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Accountable Care Organizations: An Untapped Opportunity

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With the advent of Health Care Reform in the United States, the concept of an accountable care organization (ACO) has been receiving significant attention. This is an area where actuarial skills will be needed in order to achieve success.

A group of SOA members representing the Work Group for the "Untapped Opportunities for Actuaries in Health" strategic initiative attended an accountable care organization Summit, in Washington, D.C. June 7-9, 2010.

What is an ACO?

Section 3022 of the PPACA specifies that Medicare will establish a "shared savings program" by Jan. 1, 2012, to promote accountability for a patient population, through accountable care organizations (ACOs). According to the Medicare Payment Advisory Commission (MedPAC), an ACO is:

"A group of providers held responsible for the quality and cost of health care for a population of Medicare beneficiaries."

An ACO can be a combination of one or more hospitals, primary care physicians and possibly specialists, and is accountable for total Medicare spending and quality of care for the Medicare patients served. Bonuses and penalties are tied to overall Medicare spending and quality measures.

Although an ACO resembles an HMO or other managed care plan, one key difference is that Medicare beneficiaries will not actually enroll in any plan, but will instead be "attributed" to a group of providers based on their health care utilization patterns. Attribution is a key concept discussed later in this article.

ACOs: Risk and Opportunity

ACOs present a spectrum of provider risk options; the ACO Summit summarized the spectrum into three levels. Level 1 is a shared savings model, where providers can receive bonuses for high-efficiency care e.g., when overall actual costs are below target costs. Other than the shared savings bonus, providers would not assume any additional risk. The initial Medicare ACO program will fall into Level 1.

Level 2 is a symmetrical model, in which risk is shared between the payer and provider. In many cases, the ACO will accept payments retroactively (instead of fee-for-service payment to each provider), and the ACO will allocate revenue within its organization according to its own risk model. Savings would likely be shared between the payer and ACO.

Level 3 is a partial capitation model, in which the ACO accepts a prospective capitation payment for all or a portion of care for a given set of patients. The upside revenue potential is higher, but the downside risk is greater.

Themes of the ACO Summit

At the conference, we noted several important themes about ACOs and the future of provider payment, which hold important opportunities for actuaries.

Theme 1: The initial Medicare model of shared savings, with no real downside (Level 1 as outlined above), will not be enough to motivate change in the system.

Changing health care delivery practices is not a simple task. Without a downside risk to the current system, providers will not have enough financial incentive to make necessary investments in infrastructure, or to make higher-quality, efficient changes in their practice. Several experts at the summit spoke of the need to make the status quo unpalatable, in order to facilitate change in outcomes and efficiency.

Two-way risk needs to be part of the ultimate plan, if an ACO is going to be successful. ACOs need to begin incorporating greater risk into their long-term strategic planning if they are not already doing so. The ACO's current level of risk assumption will be an important factor in how far down the risk path, and how quickly, the organization will travel.

Opportunity for Actuaries: These organizations will need actuaries to evaluate risk and model shared savings strategies. They may also need a third-party, objective analysis when they are at the table bargain-

ing for risk sharing and shared savings payments from payers. To the extent that provider organizations are taking on increased risk, they will need to explore reserves and reinsurance alternatives. Providers may not realize it, but they need actuaries; regulators may need support as well, as innovative forms of risk sharing models proliferate.

Theme 2: The leadership of health care organizations who are, or wish to become, ACOs must make accountable care a strategic priority.

Leadership, and especially Boards of Directors, of ACOs will be of utmost importance. ACOs require investment in infrastructure, changes in administrative practice, coordination among providers, and adjustments in clinical practice in order to be successful.

Opportunity for Actuaries: Managed care might have been a longer-term, sustainable way to control health care costs if actuaries had been at the table with providers earlier in the process. ACO leadership should include actuaries, or at the very least have the counsel of actuaries in their strategic planning phases. The up-front planning will require pro-forma modeling, as well as initial capital, and possibly even risk-based capital.

Theme 3: Attribution—or how members/beneficiaries are assigned to an ACO—is a key factor in the success of the ACO

The concept that an ACO member/beneficiary does not need to enroll in a plan is new territory for both the payer and provider sides. However, most patients receive the majority of their care from a closely-aligned group of providers (hospitals, physicians, other providers); attributing a patient to a particular group encourages coordination of care and rewards providers of high quality, cost effective services with the opportunity to share the resulting savings.

Another concern in the discussion of attribution is the necessary size in the number of beneficiaries and in providers. The size will depend on many things, including (but not limited to) the ACO's

area population, provider capacity, mix of Medicare/Medicaid/Commercial group/Commercial individual insured business, and practice patterns.

The attribution method for the Medicare ACO program has not yet been finalized, but will likely be based on existing methods. Typical methods involve building a hierarchy based on a patient's actual provider utilization, with primary care at the top of the hierarchy. For example, a patient is attributed to a particular group of providers based first on primary care utilization, and then on utilization by other types of providers.

Attribution is also discussed in the context of Patient Centered Medical Homes (PCMHs), which can fit into the construct of an ACO, or can be an independent entity.

Opportunity for Actuaries: Attribution is an area where actuaries can lead the industry. We can begin with existing attribution methods, modeling the long-term impact of potential methods, and narrowing this analysis when a method is finalized for Medicare ACOs. We can assist in adapting the Medicare method to commercial populations as well. We can develop new methods of attribution for ACOs, based on our experience with claims data and risk adjustment. Finally, we can assist with the

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statistical analysis of required population and membership for a viable ACO with credible results for shared savings.

Theme 4: Measurement will be more important than ever.

If ACOs are to achieve high quality, efficient care, they must develop and maintain a measureable set of goals and track their success in achieving these goals. Health care organizations have metrics for quality and efficiency, and they must be applied rigorously within the context of an ACO.

For Medicare ACOs, the development of the target per capita cost benchmark will be critical in the measurement of shared savings. PPACA specifies that that the benchmark be adjusted for beneficiary characteristics and other factors.

Opportunity for Actuaries: Actuaries can get involved now to help establish standard metrics to measure quality and efficiency within and across ACOs. We can also participate in ongoing measurement and improvement. The Medicare per capita benchmark, with its legislative mandate for risk adjustment, begs for actuarial expertise. Finally, actuaries can assist an ACO in appropriately allocating shared savings payments among the ACO's providers.

Want to learn more?

To learn more about ACOs, here are some additional resources

McClellan, et al. "A National Strategy to Put Accountable Care into Practice." Health Affairs, May, 2010 p 982. *http://content.healthaffairs.org/cgi/reprint/29/5/982*

McKethan, Aaron and Mark McClellan. "Moving from Volume-Driven Medicine Toward Accountable Care." Health Affairs Blog, August 20, 2009 *http://healthaffairs.org/blog/2009/08/20/moving-from-volume-driven-medicine-toward-accountable-care/* (accessed May 11, 2010).

Goldsmith, Jeff. "The Accountable Care Organization: Not Ready for Prime Time." Health Affairs Blog, August 17, 2009, *http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/* (accessed May 11, 2010).

The website for the Brookings-Dartmouth Accountable Care Organization Learning Network, including this information page: *https://xteam.brookings.edu/bdacoln/Pages/BackgroundInformationonACOs.aspx* ■