The Economics of Accountable Care Organizations (ACOs)

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Introduction

What are ACOs?

- Groups of physicians or groups of physicians and hospitals who sign a 3-year agreement with Medicare
- Governing board has to be 75% local
- Can't use a hospital tax ID number
- Obligated to accept all Medicare patients seeking care
- Substantial infrastructure costs
  - Estimated $580,000 to $1.6 million, but subsidies available

Why did the 2010 ACA set them up this way?

- The government didn't want hospitals driving ACOs
- Reluctance to have outside entrepreneurs profit too much

Incentives

ACOs get paid if costs are low or quality is high

- 33 quality metrics:
  - Prevention, care coordination, safety measures
  - Clinical: mostly cardiovascular, diabetes, hypertension
  - Readmission rates

ACOs can opt into two incentive schemes

1. Symmetric:
   - ACO gains if cost/quality better than baseline and loses if cost/quality worse than baseline
   - Substantial downside risk!
2. Asymmetric:
   - ACO gains if cost/quality better than baseline
   - Less generous than symmetric scheme
   - Still has first dollar gain from cost savings
   - Only available for first three years

What is the baseline for cost savings?

- The government will develop a risk adjustment formula for each enrollee
- Formula will depend on claims history from past 3 years
  - Most recent year given 60% weight
- Future claims will be projected based on amount and nature of past claims

Are ACOs just managed care plans in disguise?

No!

- No active enrollment/disenrollment decision from patient
  - If majority of claims are from an ACO, patient is automatically "enrolled" in ACO – with notification
- No ability to restrict provider network or procedures
  - ACO patient can still choose all Medicare providers
  - Patient can even opt-out of personal data sharing
- Government also consciously made *physicians* the drivers of ACOs
- Better analogy is to PPS implementation

Why was policy done this way?

- Probably because people are averse to the idea of being forced into managed care plans

Why have ACOs?

1. We need to "bend the cost curve" of healthcare costs
   - Medicare doesn't pay too much for procedures – it pays for too many of them and for the wrong ones
     - Too much imaging, end-of-life care, hospital readmissions and surgery; not enough care coordination
   - How do we solve this?
     - Restrict payments to specialists (Canada)
     - Restrict construction of hospitals (U.K.)
     - Legislate high copays (France)
     - ACOs try to do this by incentivizing cost savings by sharing them with providers
2. We want to improve quality
   - Quality measures are pretty easy to meet
     - Most hospitals in precursor PGP demonstration project met the goals
   - To me, quality measures were a side point to get buy-in
   - Probably ensure that ACOs meet a baseline quality level

The risks of ACOs

Medicare enrollees bear very little risk:

- Can always leave ACO and return to non-ACO physician
- Designed to avoid switching costs, which are large

Tradeoff is risk of negative spillover to private-pay market:

- Easiest way to coordinate care is to vertically integrate
  - Not a big deal for Medicare, but it increases bargaining leverage versus private managed care organizations
  - Expect private pay patients to pay more
    - May be already happening!
- Horizontal integration is also useful
  - Turns an ACO into an HMO by restricting procedures
  - Also implies more bargaining leverage

Gaming the system is another concern:

- Incentives to select patients who appear costly but aren't
- May result in a lot of wasted resources

How do we lower cost growth?

1. Care coordination
   - Requires use of health IT
   - These products have both economies of scale and network effects
   - Requires private market to develop these products
2. Primary and secondary preventive care
   - For instance, diabetes mellitus costs can be lowered by better self-management
   - Even better is exercise
   - Health IT might help here too
   - Information goods with big externalities
3. Utilization review
   - Some managed care companies are much better than Medicare

We need to develop complementary goods markets:

- WalMart revolutionized supply chain management
- They couldn't have if they only had stores in one city

Will ACOs work?

Pluses:

- Final rules designed to encourage entry
  - At this stage, entry may help evaluate best practices
  - But, this is a very indirect incentive scheme
- Physicians may be better positioned to change physician practices than managed care executives

Minuses:

- Evidence from Physician Group Practice (PGP) demonstration project not encouraging
  - Most PGPs didn't meet cost targets
  - National roll-out here may be helpful in innovations in developing complementary goods markets
- Serious concern about hurting private pay market
  - Operational efficiency at expense of market power

How could the program be improved?

- I believe that capitation is the solution
  - ACO program takes only baby steps towards capitation
- We need to make ACOs more like managed care
  - Stronger incentives if they can restrict enrollee providers and provide utilization review
  - Eliminate need for consolidation as a mechanism to get patient compliance
  - Indirect incentives used here may be problematic
- What about the downside of managed care?
  - Biggest problem with Medicare Advantage is consumer switching costs (Nosal, 2011)
  - Solution: require companies to offer a given plan with stable benefits for 5 years
- Allowed ACO benefits are too small (max 5 percent)
- We should allow complementary goods innovators to gain from their innovations
  - Eliminate governing board ownership restrictions

Conclusions

What do you think?