Accountable Care Organizations Save Billions, But Struggles Remain in the Shift to Value-Based Care

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Accountable care organizations (ACOs) are reshaping American health care, cutting billions in costs and improving patient outcomes through a patient-centered, preventive approach. Despite these successes, ACOs are facing growing challenges, prompting calls for reform to help these models achieve their full potential.

The money saved by ACOs often comes from seemingly small changes in clinical practice that can yield outsized benefits. An example comes from Hospital Sisters Health System (HSHS), which launched its ACO in 2015 in central and southern Illinois. At the time, doctors rarely screened for depression during visits, even though the condition puts a substantial clinical and financial burden on both the patient and the health care system.

Experience and research show that patients with untreated depression have high use of acute care services, and that is costly, especially when the underlying condition isn't addressed, explained Dr. Leanne M. Yanni, president and CEO of Illinois Physician Enterprise for HSHS.

The organization wanted to do more for patients to respond to this "common mental health condition that needs both screening and timely treatment," she said.

As part of the Medicare Shared Savings Program (MSSP), a value-based ACO model established by the Affordable Care Act and implemented by the Centers for Medicare and Medicaid Services (CMS) in 2012, the organization made depression screening a priority. As a result, screening rates increased from 2 in every 10 patients to near universal levels, leading to more prompt treatments and better patient outcomes, Yanni said.

ACOs, like this one, have shifted away from a fee-for-service model toward a coordinated, preventive care approach that targets chronic conditions and social and behavioral determinants. The approach is producing tangible benefits. In 2023, the MSSP ACOs generated more than $3 billion in total earned shared savings, according to CMS.[1]

"The story of ACOs has been a very positive story, about growth, savings, improved clinical outcomes, better care, better health, lower cost," said Emily Brower, president and CEO of the National Association of ACOs (NAACOS), which advocates for health care members of these organizations. "They've been incredibly successful."

While they've shown broad improvements overall, ACOs are not equal, said Rob Saunders, PhD, senior research director for health care transformation at the Duke-Margolis Institute for Health Policy. "There are ACOs out there that have done amazing things and have really bought in, and their leadership is on board," he said. Other ACOs have struggled. They may have conflicting

incentives, limited capital for making upfront investments, or their leadership is managing multiple priorities, he explained. "Not surprisingly, their results are often underwhelming."

Spotty commitment isn't the only issue affecting ACO performance. NAACOS and other advocates say that more than a decade into the ACO era, structural challenges with models, including the MSSP, are hindering progress. NAACOS is now advocating for revised reimbursement structures that better reward high performers and reduce administrative burdens. They also seek to create incentives to encourage organizations that are still sitting on the sidelines to engage in these value-based initiatives. Nearly 90% of 168 health care professionals in a recent NAACOS survey cited financial risk as a primary barrier to value-based care.[2]

"We've produced enough evidence that these models are good for patients and providers. Let's keep going and keep making it better," Brower said. "Nobody wants to revert to fee-for-service because there's not enough opportunity, or for organizations to drop out of ACOs because of the heavy administrative or regulatory burden."

ACO MODELS AND MARKET DYNAMICS

ACO models come in many different forms. Medicare's MSSP was the first major driver for ACO adoption, although there were some earlier predecessors, Saunders said. Today, it's one of several federal ACO models, including CMS Innovation Center models such as ACO Reach, ACO Primary Care Flex Model and the Enhancing Oncology Model, among others.[3] More than half of Medicare beneficiaries are now aligned in an accountable care relationship with a provider, according to CMS.[4] In addition, Medicare Advantage plans, which now cover more than half of Medicare beneficiaries, are also driving value-based care, but do it by using capitated payments for each patient, rather than the ACO shared savings approach.[5] (Capitated payments are fixed, prearranged payments per patient.)

There are also commercial ACOs, coordinated by insurers such as Aetna, UnitedHealthcare and Cigna, which were once smaller than federal programs, but have grown rapidly and now rival or exceed Medicare ACOs in size, Saunders said. In 2022, approximately 45% of doctors participated in commercial ACOs, compared to about 38% in Medicare ACOs, according to the American Medical Association.[6]

Shared savings models vary in the amount of financial risk they place on ACOs. Some offer upside-only arrangements, where organizations only get a share of savings and no penalty for losses. Others, such as the MSSP Enhanced track, offer the opportunity to earn more from shared savings, but the program can also cost them more in losses.

Since they began, ACOs have achieved a 2% to 3% improvement in overall cost trends. While these percentages may sound slight, the reductions are in relation to trillions in expenditures, Duke's Saunders said.

St. Louis-based Mercy has seen successes through its participation in the Enhanced track of CMS's MSSP, the higher-risk and reward model. "Over the last five years, we've managed the total cost of care at 6% to 8% [it varies by year] lower than our peers in our given markets and our given communities," said Dave Thompson, senior vice president, chief growth officer and president of population health at Mercy.

In contrast to high-performing organizations like Mercy, many struggle to achieve results. Nearly 40% of Medicare ACOs made no savings or incurred losses, according to a report from Arcadia CareJourney.[7]

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Comparing results from federal and commercial programs is difficult because commercial programs rarely release public data and because of program variability. This variability also presents a challenge for organizations trying to participate across multiple programs, Saunders said.

While data isn't available on all ACOs, a Congressional Budget Office report identified performance trends across Medicare programs. Those that do the best are those run by physician groups or have a larger proportion of primary care providers, and those who initially invested more in the programs than the regional average.[8]

It's not surprising that physician-led ACOs tend to outperform hospital-led models because it's often an apples-to-oranges comparison, Saunders said. Hospitals, which tend to be larger organizations with a lot of infrastructure, may face difficulties if they try to quickly change things like their workflows, processes and structures, he explained.

In addition, hospitals often face built-in disincentives under ACO models for hospitals. An ACO program typically allows an ACO to share in savings if health care quality remains constant or improves. However, a hospital may lose direct revenue if it cuts down on inpatient admissions or the number of emergency room visits. This means a hospital-based ACO might not be in a better place financially if it makes improvements. "However, an ACO led by a physician group would not have the same conflict if they reduce hospitalizations or emergency room visits," he said.

FOSTERING BETTER PATIENT OUTCOMES

While there are financial risks associated with ACO participation, many think the long-term benefits outweigh the challenges. Michelle Wieczorek, former HSHS system director of accountable care, said their organization joined the MSSP to better align with its Franciscan mission of delivering compassionate, high-quality care to Medicare beneficiaries.

An ACO can help turn intent into reality. "Every provider wants to give their patient 'good, high-quality care.' Despite that intention, most providers still struggle to provide recommended care that is known to produce the best outcomes," said Dr. Christopher Funes, president of the Louisiana-based Health Leaders Network (HLN) and the Franciscan Missionaries of Our Lady Health System (FMOLHS) medical director for ambulatory quality. "The difference under the ACO is intentionality. We don't just recommend that our patients get colon cancer screening. We ensure that our providers can easily order it, follow up to make sure the patient has done it, and work continuously to close those care gaps using a 'whole team' approach."

Today, more than 80% of HLN patients get the recommended colon cancer screening, compared to 30% at the program's outset. "We're catching more colon cancer earlier, when it's more easily treated, and preventing colon cancer deaths," Funes said.

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— DR. CHRISTOPHER FUNES

ACOs also help health care organizations take a broader view of care. "There's a holistic approach to patient care with an ACO approach that really reinforces the importance of being proactive in a patient's care and also providing high-quality preventative health screenings and behavioral changes, addressing the whole patient, and certainly the social drivers of health as well as behavioral health," said Dr. Gavin Helton, president of primary care at Mercy.

OVERCOMING KEY BARRIERS TO PARTICIPATION

Despite their successes, several factors hinder ACO performance. Administrative complexity is one. Tracking ACO requirements, measures and charting progress takes a lot of effort and

money. And recent program changes have added to the burden. CMS recently rolled out updated quality reporting requirements, Thompson said. "They're well-intended, but they're more focused on administrative tasks versus actual outcomes. So, it's crucial that we keep that outcome orientation."

Financial benchmarks also present barriers. Program targets are often based on past performance, so as organizations improve, it becomes harder to generate savings.

"On the Medicare side, we're now seeing some groups that were the rock star ACOs start to drop out because the cost benchmarks that they're being held accountable to were ratcheted down. At some point, that's not sustainable for them," Saunders said. "The ACO program design is going to need to be tweaked in order for them to be effective going forward."

Yanni said that fluctuations in reimbursement, like annual fee schedule changes, also make it difficult for organizations committed to an annual budgeting process to participate in ACOs, because it's difficult to plan and stay on track financially.

There are other factors as well. "One of the biggest challenges to success in ACOs is the amount of investment required to be effective in value-based care," Funes said. Certain types of facilities, including rural hospitals and community-based practices, however, face even steeper hurdles getting into the ACO model. Brower said NAACOS also hopes that future reforms will include new incentives to help more organizations clear those barriers.

Funes agrees that support could encourage participation. "More resources are needed in human capital, data and analytics, and in processes and support systems for providers," he said. "It's hard to make that kind of investment when you can't be sure of the return. If we're doing well in a particular ACO model, but CMS suddenly cancels that model, or pushes our group out of that model, it makes it really difficult to make future investments."

SETTING A PROGRAM UP FOR SUCCESS

However, some of the drag on performance comes from operational issues within the ACO. Many groups aren't involving doctors in the improvement process. "It's really important for hospitals to work with primary care well. It's important for our specialists to work with their primary care referral points in the hospitals," Wieczorek said.

But many organizations don't take this step. "ACOs have used different strategies for improving care. Some ACOs have tried involving care coordinators to smooth transitions from hospital to home or to manage referrals and data between different clinicians. These ACOs have not really engaged their front-line clinicians," Saunders said. "And there's a reason for that, but it makes it hard to get buy-in from clinicians for broader care delivery improvements."

Changing clinical practices requires commitment from the doctors providing care. It also requires feedback. Providers need to see and understand what strategies are working and which are not, Wieczorek said.

A 2024 NAACOS report outlined some additional characteristics of the highest-performing ACOs.[9] Many of the most successful organizations establish value-based care agreements with multiple payers and have tools in place that allow them to track and manage the different policies and programs. They also have engaged leaders who are committed to accountable care and lead the culture shift. Additionally, they use data and tools to identify areas for improvement, track progress and build trust with patients by involving them in the care decisions.

FUTURE OUTLOOK FOR ACOs

Experts are now pressing for changes to help ACOs thrive and to encourage more organizations to join in outcome-focused initiatives. These efforts come amidst new uncertainties about the road ahead.

"A year ago, I would have said there's predictability in the evolution of ACOs, we don't think it's going to go away, but we think it's going to continue to evolve in a positive way with increasing risk and hopefully more nationally directed support for what hospitals need to be successful," Yanni said. That picture has shifted. If carried out in their present form, Medicaid cuts enacted through the recent federal budget reconciliation bill could affect ACO participation by increasing financial pressure on health systems and hospitals, Yanni said. "That will likely have a significant negative impact on health system finances, creating less willingness and ability to invest in value-based care," she said.

With Medicaid cuts and benchmarks potentially squeezing ACOs, the question is: Will

policymakers tweak ACO models quickly enough to keep providers on board?[10] NAACOS's Brower remains confident that there is bipartisan support for value-based models. "I think what we're seeing today is still lots of support for accountable care from the new administration and continuing support from members of Congress," she said.

Even so, organizations are preparing for change. Wieczorek said there's work to be done to prioritize investments to keep the program on track. "We have been successful because we've developed the rigor and the discipline and the teamwork that it takes to do work in these risk-bearing structures. It'll just be harder as fiscal realities are challenging us," she said.

Experts hope that ACO programs will continue to make progress. As the U.S. health care system continues to evolve, ACOs remain a central pillar of patient-centric reforms. But policy adjustments will be critical if they are going to realize their full potential.

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NOTES

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