

³ American Academy of Family Physicians, Joint Principles of the Patient-Centered Medical Home, February 2007.

capability of the ACO to manage the various levels of risk. The ACA regulations offer new shared savings arrangements from CMS. The provider can choose between several options, including both retroactive and prospective calculation of shared savings. Further, alternative payment options are being created in the private sector and additional CMS payment alternatives are being developed through the Center for Medicare & Medicaid Innovation (also referred to as the Innovation Center).

Even with recent developments, some core challenges remain. Payment reform is essential to create aligned incentives, health information technology needs to be implemented broadly to enable better coordination and management, and systems of care need to better address diverse consumer health care needs and expectations.

Actuarial Considerations

A number of financial and actuarial issues need to be considered when designing and implementing an ACO or similar program, such as PCMHs.

Defining Patient Populations

The method by which beneficiaries are aligned with the various ACOs is critical for the long-term success of an ACO. A flawed assignment methodology could lead to a bias in risk characteristics among ACOs, resulting in excessive financial risk for an ACO without compensation that is commensurate with that risk. The assignment process ideally should alleviate the potential for an inordinate proportion of certain risks going to any particular ACO. For example, a certain ACO may be assigned the majority of a certain socioeconomic class or those with preexisting conditions, consequently increasing the risk profile of the population assigned to that ACO.

Analysis of a population's underlying risk characteristics is important in any attempt to determine financial risk for an ACO. Risk characteristics can be measured as a part of this

analysis, including prior health claims, age, gender, education, and socioeconomic status. An ACO with an unusually high proportion of any of these risk characteristics could have issues in the future should these risks be excessive.

These calculations can be complex. For example, under the MSSP, a beneficiary will be assigned to the ACO that provides the beneficiary the plurality of PCP services as calculated by allowed charges. The beneficiary does not choose how he or she is assigned, and the beneficiary can choose to go to a physician inside or outside of any ACO. This could increase risk for ACOs since physicians have little control over which physicians, professionals, or facilities that a beneficiary sees.

It is also possible that an ACO may attempt to improve its risk profile through manipulation of the claims that fit both the PCP service and physician categorization criteria, although the likelihood of this is unknown at this time.

Performance Measurement⁴

ACOs and PCMHs build on a variety of measurement approaches for quality, efficiency, and resource use. These metrics often are backed by studies showing improved performance. The ACA quality of care provisions have encouraged increased national attention to performance measurement. Some of these key developments include:

- Increased public access to basic measures of quality through the internet and other sources;
- Stronger hospital quality measures (e.g., more measures, greater depth, examples of specific organizations that have proven improved performance);
- New evidence-based clinical metrics to measure quality;
- Improved efficiency and resource-use metrics;
- New episodes-of-care metrics, which can improve communication and understanding between purchasers' financial focus and

⁴Society of Actuaries, *Measurement of Healthcare Quality and Efficiency: Resources for Health Professionals* (October 2009): <http://www.soa.org/research/research-projects/health/research-quality-report.aspx>. Some of the more commonly used measures include the Hospital-Patient Experience and Select Clinical Quality report for Medicare, Leapfrog Survey, HEDIS carrier/physician measures, and Physician Quality Reporting Initiative.

providers' focus on individuals and specific illnesses;

- A variety of existing pay-for-performance programs that are predecessors for payment reform and broader ACO and PCMH programs;
- Pilot programs to reduce inpatient complications and readmission rates;
- Alternative networks offered to members in certain locations.

Since health care delivery systems are complex and continuously changing, these measures are likely to be enhanced and improved on an ongoing basis. The baseline data are important in measuring quality of care improvements—for example, under the MSSP, ACOs and PCMHs initially will be responsible only for measuring quality of care provisions for a subgroup of the population. This potentially makes comparison with subsequent periods difficult. Further complicating the issue, many Medicare approaches will determine this subgroup of patients retrospectively.

Using risk characteristics and prior results to project results for future periods can be complicated. One approach to this challenge is for an ACO to set up and track a control group, or other comparison group, similar to the structure of a formal quality study. This control group would have similar characteristics to the attributed population but would not have an ACO accountable for its care.

ACO Payment Arrangements

There is significant discussion about the need to address misaligned incentives in traditional FFS arrangements by creating payment systems that better align payments with value and performance. A distinguishing characteristic of both public and private ACOs is their assumption of greater responsibility and financial risk for performance. By transferring a degree of financial risk to ACOs, payers create an incentive for providers to manage the delivery of care and provide funding for alternative ways to support patients. Although a wide

range exists in the degree of risk borne by the provider organization under these alternative payment arrangements, such payment arrangements generally can be grouped into the following models.

■ “ONE-SIDED” SHARED SAVINGS (BONUS

ONLY): In a shared-savings arrangement that offers a bonus only, providers are eligible to receive a portion of savings if they meet quality of care standards while providing care at lower-than-projected costs. In a one-sided shared-savings arrangement, ACOs have some incentive to cut costs and increase efficiency to obtain a share of savings. If they are reimbursed under a FFS arrangement, however, they would receive a financial reward for performing more services. On balance, the effect of these conflicting incentives would depend on the details of the arrangement, but the payer continues to bear most of the opportunities and risks either way.

Designers of shared-savings arrangements should be wary of unintentionally creating misaligned incentives. For example, if bonuses are benchmarked on historical costs, an ACO has an incentive to increase utilization and incur higher costs in the benchmark period, thereby creating opportunities for savings in future years. In addition, if benchmarks are based on the previous experience of the various providers and not adjusted, shared-savings arrangements may disproportionately reward organizations that previously were inefficient and wasteful. This type of arrangement, if not designed carefully, could penalize cost-efficient providers. A final point to consider is the size of a savings pool over a group of providers. If an individual provider's share of the pool is small relative to its FFS reimbursement, the financial incentive to improve efficiency may be weak.⁵

In any case, determination of whether savings have occurred can be complex and potentially problematic. There can be dis-

⁵Medicare Payment Advisory Commission letter to CMS Administrator Dr. Donald Berwick regarding the request for comments on ACOs and the Medicare Shared Savings Program (Nov. 22, 2010): http://www.medpac.gov/documents/11222010_ACO_COMMENT_MedPAC.pdf.

putes between parties on whether program savings actually have occurred and the magnitude of such savings. Predefining a multiyear methodology can mitigate some of these concerns. As an alternative, stakeholders may consent to an initial definition of savings, with an agreement to refine the methodology in future years.

- **“TWO-SIDED” SHARED SAVINGS:** Under a two-sided shared-savings model (with downside risk), ACOs still would receive payment primarily on a FFS basis and would be eligible to receive a portion of the savings. They also would be at risk, however, for a portion of spending over the designated target. Under this model, the incentive to reduce costs and control spending would be strong, even if it resulted in lower FFS revenues as providers perform fewer services. As mentioned above, determination of savings is complex and there is potential for misaligned incentives.
- **BUNDLED/EPISODE PAYMENTS:** Further along the spectrum of financial risk that an ACO could bear is the concept of bundled or episode payment arrangements. Under this type of arrangement, provider organizations receive a single payment for all the services a patient requires for an entire episode of care. In the case of a hip fracture, for example, this payment would cover the hospitalization, surgery, purchase of a prosthetic hip, and all other associated expenses necessary to care for the episode. In such a payment arrangement, the payer bears the incidence risk—or the risk that the illness/injury occurs. The ACO and its providers bear the severity risk—or the risk related to the degree of complication in the patient’s case. ACOs, accordingly, take on more financial risk under this arrangement than in a bonus-only shared-savings arrangement, as they would now assume the downside financial risk for each case—that the cost to treat an episode will exceed the payment. The ACO, however, does not assume the incidence risk, which still is borne by the payer.
- **PARTIAL CAPITATION/GLOBAL PAYMENTS:** In a partial capitation model, an ACO is at

financial risk for some, but not all, of the items and services provided to its patients. An ACO may be at risk for some or all physicians’ services, for example, but not for hospital or other non-physician services.

- **GLOBAL PAYMENTS:** Global payments lie at the far end of the spectrum of financial risk an ACO can assume. These arrangements call for setting budgets for health care services and paying the ACO’s specified monthly or annual payments regardless of services rendered or costs incurred by providers. This shifts both the incidence and financial severity risks—which traditionally are associated with payers (e.g., government, self-funded employers, or insurers)—from the payers to ACOs. Under a global payment arrangement, the ACO bears the risk that payments received are insufficient to cover the costs of the services it provides. To assume global risk successfully, ACOs need a suite of tools and systems to monitor and manage cost and utilization that is similar to those currently used by payers. Solvency is also an issue and considerations are discussed later in this brief.

In a global payment arrangement, the only way for a provider to increase its financial benefit is to increase efficiency and reduce costs. Episode payment arrangements exert similar pressure, albeit only for specific instances. Under both arrangements, ACOs also have incentives to better coordinate care among multiple providers treating a patient or to replace inappropriate care settings (e.g., emergency rooms) with more efficient settings (e.g., physician offices). In addition, because payment under these arrangements is not tied to specific procedures, these models create an incentive for ACOs to try new and nontraditional treatment methods that would not have been reimbursed under a FFS arrangement.

There are many payment approaches being used across the country. In the private sector, all approaches are used—for example, capitation or global payment is used in some major insurance programs and in Medicare Advantage. In the public sector, the federal ACO regu-

lations offer an ACO two possible financial arrangements: a one-sided and a two-sided method. There are substantial differences between the approaches.

A significant amount of research currently is underway to develop and test new arrangements by numerous payers. One notable example is the recent establishment of the CMS Innovation Center. The ACA defines the center's purpose expressly "to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care."⁶ The Innovation Center may use other financial arrangements beyond the one-sided and two-sided approaches.

Regardless of the payment structure implemented between the payer and the ACO, the payment of individual providers within the ACO also must be considered. The risk tolerance of individual providers, the potential for disproportionately high- or low-risk patients, and the past and future efficiency of the provider, among other factors, will affect how each provider is reimbursed by the ACO. The success of an ACO is affected by the degree to which its individual providers are aligned and willing to participate and coordinate care. If a program only impacts a small portion of a provider's compensation or is very complex, the potential behavior change for that provider may be limited.

Performance Benchmarks

As noted above, all ACO payment arrangements rely heavily on comparison of actual performance to some benchmark target. The methodology and data used to calculate this benchmark must be considered carefully in the strategic set-up of the ACO and its payment method. There are two key issues:

- Development of the starting benchmark—what would the program have paid if no changes were made?
- How to pay only for real change, not random fluctuation—especially when the one-sided approach is used.

The development of a benchmark is done

by professionals, such as health actuaries and a variety of analytic techniques are used. These techniques involve taking historic experience and projecting results into the future. Future projections can be calculated anticipating a percentage growth rate or based on a flat dollar amount. In some cases, the calculations are quite detailed, breaking results into location, illness, and separate major components—such as hospital inpatient, outpatient care, and outpatient pharmacy. In others, the projection focuses entirely on the total program costs.

How to determine whether the savings are real or random is a challenging technical and financial issue. Health care claims can be higher- or lower-than-expected benchmarks due to randomness, and random fluctuation is more pronounced for smaller programs. This becomes further complicated when one-sided shared savings is introduced. ACO X, for example, could experience costs that are 3 percent lower than expected, and ACO Y could experience costs that are 3 percent higher. If the apparent 3 percent gain is shared with ACO X, then the overall system still experiences a loss for ACO Y, creating costs that are higher for the payer than they would have been without the shared savings. The variation should be considered for all programs, but the asymmetry is most important to overall savings reductions when only gains are shared (e.g., under one-sided financial arrangements).

Risk Adjustment

While ACOs are intended to encourage providers to reduce the growth in spending and deliver more efficient care, past experience has shown that providers' behavior can change in unanticipated ways. Transferring financial responsibility and risk to ACOs, for example, could create unintended incentives for providers to choose not to treat certain members if they are unhealthy. Some level of risk adjustment would help mitigate this concern. This is a tactic that must be considered when designing any ACO payment arrangement.

Properly implementing a risk-adjustment mechanism is critical to assigning budget re-

⁶ Section 3021(a) of the Affordable Care Act: <http://docs.house.gov/energycommerce/ppacacon.pdf>.

sponsibility to an ACO intelligently.⁷ To align an ACO's payment with the actual budget of its enrolled patient population, use of risk adjusters should be considered to set payment levels accurately so that ACOs with less healthy patients are not disadvantaged unfairly. If an ACO is operating under a shared savings arrangement, the benchmarks used to calculate savings similarly should be risk-adjusted to ensure that ACOs are rewarded for efficiency and not their ability to select risk. In general, risk adjustment should be implemented so that ACOs are responsible for cost increases because of an increase in the cost of treating individuals of a given level of disease severity. They should not be penalized financially for increases in the average illness of their enrolled population.

The ACO regulations recommend risk adjustment using the CMS-HCC risk adjustment model that already is used to adjust for risk under programs such as Medicare Advantage. This calculation would be done once at the start of the program.

Reinsurance

Under many payment reform models, ACOs take on the risk of treating unusually high-cost patients or high numbers of patients with multiple or severe conditions. ACOs should consider the advantages of reinsurance arrangements to limit their exposure to these catastrophic risks.⁸

Solvency Considerations

If an ACO assumes significant risk (either partially or completely) based on the collective financial and clinical performance of the covered population, the issue of ACO solvency becomes a heightened concern. If an ACO is managed improperly or unfavorable circumstances arise—for example, inadequate pricing resulting from unexpected inflation, a shift in the covered population's demographic characteristics, or one or more very expensive claims—the ACO's financial sustainability could be threatened.

The National Association of Insurance

Commissioners (NAIC) has adopted various methods to monitor the financial and operational condition of insurance organizations, including promulgating RBC standards for health organizations (e.g., HMOs, insurers, providers) that take on financial risk. RBC standards establish capital requirements based on the risk characteristics of a health organization. It would be reasonable to conclude, for example, that relatively less capital would be required for an ACO that takes risk only on the care its organization actually delivers. More capital would be required if it also takes on the risk for care delivered outside its organization. RBC models can be adapted to the different circumstances as new and innovative risk arrangements arise in the context of ACOs.

Data Availability and Management

Data about health history, including chronic conditions, can be useful tools to improve quality and manage costs. The earlier this data can be made available, the greater the opportunity for timely patient support.

Data management also is key to setting target measures of efficiency, quality, and value; calculating results; and identifying opportunities for improvement. Historical experience data often are used as a baseline target from which improvement can be measured and to determine budget splits by category of care, service, or trend. Current data are needed for ACOs to provide feedback to physicians, as well as track patients with complex medical needs.

Payers have claims data that are useful to measure processes and costs—for example, did a particular service happen, was a treatment protocol followed, and what was the cost? Many quality measures are based on such process measures.

Health information technology, such as electronic medical records for physician, hospital, lab, imaging, and other services, can provide additional data, which are valuable to determine patient outcomes. If an ACO is responsible for the care of a diabetes patient,

⁷ American Academy of Actuaries, *Risk Assessment and Risk Adjustment*, May 2010 issue brief: http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf.

⁸ American Academy of Actuaries, *Medical Reinsurance: Considerations for Designing a Government-Sponsored Program*, January 2005 issue brief: http://www.actuary.org/pdf/health/reinsurance_jan05.pdf.

for example, knowing the results of a patient's HbA1C test and showing improved and/or stable sugar levels (outcomes) is more valuable than simply knowing that the HbA1C test was performed.

Disease registries and state immunization registries offer additional data to help round out information about specific patients. Annual/seasonal flu shots are a good example. Patients often receive a flu shot at a retail pharmacy, but if the flu shot is not covered by the payer, the payer will not receive that information. The data related to the flu shot should be in the immunization registry.

DATA INTEGRATION

Integrating the data from these disparate sources can provide more comprehensive information on the delivery of efficient, quality care to patients. Even if payer claims data are all that is available initially, if an ACO can receive and manage the detailed claim and cost data of all payers, it can aggregate more easily the results across the payers.

Payers historically have not had access to medical record information. The ACO, therefore, may be in a better position to manage that information.

Integrating large proprietary databases from multiple carriers, including Medicare, will add complexity to these arrangements. In addition, the ACO may need to receive and integrate care provided by non-ACO providers as some patients will obtain care outside of the ACO network.

IMPACT OF CLOSED VERSUS OPEN SYSTEMS

Some ACOs may operate as open systems and some may operate as closed systems. In a closed system, such as an HMO, members are required to see physicians and use hospitals within the HMO network. In an open system, such as a preferred provider organization (PPO), global or indemnity system, members can seek treatment outside of a strictly defined network. Under Medicare, in which members are assigned to an ACO, the ACO essentially operates as an open system.

From a data perspective, a closed-system payer may not have all the information available on care provided to the patient unless it

also maintains data on denied out-of-network claims. This information may be necessary for measuring the continuum of care provided to a patient, even if the care was not provided by the ACO.

Open-system payers should have readily available information on claims whether or not there is an in-network only option.

It is imperative to determine the cost metrics that the ACO will be measured against and how data on costs outside of a closed system and beyond benefit maximums will be handled. This determination may depend on the level of risk the ACO accepts from a payer and whether the ACO accepts different levels of risk from different payers. And, beyond the formal external metrics, a variety of additional analytic tools would be useful.

Whether the ACO or the payers perform the quality, efficiency, and value measurement depends on the capabilities of the ACO, the willingness of organizations to share detailed information, and the availability of experts to manage health information technology data, such as medical record data. While certain data may be considered proprietary or confidential, success could be contingent on addressing these concerns so that data can be shared appropriately within the ACO.

Other Significant Considerations

When implementing an ACO, a number of nonactuarial considerations also should be evaluated. A PCMH may not be as robust an organization as one with the ACO model, but it still might need to address the considerations outlined below.

Level Playing Field

The dynamic of the provider marketplace can change from independently run physician groups with separate financial and quality goals to larger, multispecialty physician groups with a common set of financial and quality goals. Hospitals also may be part of the ACO model. Hospitals are both partnering with and acquiring physician groups to offer patients a broad and connected spectrum of care. The challenge is to offer a level playing field for ACOs by providing transparency to consum-

ers on their scope of services, efficiency, and quality of outcomes, so that consumers can evaluate their choices among competing ACOs as well as traditional care venues.

Concentration of Economic Power

The dynamic of the provider marketplace can change depending on how the ACO model develops. ACOs could become so large that single physicians or small physician groups might no longer find it feasible to practice without being a part of an ACO. If an ACO becomes too large, it could result in a negotiating advantage shift to the ACO. An ACO that has greater network strength and membership with a particular insurer could negotiate for higher prices. In addition to these pricing concerns, a consolidation of market share could raise federal antitrust concerns.

Impact of Mixed Systems of Reimbursement

The incentives under FFS programs are quite different from potential new arrangements. And, in the short term, both systems of reimbursement would continue for many provider organizations. As a result transitioning will be a challenge.

The effect on each provider will be different and should be evaluated. If an effective physician participates in an ACO, for example, the ACO and physician can earn various levels of revenue depending on how much performance risk the ACO takes on. The ACO leadership needs to decide what revenue stream makes the most sense for the ACO (e.g., it could start with FFS and accept more risk over time), recognizing that physicians could leave the ACO if it does not provide a stable revenue stream for them.

For ACOs that take on more risk, the ACO and affiliated providers also will need to have contracts that clearly state how gain-sharing or global payments will be distributed among all applicable parties. Consumers also might share in the savings—either directly through future premium reductions or indirectly through lower cost sharing.

Challenges to Entry

From the provider perspective, a number of challenges are associated with becoming an ACO. These include having a variety of physician disciplines available to patients, hiring new staff to help with administration and monitoring the budget structure, investing in new information technology, tracking patient medical records, developing secure data retention practices, and tracking and measuring data against efficiency and quality standards.⁹ In addition, a focus on maintaining the health of a population can be much different from an approach that focuses on providing patient care based on a specific office visit or admission.

ACOs are required to set up a management oversight committee that is responsible for monitoring the budget and quality of care delivered within their ACO. Some physicians and physician groups have not had to work within this type of model in the past. Providers should determine who will fill leadership roles within the new organization and who will fill the care delivery roles. Regarding care delivery, physicians could change how they practice medicine so that the physician, and in turn the ACO, meet certain quality standards. Providers will need to accept recognized clinical guidelines, which may differ from their past practice.

In addition, ACOs being developed for commercial markets face a challenge regarding essential community providers (ECPs), which are safety-net providers and entities such as federally-qualified health centers that predominantly serve low-income, medically underserved populations. The ACA requires qualified health plans offered through the exchanges to contract with ECPs. This can create network configuration issues. For example, an ACO building a physician network around a particular multispecialty group practice that does not include ECPs either must bring ECPs into its practice, create contracted arrangements with ECPs that are outside of the medical group, or seek a waiver of the ECP requirements.

⁹ For more information, see the Brookings-Dartmouth ACO Toolkit: <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>.

Privacy Issues

The Health Insurance Portability and Accountability Act (HIPAA) privacy constraints should be considered. In a coordinated care environment, providers will need to be able to share personal health information with other providers in the ACO. The providers may be split among a variety of facilities. This sharing of information needs to be done without breaches of security. The requirements also are different for each payer (i.e., Medicare, fully insured commercial population, or self-funded employer-based programs).

Implications for Policymakers and Other Stakeholders

The current growth in health care costs in the United States is not sustainable and there is a need to support new provider configurations and financial arrangements that promote and encourage high quality care that is delivered on a more efficient basis. ACOs and PCMHs can play an important role in the longer-term evolution of the health care system by delivering, coordinating, and managing health for defined populations.

ACOs that take more responsibility for performance and financial risk will need to have sufficient membership thresholds to achieve credible results that allow it to measure and ensure the success of the entity. The minimum membership will vary by market segment (e.g., Medicare, commercial) and can vary based on other parameters if specialty entities, such as chronic care or cancer ACOs, emerge. Membership thresholds will be an important tool to help ACOs achieve success. Smaller ACOs could agree to be subject to performance metrics as an alternative to taking financial risk. While the MSSP offers provisions favorable to the establishment of smaller to mid-size ACOs, the perceived complexity of the regulations has thus far challenged the creation of smaller ACOs.

Underlying all of the possible ACO configurations is the use of health information technology, such as electronic medical records or disease registries. This electronic infrastructure will facilitate greatly the coordination of

care. At the same time, it will enable the creation of “virtual” ACOs that link providers in separate locations. Even physicians in solo practices, who in the past could not have participated in coordinated care networks, could be linked over time to virtual ACOs.

As ACOs become more integrated and sophisticated in managing the health of their patients, health plans will want to consider whether their existing medical management processes are duplicative in effort and administrative costs.

ACO infrastructures will need to better adopt and disseminate evidence-based medicine as ACOs look to be more cost-effective in delivering quality care. Standardization of quality and performance measures, risk-adjustment methodologies, and payment mechanisms will help to streamline workflows and provide uniformity within and across geographic regions.

The way members are assigned, or attributed, to an ACO (e.g., prospectively versus retrospectively) will affect the risk profile of the ACO and its ability to manage the risks for which it will be accountable. An accurate risk-adjustment mechanism mitigates adverse risk whether arising from selection or assignment. The risk-adjustment mechanism can alleviate concerns that providers will deny coverage to less healthy patients.

There will be a variety of payment mechanisms, along a continuum from FFS (with shared savings) to partial capitations or global payments. ACOs can move along this continuum as they gain operational and financial experience in recognizing, assessing, and managing their risks. Uniform criteria for moving along this continuum would serve to protect both ACOs and subscribers.

To the extent that an ACO is and will be affiliated with many different organizations and providers, shared savings and risk sharing will present additional issues related to the allocation of gains and losses among its various entities. The ACO’s financial structure needs to be defined clearly.

ACO management should understand the risks taken and the ACO’s financial structure should reflect those risks accordingly. If ACOs

take on the same risks as an insurer or health plan, their solvency risks should be recognized and regulated in a comparable manner. The amount of risk an ACO takes on should be commensurate with its ability to assume risk. The ability of an ACO to manage and absorb risk is influenced by many factors, such as size, capital, and its provider payment agreements (including new alternative payment systems). States likely will play a major role in regulating ACOs, including solvency oversight. Comparable treatment of insurers and ACOs for comparable risks, after adjustment for new payment systems, will help ensure the financial stability of both types of entities and will provide the same level of solvency protections to subscribers.

A final key element for success relies on broad acceptance of these new structures and

payment methodologies. Enough providers and payers must be willing to accept these new structures and methodologies to sustain a behavioral shift away from rewarding quantity and toward rewarding quality and outcomes.

The management of ACOs needs to be reinforced by new metrics, analytic techniques, and other payment reform programs that are currently under development. In-depth analysis, integration of claims, and clinical information will help ACOs meet their new responsibilities and overall financial commitments.

In transitioning to this new environment, ACOs will need to coordinate with multiple federal and state-level entities. Regulators, providers, and payers should work together to coordinate rulemaking, definitions, timing, and oversight to facilitate as smooth a process as possible.



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