

# The Future Success of ACOs Depends on Fixing Current Challenges

LAURA JOSZT, MA

**W**hen the Affordable Care Act passed, accountable care organizations (ACOs) seemed like the future hope for health care in the United States, but the reality 10 years later is that implementing ACOs and changing health care has not been as simple as initially expected, said Francis J. Crosson, MD, immediate past chair of the Medicare Payment Advisory Commission (MedPAC), during a session at the National Association of ACOs fall meeting.

He was joined by Michael E. Chernew, PhD, the current MedPAC chair and a co-editor-in-chief of *The American Journal of Managed Care*<sup>®</sup>, to discuss the future of value-based care.

Crosson noted that it has become apparent to those involved in the day-to-day work of managing ACOs that implementing them successfully has been challenging due to a number of factors. During his presentation, Crosson focused on 4 major barriers outlined in a June 2020 report from MedPAC.<sup>1</sup>

“We believe that if these can be addressed or resolved, it can make a major difference in the success of the ACO movement,” Crosson said. “ACOs have a big fan in MedPAC.”

**1. Medicare beneficiaries may not understand what ACOs are and feel no particular inclination to join them or cooperate with them.**

Crosson highlighted the success of Medicare Advantage and pointed to how much these plans advertise and explain what the program is around enrollment time. In contrast, ACOs need to do a better job of educating beneficiaries and implementing some practice incentives to get beneficiaries to accept and maintain a relationship with ACOs.

**2. ACOs do not have incentives to manage Medicare Part D drug costs at a time when these costs are increasing.**

Rising prescription drug costs are a well-known issue and have the attention of the broader public, and “it would be good if ACOs were seen as and were actually

the solution here,” Crosson said. “But that’s not the case at the moment.”

One option would be to add Part D spending to the ACO benchmark, but most of the MedPAC members didn’t think that was a good idea, he said. Another more feasible idea would be to have CMS facilitate a voluntary association of ACOs with Part D plans with incentive sharing.

**3. Most hospitals having conflicting financial incentives with ACOs.**

Few hospitals operate off global payments; instead, their revenue is based on “heads in beds.” However, savings come from managing the cost of hospital care and drug costs.

“It’s always been my concern that to achieve what ACOs can achieve without an ability to manage hospital costs and manage costs of prescription drugs leaves ACOs with a relatively narrow set of options on the cost savings side,” Crosson said.

It remains a challenge to align hospital financial incentives with those of ACOs, which may be why hospital-owned ACOs don’t do as well as physician-led ACOs, he conjectured.

**4. Most ACOs are still wedded to fee-for-service (FFS) payment.**

If it is known that FFS causes overutilization, Crosson asked, why aren’t we pushing for a different form of payment? In Europe, FFS works because it is paid in the context of a global budget. In the United States, ACOs should look at how they pay their physicians and use less FFS payment, he said.

Chernew then noted that the federal government is facing serious financial pressures, so despite talk about value with

alternative payment models (APMs), what's really driving the move to APMs is fiscal performance. However, the commercial sector is facing many of the same financial problems as the Medicare program.

In Medicare, the demographics are a challenge. "It doesn't take a genius to understand that if there are more beneficiaries per worker, the workers have to pay more to fund the care for the beneficiaries," Chernew said. As a result, the country has to pay close attention to financing the care of baby boomers, but "many of the potential sources of savings have already been harvested, in a budget sense," he said.

Because no more money is coming from the federal government, the United States needs to be more efficient in producing care, Chernew said. The theory behind APMs is that they provide flexibility in how to provide health care services to produce health outcomes. The question is how to get them right.

ACOs do save money, but they don't save that much money and they either maintain quality of care or improve it by just a little. "Right now, I think unambiguously these programs are a success, just not that much of a success," Chernew said. "Not yet."

However, it is clear that ACOs can perform better. In general, the move to value is a long-term endeavor, which will provide time to learn more about doing a better job, and research has shown that ACOs do better over time.

Progress has been slow with ACOs because they face operational difficulties, such as risk adjustment and the benchmark

design, as well as cultural issues. Chernew's biggest concern is that CMS is providing mixed and overwhelming messages with too many programs. He recommends that the number of models be reduced in the future and that the existing models be aligned and harmonized.

As for risk and benchmarks, Chernew noted that although he is a fan of downside risk, he believes it's overrated. Not only is the impact more modest than once thought, but there are participation concerns. As for benchmarks, they currently put organizations in the situation whereby their benchmark goes down if they save a lot of money, and if they save more money, the benchmark goes down again.

Finally, Chernew pointed out that what works is targeting low-value care broadly, as opposed to setting up broad disease-management programs. Evidence has shown that organizations do not necessarily save money by spending money or bringing more patients in and testing them all. Instead, getting rid of unnecessary care or shifting to more efficient sites of care works to save money and improve quality.

"It's really about reducing things that weren't needed," Chernew said.

## REFERENCE

1. Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. Medicare Payment Advisory Commission. June 15, 2020. Accessed November 10, 2020. [http://www.medpac.gov/docs/default-source/reports/jun20\\_reporttocongress\\_sec.pdf](http://www.medpac.gov/docs/default-source/reports/jun20_reporttocongress_sec.pdf)