The Potential Impact of Accountable Care Organizations With Respect to Cost and Quality With Special Attention to Imaging

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An accountable care organization is a form of a managed care organization in which a group of networked health care providers, which may include hospitals, group practices, networks of practices, hospital-provider partnerships, or joint ventures, are accountable for the health care of a defined group of patients. Initial results of the institutions participating in CMS's Physician Group Demonstration Project did not demonstrate a substantial reduction in imaging that could be directly attributed to the accountable care organization model. However, the initial results suggest that incentive-based methodology appears to be successful for increasing compliance for measuring quality metrics.

Key Words: Accountable care organization, physician group demonstration project, Patient Protection and Affordable Care Act, radiology, imaging

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INTRODUCTION

One of the most challenging problems facing our nation is the apparent uncontrolled increase in health care expenditures. In 1960, expenditures on national health care were $27 billion and represented approximately 5.1% of total gross domestic product (GDP). Twenty years later and following the implementation of the Social Security Act of 1965, health care expenditures increased to $246 billion and a proportionately higher share of GDP (12%) [1]. Political and economic pressure began to intensify in the early 1980s. The result was a change from a retrospective fee-for-service payment system to a prospective payment system for Medicare in 1983. The prospective payment system was rapidly adopted by state Medicaid programs and private insurers by the mid-to-late 1980s.

The solutions of the 1980s do not appear to have had a substantial effect on the growth of health care expenditures. In 2012, US national spending will reach $2.8 trillion and an even higher proportion of GDP (18%) [2]. Some estimates predict that one-fifth of GDP will be apportioned to health expenditures in 2021. The unabated rise in health care spending is a growing burden on families and businesses and a threat to the fiscal stability of the government. Health costs are now the third highest government expenditures following defense spending and Social Security. The high level of spending allocated to health care reduces our ability to invest in other parts of our economy and adds to our unsustainable national debt [2].

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) represents one of the most significant changes in the US health care system since the passage of Medicare and Medicaid in 1965. PPACA is aimed primarily at decreasing the overall costs of health care and reducing the number of uninsured Americans. PPACA requires insurance companies to cover all insurance applicants, regardless of pre-existing conditions. Additional reforms within the law are aimed at improving health care outcomes and streamlining the delivery of health care. As of the bill's passage into law in 2010, the Congressional Budget Office estimated the legislation would reduce the deficit by $143 billion over the first decade and estimated a second decade deficit reduction of $1.2 trillion [3].

The term *accountable care organization* was first used by Elliott Fisher, who was then the director of the Center for Health Policy Research at Dartmouth Medical School, in 2006, during a discussion at a public meeting of the Medicare Payment Advisory Commission [4]. The Accountable Care Organization (ACO) was written into law in PPACA in 2010 and is one of the most discussed provisions of the health care reform law [5]. An ACO is a form of a managed care organization in which a group of networked health care providers, which may include hospitals, group practices, networks of practices, hospital-provider partnerships, or

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joint ventures, are accountable for the health care of a defined group of patients [6]. In essence, an ACO agrees to be fully accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program. Thus, the ACO is responsible to the patients and third-party payers for the quality, appropriateness, efficiency, and total cost of the health care provided to each enrolled Medicare beneficiary with the ultimate tripartite goals being (1) improve the quality of individual patient care, (2) better population health, and (3) reduce the growth of health care expenditures [5]. By increasing care coordination, ACOs can help reduce unnecessary medical care and improve health outcomes, leading to a decrease in utilization of acute care services [4,7]. According to CMS estimates, ACO implementation as described in the ACA is estimated to lead to an estimated median savings of $470 million from 2012 to 2015 [8].

CMS Physician Group Demonstration Project

The initial ACO design was based on the results of the CMS Physician Group Demonstration Project (PGDP) [9]. Ten physician group practices participated in this project comprised approximately 5,000 physicians and 220,000 Medicare beneficiaries. CMS created a shared savings model with medical groups that permitted them to receive payments of up to 80% of the generated savings [10]. Costs were monitored for both Medicare Part A and Part B spending. The accrued savings were calculated based on growth in patient costs compared with a base year in the participating PGDP groups, compared with growth in health care costs for patients in the same local market who did not receive services from the participating demonstration group. In addition to the pure cost savings, the groups were required to comply with 32 quality measures that were phased in during the 5-year period [9].

Accountable Care Organizations

The Department of Health and Human Services proposed the initial set of guidelines for establishment of ACOs under the Medicare Shared Savings Program (Section 3022 of the PPACA) on March 31, 2011 [11]. The Medicare Shared Savings Program is the most common form of ACO and is a 3-year program in which ACOs accept responsibility for the overall quality, cost, and care of a defined group of Medicare fee-for-services beneficiaries [11].

To be eligible to become an ACO, a provider group must meet the following criteria:

- Manage a minimum of 5,000 Medicare beneficiaries (retroactively assigned to an ACO based on their "pleurality" of use of a primary care physician) for 3 years.
- Report on quality, cost, and care and coordination measures.
- Form a legal structure to share, distribute, and repay back any losses.
- Meet "patient-centeredness" criteria set forth by the HHS secretary.
- Become a separate legal entity with its own tax ID number [5].

ACOs must also quantify 33 quality measures in 5 patient-centered areas that include the following: (1) patient's experience in receiving care, (2) coordination of patient care, (3) patient safety, (4) degree of emphasis on patient health, and (5) effectiveness of treating Medicare patients who are sick and frail [12].

ACOs must inform Medicare beneficiaries that they are receiving care within an ACO and that their claims data may be shared within the ACO [13]. ACOs must also notify patients that the ACO may receive incentive payments and the patients have the opportunity to opt-out if they wish [13].

There are essentially 2 different models of shared savings for ACOs. The first option allows an ACO to receive a portion of the shared savings without any risk of loss for the first 2 years and be "at risk" the third year. The ACO would be eligible to receive up to 50% of shared savings above the minimum savings rate of 2% based on the established cost benchmark. The second option is a "2-sided" payment model. Under the 2-sided model, providers will assume some financial risk but will be able to retain a higher proportion of any shared savings that occur (60%) with elimination of the 2% benchmark threshold. The final incentive payment for both models is based on a combination of shared savings, quality measure reporting, and quality score [11].

RESULTS

The ACO model was recently implemented and no results are available. However, the results of the PGDP, upon which the ACO was based, have been reported [14]. The PGDP ended at the end of 2010. All PGDP participants did very well on the quality metrics during all 5 years of the demonstration project. By the fourth year, all 10 groups met at least 29 of the 32 measured quality metrics. By the fifth year, 7 participants achieved benchmark-level performance on all 32 measures and the remaining achieved similar levels on at least 30 measures [10]. The PGDP participants increased their quality scores on disease-specific metrics, including heart failure, diabetes, and cancer screening measures, by at least 9% over the lifetime of the program. It is debatable whether the measured "quality metrics" are actual measures that will improve the quality of patient care or will just provide a level of standardization for certain patient services and treatment in certain disease-specific areas [15]. However, it does demonstrate that the incentive-based methodology of the PGDP was successful in increasing compliance for measuring and performing quality metrics.