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Savings Goals May Elude ACO Models if They Rely Solely on FFS, Shared Savings

Accountable care organizations that rely on a fee-for-service, shared-savings model without a strong risk component may fall short of cost-saving goals that the health reform law originally intended, trailblazers of the ACO movement are cautioning.

Pankaj Patel, M.D., medical director of quality improvement and chair of the Quality Improvement and Clinical Integration Committee for Advocate Physician Partners, has helped spearhead a leading model on ACOs that has succeeded in improving quality and reducing costs. According to an article in the January 2011 *Health Affairs*, the model saved money for providers and insurers by focusing on strategies that include reducing central-line infections among intensive care unit patients using electronic claims submission, more closely managing chronic diseases to avoid complications, and boosting utilization of generic medications where appropriate. Advocate Physician Partners is a joint venture of Oak Brook, Ill.-based health system Advocate Health Care and about 3,500 physicians on its medical staffs.

Even with these early successes, Patel admits "the jury's still out" on whether any ACO, particularly those that include independent physician practices, will be able to manage total health care costs. "At best it's a tough proposition, and it's probably not for the faint of heart. I'm not sure this will lead to a windfall for anybody," he tells *HRW*.

Based on the way that ACOs are set up, most will probably hit a brick wall at some point in producing any savings, Mark Hedberg, a partner with the health care group of law firm Hunton & Williams LLP, tells *HRW*.

The monetary incentive with ACOs "is certainly to save the program money and earn some. But shared savings, if you think about it, is a race to the bottom, if that's all it ever is," he says. An ACO that receives a three-year contract, for example, probably won't generate any savings in the first year as it figures out what it's doing, he explains. It may generate some savings in the second year "and in the third year they really hit the ball out of the park, and they do great."

But as future contracts come down the road, the ACO will eventually squeeze out all of the savings it can. That's because from a year-to-year basis, "you're not going to be saving any more money, because you've already hit whatever efficiency level that the ACO is going to hit," Hedberg says.

Some health care observers may call this a "20-year glide path to full capitation — that's really all it can be at the end of the rainbow. I don't know if the regulators and politicians have thought that far ahead," he says. CMS, under direction of the health reform law, was supposed to be providing more guidance on ACO formation with forthcoming regulations, and the latest reports from health care observers are that the proposed rules may be issued between late January and mid-February (*HRW* 12/16/10, p. 4).

For those setting up ACOs, Robert Margolis, M.D., chairman and CEO of HealthCare Partners, cautions against basing their payment structure on an FFS format. "I think there's incredible evidence that well-run, well-organized coordinated care that is not based on fee-for-volume, but on the health of the population, is both doable and has been successful," Margolis tells *HRW*. In his view, providers should benefit from savings when their quality improves, satisfaction improves and they're managing the costs of all the resources.

He also says that just "shared savings," a popular buzzword in the ACO movement, won't be enough to sustain an ACO.

"Shared savings is what people propose when they don't have an ACO. Everyone's trying to figure out how to move to the coordinated care model, and the answer in the initial phase is it's a shared savings" model, Margolis says. This means looking at your respective, attributed population and what its cost history has been, adding in an inflation factor, and "then seeing if you can beat that trend in cost by trying to put more efficiency into your system. If you can, there's some shared savings over what was anticipated cost."

Incentives Must Change Behavior

This is a start, "but my honest belief is you have to have a large enough ACO population and you all have

to take some level of risk on the up and down side, so you actually have incentives to change behavior, and invest in the system of health and wellness prevention and chronic disease management. And I think the more advanced ACOs and the whole transition into ACOs is going to move us in that direction."

If you know your population and its risk profile, "then you can define an appropriate prepayment capitation with risk. As soon as you have a coordinated care organization at risk with an upside, then you can get all of the investments, and that's where the savings will generate," he says.

HealthCare Partners is a participant in an ACO pilot developed by the Dartmouth Institute for Health Policy and Clinical Practice and the Engelberg Center for Health Care Reform at the Brookings Institution. The Dartmouth/Brookings pilots, announced last year, are still in the early phases of identifying the number of attributed patients. There are five national pilots, two in California (including the HealthCare Partners pilot in Los Angeles), one in Arizona, one in Kentucky and one in Virginia.

Margolis says HealthCare Partners will leverage its experience with Medicare Advantage and commercial populations in carrying out its ACO pilot. "There are approximately 750,000 members for which we take global capitation" and are thus responsible for their long-term health and wellness. That includes patient education, prevention, smoking cessation, lifestyle and chronic disease management, and programmatic management, he notes.

An ACO should be based on a fully developed program that significantly reduces admission rates, readmission rates and complications, "so you keep people at home much longer," Margolis says. He adds that HealthCare Partners has successfully managed to reduce the number of hospital days for its MA and commercial patients.

HealthCare Partners will use a similar approach in the Dartmouth/Brookings pilot, Margolis says, although he acknowledges that the results may not be exactly the same, since the MA patients he previously referenced have chosen to be in a specific network and have agreed to stay in that network.

Patients Are Free to Leave ACOs for Care

"With an ACO, the patients are attributed to a network by their historical usage patterns and are also free to leave the network and get care anywhere they want. Because it's an open system, there will most likely be some leakage," he says. As an example, a heart transplant patient may insist on going out of network to the Mayo Clinic for his or her procedure, "and the ACO is on the hook for that. So that's why we probably will not see the same degree of savings you would see in a similar population under a fixed network like an HMO product."

Patel emphasizes that ACOs can be successful — with a lot of hard work. Advocate Physician Partners recently signed its first commercial ACO contract with the state's largest insurer, Blue Cross and Blue Shield of Illinois, a unit of Health Care Service Corp. As described in *Health Affairs,* Advocate's model organizes physicians into partnerships with hospitals to improve care, cut costs and be held accountable for the results.

Insurers do reimburse on a FFS basis, but, according to Advocate, the model also features a pay-for-performance component that addresses the shortcomings of FFS. That includes the failure to reimburse physicians adequately for chronic disease management, preventive counseling and care coordination.

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