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Pioneer Accountable Care Organizations: Lessons from Year 1

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In the three months since their release, the initial results of Medicare's Pioneer Accountable Care Organization (ACO) program have generated divergent interpretations by analysts and policymakers. Some have pointed to savings and quality improvements in the first year as evidence that the program is off to a promising start to improving the value of care. Others cite the nine organizations leaving the program and the humbling results of a prior ACO experiment in Medicare — the Physician Group Practice Demonstration (PGPD) that ran from 2005 to 2010 — as reasons to be pessimistic.

While both camps have merit, we must keep in mind that after one year, there is still more unknown than known about how the Pioneer ACOs might perform over the long run. It is also important to remember how the Pioneer ACO contracts differ from both the PGPD and current ACO contracts outside of Medicare. By putting the first-year achievements of the Pioneer ACOs in the appropriate context, they look more impressive than they might otherwise seem, although the challenges they face going forward remain daunting.

ACOs are one of the main ways that the Affordable Care Act (ACA) tackles costs. About 250 ACOs contract with Medicare for the care of 4 million beneficiaries. Most chose a one-sided model in the Shared Savings program, under which they are rewarded for savings below a spending target but are not penalized for any spending above the target in the initial three-year contract period. In contrast, the Pioneer program, which began in early 2012 and involved 32 organizations, is a two-sided model that carries penalties for excess spending but also provides greater rewards for savings. Both programs reward ACOs for reporting and performance on quality measures.

THE FIRST YEAR'S RESULTS

In Year 1, spending grew 0.3% for the 669,000 beneficiaries in Pioneer ACOs, which was 0.5 percentage points lower than the 0.8% spending increase for similar beneficiaries in the traditional fee-for-service program. (http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html) The Pioneer organizations collectively beat their spending targets by $87.6 million in the first year, $33 million of which went to the Medicare Trust Fund. These savings came largely from 13 organizations, in part through reductions in hospital admissions and readmissions. Of the 19 other Pioneers, 17 had spending that did not significantly differ from their targets, whereas two had losses totaling about $4 million.

All ACOs were rewarded for reporting quality measures. Although rewards were not tied to performance in 2012 (they will be in later years), Pioneer ACOs did better on blood pressure and cholesterol control for beneficiaries with diabetes than did managed-care plans, and better on readmissions relative to the Medicare fee-for-service benchmark. Beneficiaries in Pioneer ACOs rated their experience higher on all four patient-satisfaction measures in 2012 than did fee-for-service beneficiaries in 2011.

At the end of the year, seven organizations that did not generate savings decided to transition to the Shared Savings program, and two decided to leave the ACO arrangement altogether. The absence of financial risk in the one-sided model and in the fee-for-service program is presumed to have contributed to their decisions.

A CONTEXT FOR THE PERFORMANCE

There are two bases for comparison: the Physician Group Practice Demonstration program and, outside of Medicare, the hundreds of ACO-type contracts between physician groups and private insurers that cover 15 million to 20 million people under the age of 65.

The PGPD program is seen by many as a bellwether of today's ACOs. While all PGPD participants improved quality, only two sites achieved the minimum 2% savings in the first year needed to qualify for a bonus. Only four sites had statistically significant savings by the end of the demonstration. (http://www.ncbi.nlm.nih.gov/pubmed/22968890) Although a greater proportion (40%) of Pioneer ACOs achieved savings in the first year, the PGP experience serves as a reminder of the difficulty of generating savings. (http://www.nejm.org/doi/full/10.1056/NEJMp1110185)

Yet one distinction bears emphasizing. While the one-sided ACO model is a cousin of the Pioneer model, they are distant cousins. Bearing risk for excess spending is a strong incentive to find savings and more likely to promote serious delivery-system changes. The PGPDs, unlike the ACOs created by the Affordable Care Act, were not required to move to such a two-sided model. Thus, the initial Pioneer results may lead a different path than that of the PGPD predecessors.

There are also significant differences between ACO contracts outside of Medicare and those of the Pioneer program. ACOs in Medicare have fewer options for cost control. Unlike private insurer contracts that have the flexibility to lower cost sharing for high-value services or high-quality providers, Medicare ACOs must rely on a standardized cost-sharing structure. They cannot restrict access to physicians outside the organization, putting them at the mercy of clinical decisions that are beyond their control. They cannot achieve savings by referring patients to lower-priced providers, since Medicare prices are more or less uniform. Thus, the only way for ACOs in Medicare to lower spending is to lower utilization. They can forgo wasteful services, find less expensive substitutes, or provide care to patients at home to prevent unnecessary hospitalizations. However, none of these is easy, which makes their 0.5 percentage-point lower spending increase relative to the fee-for-service program look even more impressive.

HOW THE WORLD IS DIFFERENT AND THE SAME

That decision of nine Pioneer ACOs to leave the program after the first year may well be the most ominous result. This evokes memories of the managed-care backlash, when capitation contracts of the 1990s that placed physician groups at financial risk proved to be unsustainable. In some ways, however, today's environment is different. Physicians have more experience practicing in integrated delivery systems, contracts now include caps on potential losses, quality bonuses play a bigger role, risk adjustment has improved, awareness of wasteful spending has grown, and the urgency to slow spending has reached fever pitch.

Nevertheless, many institutional realities from the 1990s remain. (http://content.healthaffairs.org/content/31/11/2407.abstract) The basic market failures in health care are still with us. Restraining utilization remains a difficult sell to patients and providers. Moreover, the delivery system is still best when people fall ill; it is less adept at managing population health for an aging nation. As Pioneer ACOs face continued pressure to lower spending without major parallel efforts to protect them from financial risk (like improving the nation's public health system, medical-malpractice reform, and public education about high and low value care), there is no certainty that the remaining Pioneer ACOs will not someday walk away. Nor is there certainty that one-sided ACOs, mandated to transition to two-sided contracts after three years, will not walk away.

THE BIGGER QUESTION

At its core, the ACO concept has two objectives: payment reform and delivery-system reform — with the hope that the first will kick start the second. Regardless of whether the Pioneer program or similar contracts in the private sector generate savings or improved quality in the short run, the bigger question is whether they will suc-

ceed in changing the nature of the delivery system. Will physicians and hospitals begin to join forces to keep populations healthy? Will providers across specialties climb out of silos in an age of joint accountability? Will patients fare better?

Unlike designing a payment contract, delivery-system reform has no blueprint. It inherently requires changing the culture of medicine — the way providers work with each other, relate to each other, and the way the system perceives patients. It calls on physicians across the specialties to find common ground in a world with shared risks and rewards, to work in teams and coordinate care towards common goals within their organizations. It calls on insurers to help providers identify waste and inefficiency, and patients to be part of the care team. And it calls on our health care economy to see patients less as commodity and financial opportunity and more as populations whose health and dignity the medical profession was envisioned to protect.

The ACO concept is vital because it enables delivery-system reform to make economic sense, and it provides physicians the opportunity to lead in this reform. With 10,000 Americans turning 65 every day over the next two decades, for Medicare, at least, this opportunity will look increasingly like an imperative.