Accountable Care Organizations — The Risk of Failure and the Risks of Success

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An accountable care organization (ACO) consists of health care providers who collectively agree to be held accountable for the care they provide to the population of patients attributed to their ACO. Two and a half years after the beginning of the Medicare ACO programs mandated by the Affordable Care Act, there are 361 ACOs contracting with Medicare[1] and hundreds of ACO-like contracts in the private sector. Payers — Medicare and health insurance plans — give ACOs financial incentives to invest in processes to systematically and proactively improve quality and control the costs of care for their populations of patients.

In this issue of the *Journal*, McWilliams et al.[2] provide the first evidence from a large-scale study of patients' experiences in ACOs. Using a difference-in-differences analysis, they found that patients' experiences during the first year of the Medicare ACO program improved more for Medicare beneficiaries attributed to ACOs than for beneficiaries not attributed to ACOs in two important measures: timely access to care and primary care physicians being informed about specialist care provided to their patients. Patients in ACOs did not differ significantly from control patients in their overall rating of care. However, in a prespecified subgroup analysis that included only patients with multiple chronic conditions, patients in ACOs reported better overall experience of care than patients in the control group. These are the patients to whom ACOs direct most of their care improvement processes.

Also in this issue, Song et al.[3] report results from the first 4 years of the Blue Cross Blue Shield of Massachusetts (BCBS) Alternative Quality Contract, which now includes approximately 85% of all physicians in the BCBS network and is the best known of the private-sector ACO contracts. Using a difference-in-differences analysis, Song et al. found significant savings ranging from 5.8% to 9.1% across the years and cohorts of ACOs in the program. Incentive payments to the ACOs exceeded savings to the health plan during the first 3 years, but by the fourth year savings exceeded incentive payments. The ACOs also performed better on multiple quality measures as compared with national and New England averages. Finding an appropriate comparison group of providers was problematic, and the results could be confounded by other quality-improvement and cost-control efforts in Massachusetts during the past 4 years. However, Song et al. conducted multiple sensitivity analyses that support their findings.

The results of these two studies are broadly consistent with recent reports from the Centers for Medicare and Medicaid Services (CMS) that ACOs in the CMS programs have on average achieved modest reductions in costs for Medicare beneficiaries, thereby generating "shared savings" revenue for themselves and net savings for CMS, and have improved their performance on nearly all quality and patient-experience measures included in the program.[4,5] The results of these two studies are also consistent with a recent evaluation of the Medicare Physician Group Practice Demonstration (the predecessor to the ACO program) that showed improvements in quality scores and modest reductions in cost.[6]

The fledgling ACO movement involves two large risks. The first is that it will fail. The second is that it will succeed, but for the wrong reasons.

Traditionally, physicians and hospitals have been paid on the basis of the volume of services they provide to whichever patients happen to seek care, without regard to the appropriateness or quality of these services. They are not paid to identify patients who are in most need of care and to give them whatever attention they need, to use nurses and other staff to help patients learn how to manage their chronic illnesses, or to communicate with patients by phone and e-mail as well as in face-to-face visits. ACOs represent the best attempt to date to move away from business as usual and toward health care that will improve patients' health and will not bankrupt the country. If ACOs fail, it may be a long time before a similarly bold concept emerges.[7]

Despite rapid growth, the success of the ACO

movement is far from certain. The performance of ACOs to date has been promising but not overwhelming. Although some ACOs have gained a substantial return on their investment in improving the health of their patients, many have not.[1,4,8] Furthermore, unless and until a high percentage of their patients — including privately insured patients — are covered by ACO contracts, hospitals and physicians will be in the difficult position of dealing with diametrically opposed sets of payment incentives.[9] One set rewards increasing the volume of services provided, and an opposing set rewards containing costs and improving quality. In addition, CMS ACO programs as currently constituted are frequently criticized for lack of flexibility, inaccuracies in attributing patients to ACOs, and incentive formulas that penalize ACOs that are already providing cost-effective care.[1] Some prominent hospitals and medical groups have decided not to sign a CMS ACO contract or have dropped out — for example, more than one third of the vanguard ACOs in the Pioneer program have withdrawn from it.[4] The ACO movement is unlikely to succeed unless health insurance plans dramatically increase their number of ACO contracts and unless CMS modifies specifications for its ACO programs — a course that the agency is considering.[1] Even then, many if not most ACOs may take years to reach their potential for improving care, and it is possible that neither policymakers nor ACO leaders will be willing to wait that long.

It is also possible that the ACO movement will succeed, but for the wrong reasons. The movement has added impetus to efforts by hospitals to merge with each other and to purchase physician practices. Hospitals can bring substantial resources to ACOs. However, very large, hospital-centered ACOs could dominate the market not by providing better care at reasonable cost but possibly by commanding high payment rates from health insurers, marginalizing smaller hospitals and medical groups, and consigning the experience of human scale in medical care to oblivion. Antitrust enforcement may not be enough to avoid this outcome.[10] It would be helpful if more physicians step up to the plate and take an active role in organizing and governing ACOs — a role that CMS and health insurers encourage.[7,11]

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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