

## FACT SHEET

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*For decades, the U.S. healthcare system has experimented with various organizational structures for payment and care delivery. Each of them has sought to strike the appropriate balance to achieve better access to high quality care and outcomes at an affordable cost. The Patient Protection and Affordable Care Act of 2010 brought expanded healthcare coverage for Arkansans but also disruptive challenges and opportunities for the state's healthcare system. As a result, public and private payers in Arkansas and across the nation are transitioning from volume- to value-based payment strategies. Providers are responding by creating unique financing and care delivery arrangements that share capacity and optimize efficiencies. Accountable care organizations (ACOs) are an example of these efforts. This fact sheet provides an introduction to ACOs and describes various ACO payment models, classifications, and initiatives.*

## INTRODUCTION

Hospital-physician integration models existed before the Affordable Care Act (ACA) and ranged from the traditional medical staff relationships to service agreements between a health system and a physician group.<sup>1</sup> The concept of ACOs was introduced in 2006 as an approach to improve quality and lower cost of care by holding providers, mainly hospitals, accountable for patient outcomes across care settings. ACOs were adopted by provisions of the ACA directing the Secretary of the U.S. Department of Health and Human Services (HHS) to establish a shared savings program in Medicare that promotes accountability, coordinates care, and encourages infrastructure investment. Although ACOs began as a Medicare demonstration program, state Medicaid programs and the private sector are also utilizing ACOs.

## WHAT IS AN ACO?

An accountable care organization (ACO) is an organization of providers who work collaboratively to coordinate patient care and are accountable for the cost and quality of care in a defined patient population. (Figure 1 shows how ACOs work.) This approach differs from managed care organizations (MCOs), which are governed by a health plan that contracts with a closed network of providers. ACOs are provider-centric. Patients are assigned to ACOs, but, unlike MCOs, patients may choose a non-ACO provider.

Three driving principles of the ACO model are accountability, performance measurement, and shared savings.<sup>2</sup> Most ACOs have only one contract—the mechanism that brings providers and payer into alignment and describes the payment model, risk, quality measures, and attribution—either with a private payer or Medicare. Sixteen percent have a contract with both Medicare and a private payer.<sup>3</sup>

ACOs align with the shift toward value-based payment strategies inserting new financial incentives on provider to improve quality and contain cost. In general, there are three types of ACO payment models: shared savings, capitated payments, and global budgets.<sup>4</sup> Table 1 outlines these three types of payments, each of which shifts some level of clinical and financial risk from the payer to the ACO. In addition, payment arrangements, including the distribution of shared savings or recoupment of losses, between the ACO and its provider participants add another layer to the ACO financial structure.

**Figure 1. How ACOs Work**



**Collaboration of healthcare providers**



**Establish a spending benchmark**



**Shared savings**

- Costs below benchmark
- Quality targets met

**Table 1. Payer to ACO Payment Models**

SHARED SAVINGS	CAPITATED PAYMENTS	GLOBAL BUDGETS
<ul style="list-style-type: none"> <li>• Layers over a fee-for-service (FFS) payment system</li> <li>• Shared savings if costs are below targets and quality expectations are achieved (upside-only or one-sided model)</li> <li>• Some ACOs share losses (upside-downside or two-sided model)</li> </ul>	<ul style="list-style-type: none"> <li>• ACO receives a fixed payment per patient, expressed as per member per month (PMPM)</li> <li>• At risk for costs above PMPM</li> <li>• Under partial capitation, ACO assumes risk for specific services and is paid using a FFS approach for other services</li> </ul>	<ul style="list-style-type: none"> <li>• Overall budget is based on historic costs</li> <li>• Retain savings if costs are below the budget and losses if costs are above the budget</li> <li>• Incentive to coordinate with providers outside the hospital to manage care</li> </ul>

ACOs are graded on several quality and performance measures to determine eligibility for shared savings. ACO quality measures have been integrated as a way to protect patients against cost containment at the expense of patient care, a criticism of health maintenance organizations (HMOs). One report has shown that top earning ACOs typically had higher quality scores; however, higher quality did not generally correlate with shared savings.<sup>5</sup>

Cost and quality performance are assessed from ACO-attributed patients. Patients are assigned or “attributed” to an ACO based on a pre-established formula. For the Medicare ACO program, this means that if a patient receives a “plurality of services” from a designated provider within the ACO, the patient is attributed to that ACO. Unlike HMOs in which patients must choose from a network of providers, ACO patients may choose where they get care. ACOs are accountable for the quality and cost of care regardless of patient choice of provider.

## ACO CLASSIFICATIONS

Hospital systems led the way in ACO adoption, making up the majority in the early years. Gradually, physician-led groups or joint operations began establishing ACOs now making up 51 percent of ACOs.<sup>6,3</sup> There are generally three classifications of ACOs:

1. **Integrated delivery systems**—generally led by hospitals but comprised of a large number of clinicians including primary care and specialist physicians and offer a broad range of services including post-acute care.<sup>7</sup>
2. **Physician-led ACOs**—generally smaller, serve fewer patients, and offer a smaller number of services. This category of ACOs have grown in popularity, now outnumbering hospital-sponsored ACOs. Improvements in care coordination and disease management result in more services provided in outpatient care settings.
3. **Hybrid ACOs**—jointly led between physicians and hospitals; generally smaller than integrated delivery systems and offer an intermediate range of services.<sup>8</sup>

## MEDICARE ACO INITIATIVES

Medicare, in concert with the Centers for Medicare and Medicaid Services (CMS) Innovation Center, is currently pursuing several initiatives to achieve better care for individuals, improve population health, and reduce expenditures. Table 2 provides details on Medicare ACO models.

**Table 2. Medicare ACO Models**

MODEL	DESCRIPTION
<b>Medicare Shared Savings Program (MSSP) ACO</b>	Providers are paid on a traditional FFS basis with the potential to share in savings. Some participants elect to increase their accountability and thus their risk for potential losses in order to be eligible for greater savings. Shared savings payments are dependent on how well providers perform on quality measures. <sup>a</sup>
<b>Advance Payment ACO Model</b>	This model was designed to help smaller organizations participate in the MSSP by providing upfront financial support for infrastructure and staff. Each ACO received an upfront fixed payment and an upfront and monthly variable payment based on the number of beneficiaries. The advanced payment was recovered through shared savings achieved by the ACO. <sup>9</sup> This model concluded December 31, 2015.
<b>ACO Investment Model</b>	This model builds on the experience with the Advance Payment ACO Model. <sup>10</sup> It is intended to encourage ACO formation in areas of low ACO penetration. Eligible ACOs will receive pre-payment of shared savings in upfront and ongoing per beneficiary per month payments with periodic reconciliation to ensure savings occur.
<b>Pioneer ACO Model</b>	Payments are based on shared savings and losses at higher levels than the MSSP. Pioneer ACOs that have shown savings will be eligible to move to a capitation arrangement, or PMPM payment, intended to replace some or all of the FFS payments. <sup>11</sup>
<b>Next Generation ACO Model</b>	This model offers financial arrangements with higher levels of risk and reward than other ACO initiatives. Unlike the MSSP and Pioneer ACO Models, this model includes a prospectively set benchmark, allows beneficiaries to choose to be aligned to the ACO, and tests beneficiary incentives for seeking care at Next Generation providers. <sup>12</sup>

<sup>a</sup> On June 6, 2016, CMS released a final rule that changes the way financial targets are calculated accounting for the difference in spending compared to other providers in the region.

## MEDICAID ACO PROGRAMS

Some states have developed Medicaid ACOs in an effort to move toward value-based care. Similar to Medicare ACO models, these programs are based on either a shared savings arrangement or global budget model.<sup>13</sup> A few examples include Colorado's Regional Care Collaborative Organizations (RCCOs), Minnesota's Integrated Health Partnerships program, and Oregon's Coordinated Care Organizations.<sup>14</sup>

### STATE PROFILE: OREGON

**Oregon's Coordinated Care Organizations (CCOs)** launched in August 2012 under a CMS-approved 1115 waiver.<sup>15</sup> CCOs include healthcare providers (including mental health and dental care providers) and community members. Key features include:<sup>16</sup>

- Local governance to address community needs through a partnership of healthcare providers, community members and stakeholders in the health systems that have financial responsibility and risk
- A single budget that grows at a fixed rate
- Accountability for the health outcomes of the population served

In exchange for implementation funding provided by CMS, Oregon agreed to reduce the rate of spending by two percent while maintaining quality care. The model uses global budgets to compensate CCOs. Although the reform is still in progress, Oregon has met spending targets, decreasing PMPM spending for inpatient care by 14.8 percent and for outpatient care by 2.4 percent in 2014.<sup>17</sup>

## ACOS IN ARKANSAS

There are four MSSP ACOs located in Arkansas and several others that include Arkansas in their service areas.<sup>18,19</sup> Figure 2 shows the steady uptick in ACO adoption in Arkansas over time. The Fort Smith Physicians Alliance ACO was the only Arkansas ACO that participated in the Advance Payment ACO Model. Based on 2014 performance information, only one Arkansas ACO, Arkansas Health Network, earned a shared savings payout.<sup>20</sup> The other four ACOs fell below the payout threshold. Two ACOs generated savings but did not earn a shared savings payout. Two ACOs generated losses, but because all Arkansas ACOs participated in the upside-only model, these ACOs did not share in those losses.

**Figure 2. ACO Adoption in Arkansas**



## CONCLUSION

Despite increasing prevalence of ACOs, limited start-up funding, resistance to change, and insufficient infrastructure remain as obstacles to ACO proliferation. The lack of interoperability of electronic health records—critical for patient care coordination between providers in order to manage high-risk patients—has been cited as a significant barrier. ACO provider agreements may also create potential antitrust concerns. There is risk of agreements resulting in price-fixing that could reduce competition and increase prices. Finally, as HHS continues to experiment with additional alternative payment models, the overlap of participating providers and beneficiaries may create confusion, conflicts, and misaligned incentives. While ACOs have demonstrated progress towards reduction in spending and improvement in quality of care resulting in a promising approach moving forward, states and private payers should closely examine the value and complexities of the ACO model relative to existing or future provider payment models.<sup>21</sup>

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