## Health Law Update

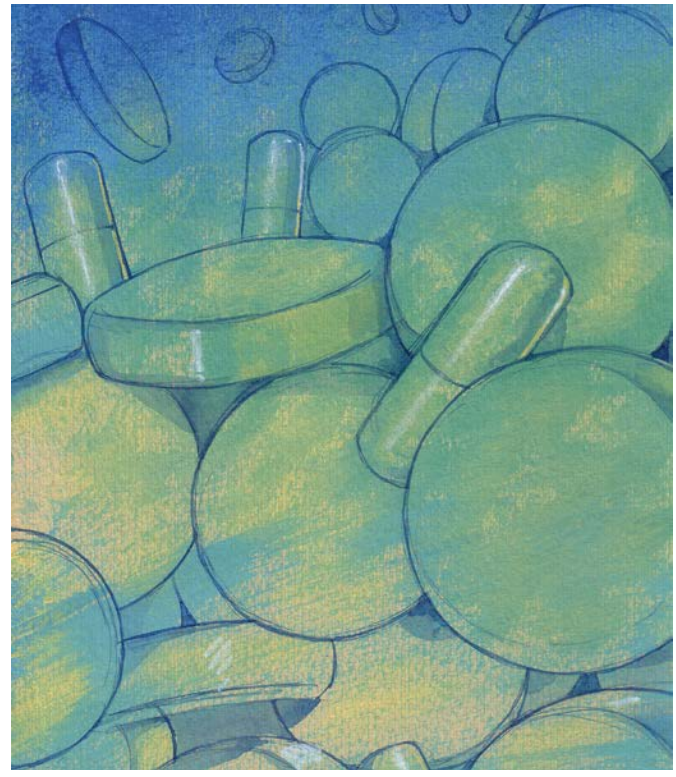
by John Okray

# Accountable Care Organizations Start to Pay Dividends

**The Centers for Medicare and Medicaid Services (CMS)** recently announced that accountable care organizations (ACOs) formed following the enactment of the Affordable Care Act have improved care and lowered cost growths.[1] CMS describes ACOs as "groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program."[2]

More than 360 ACOs have formed after the passage of the Affordable Care Act, serving a population of 5.6 million Medicare beneficiaries. CMS has announced that strong interest from providers continues, and it anticipates announcing additional ACOs soon. Providers can either join the program with no risk, or if they want to be eligible for a larger reward (share of the savings), they must agree to repay CMS if they do not meet their performance and savings targets.

In its September 2014 announcement, CMS reported the following findings.



*For Pioneer ACOs, providers that were already experienced in ACO type arrangements:*

- Generated estimated total model savings of more than $96 million during the second performance year and at the same time qualified for shared savings payments of $68 million. They saved the Medicare Trust Fund approximately $41 million.
- Achieved lower per-capita growth in spending for the Medicare program at 1.4 percent, which is about 0.45 percent lower than Medicare fee-for-service.
- Increased the mean quality score (for quality of care and patient experience) by 19 percent, from 71.8 percent in 2012 to 85.2 percent in 2013.
- Showed improvements in 28 of the 33 quality measures and experienced average improvements of 14.8 percent across all quality measures. These measures included screening for future fall risk, screening for tobacco use and cessation, patient experience in health promotion and education, and controlling high blood pressure.
- Improved the average performance score for patient and caregiver experience in six out of seven measures, suggesting that Medicare beneficiaries who obtain care from a provider participating in Pioneer ACOs report a positive patient and caregiver experience.

*For providers in Shared Savings Program ACOs, which commenced after the Pioneer ACO Program:*

- Fifty-three Shared Savings Program ACOs held spending $652

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Finally, at the Annual Meeting, the Bankruptcy Law Section seated a new slate of officers for 2014-15 as follows: Mark Desgrosseilliers of Womble Carlyle Sandridge & Rice, LLP in Wilmington, Del., chair; Lisa Lambert, assistant U.S. trustee for Region 6 in Dallas, chair-elect; Judge Craig A. Gargotta of the U.S. Bankruptcy Court for the Western District of Texas in San Antonio, Texas, treasurer; and Chris Sullivan of Diamond McCarthy LLP in San Francisco, Calif., secretary. The section extends its gratitude to its outgoing chair, Robert Weber of Skadden, Arps, Slate Meagher & Flom, LLP, for his tireless devotion throughout the past two years and to all of the members of the executive committee for their continuing efforts on behalf of the Bankruptcy Law Section.

During the next year, the section will continue to support continuing legal education, scholarship, and opportunities for members of the bankruptcy community to get to know each other a little better. We need the continued active engagement of our members to continue having an effective and responsive Bankruptcy Law Section and building on the strong foundation laid by the efforts of prior members, officers, and executive committee members. If you have an idea for an event (including co-sponsorship opportunities with other sections or chapters of the FBA) or would like to get more involved in the Bankruptcy Law Section, please reach out to any member of the executive committee or any officer of the section. ⊙

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million below their targets and earned performance payments of more than $300 million as their share of program savings. One ACO overspent its target by $10 million and owed shared losses of $4 million. The Medicare Trust Funds will save about $345 million, including repayment of losses for one ACO.

- An additional 52 ACOs reduced health costs compared to their benchmark but did not qualify for shared savings, as they did not meet the minimum savings threshold.
- Shared Savings Program ACOs improved on 30 of 33 quality measures. Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctor, health promotion and education, screening for tobacco use and cessation, and screening for high blood pressure.

In their first four years, ACOs are anticipated to save Medicare up to $940 million.[3] This makes up a very small fraction of Medicare spending during that same period; however, the program appears to be aligning the interests of Medicare, providers, and their patients. The Secretary of the Department of Health and Human Services may also further expand the program.

Some industry analysts are concerned that the model is encouraging hospital and provider mergers and consolidations, which reduces competition and gives larger health systems more bargaining power with insurers. However, the Federal Trade Commission and the Department of Justice Antitrust Division have jointly issued detailed guidance on behaviors ACOs should avoid and how they can operate within an antitrust "safety zone." Other industry participants have criticized the fact that most ACOs have opted for the one-sided risk program (providers being bonus eligible with no downside risk) rather than the two-sided risk program with higher bonus potentials but also financial risk to providers who fail.[4] Another area to monitor will be ACOs that partner with entities other than physician groups or hospitals, such as drugstore chains or large insurance companies.

For the ACO program to be deemed successful in the long term, it will need to evolve and demonstrate that it meaningfully reduces Medicare costs and improves patient outcomes, without facilitating market dominance by a small number of large providers. ⊙

### Endnotes

[1]*See* www.hhs.gov/news/press/2014pres/09/20140916a.html.

[2]*See* www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO.

[3]*See* www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx.

[4]*See* www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-(june-16-2014).pdf?sfvrsn=0.