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ACO Models – Studies Examine Sustainability

One of the main objectives of the 2010 *Patient Protection and Affordable Care Act* (ACA) is to decrease the rapid growth of health expenditures.[1] One of the steps taken by the federal government to address these concerns was to implement *Accountable Care Organization* (ACO) models.[2] Through these models, the *Centers for Medicare & Medicaid Services* (CMS) encourages hospitals and physicians with financial incentives (e.g., bonus payments, cost-savings, risk-sharing, and other financial penalties) to improve the quality and efficiency of care, in part through provider collaboration.[3] Two voluntary ACO model tracks were initiated – the *Pioneer ACO Program* and the *Medicare Shared Savings Program* (MSSP).[4] While the MSSP was designed for eligible health organizations seeking to switch from a traditional *fee-for-service* payment model to a *value-based* payment model, the Pioneer ACO Program was designed for more mature health organizations that were already experienced in coordinating care.[5] The latter program sought organizations that wanted to transition from a *shared savings model* to a *population-based* model on a track consistent with, but separate from, the MSSP.[6] These initiatives were intended to be an experiment in health policy; however, their viability has been recently questioned by both health professionals and policy makers.[7] The sustainability of ACO models has already been called into question, as Pioneer ACO Program began with 32 participating health organizations in 2012 and concluded with only 8 in December 2016.[8] In this *Health Capital Topics* article, the practicality of ACO models, as well as alternative options to promoting sustainable payment and delivery models, are addressed.

Data from these original initiatives suggest that both ACO models have failed to decrease the continuing rise in health expenditures. In a *New England Journal of Medicine* (NEJM) study examining the cost of care under the 2012 Pioneer ACO Program, Medicare only realized a net savings of 0.4 percent per quarter after accounting for the bonus incentives it paid out to participating organizations.[9] In another NEJM study (conducted by the same authors) evaluating the MSSP program, a lower cost of care was realized by Medicare in 2012, but the cost savings were offset by bonus payments paid out to organizations, totaling a $6 million loss.[10] When the study was conducted again for 2013 program implementation, no cost savings were realized by Medicare.[11] Although omitting bonus payments paid out to organizations would have resulted in cost savings for Medicare, organizations would have had little incentive to participate in either program without a financial reward.[12] Therefore, the two programs may be less financially practical than originally estimated. If the burden of healthcare costs are indicated to increase in subsequent years, an alternative payment model more capable at lowering Medicare expenditures may need to be discussed, developed, and implemented.

The development of ACO models has further contributed to the consolidation of health organizations.[13] This is in part due to the attempts by healthcare organizations to absorb the financial risks involved in establishing and operating an ACO through operational efficiencies.[14] Although healthcare organizations were consolidating before the creation of ACOs, these *emerging healthcare organizations* (EHOs) have likely contributed to the accelerating rate at which organizations are consolidating.[15] This trend has ultimately led to the accumulation of market power by health systems, giving them more leverage to negotiate higher prices for healthcare services with private payors.[16] One study found a 15.3 percent increase in price for health services when a health system monopoly was present, compared to a market with four or more hospitals.[17] Moreover, prices for hospitals situated in duopoly and triopoly markets were 6.4 percent and 4.8 percent higher than hospitals located in markets with four or more hospitals, respectively.[18] In another study conducted by the Robert Wood Johnson Foundation, it was found that hospital consolidations resulted in price increases of up to 40 percent.[19] As a response to the higher payments required by health organizations from payors, insurance companies have begun distributing the burden of increased costs onto consumers and employers in the form of *out-of-pocket* caosts, making health services less affordable to the average consumer (patient).[20]

Given the insufficient data available to support the financial viability of hospital-based ACOs, alternative payment models have been proposed and implemented in an attempt to lower health expenditures. One promising model has been physician-led ACOs.[21] Unlike hospital-led ACOs, which encourage the formation of a costly hospital-based health delivery infrastructure, physician-led ACOs financially incentivize physicians to promote the utilization of low-cost health services, such as those situated in primary care or outpatient facilities.[22] Although both hospital-based and physician-led ACOs

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receive bonuses for avoiding hospitalizations, the financial incentives to lower health expenditures are greater for physicians because they are not conflicted with lost revenue from decreased hospital admissions.[23] As the author of one of the first NEJM studies examining MSSP performance states, *"[Physician-led ACOS] have stronger incentives to lower inpatient and hospital outpatient spending than groups integrated with hospitals because their shared-savings bonuses are not offset by foregone profits from reductions in hospital care."*[24] The development and assessment of new innovative payment models by CMS, such as the one listed above, may be a more effective approach to combatting the economic ailments of the U.S. healthcare industry.

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