Accountable Care Growth In 2014: A Look Ahead

On December 23, 2013, the Centers for Medicare and Medicaid Services announced 123 new Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs). This represents the fourth round of MSSP participants, which, coupled with the Pioneer ACOs, brings the number of Medicare ACOs to 366. Some of these organizations were already known to be ACOs, including those that transferred from the Pioneer ACO program, but many were new to accountable care, bringing the total number of public and private ACOs to 606.

With continued government support of ACOs and considerable growth in the number of organizations becoming ACOs, the prospect of ACOs becoming a dominant model in care delivery seems very real. In this post I will evaluate how the accountable care movement has grown and suggest what industry observers should look for in 2014.

Overview of Accountable Care Organizations

An accountable care organization, at its most basic level, is a group of health care providers that accept responsibility to care for the health needs of a defined population while meeting predetermined quality benchmarks. The specific goals of ACOs are to improve quality outcomes, improve the experience of care, and lower costs. Without conveying all the details of what that definition includes, it is important to recognize that the definition is relatively broad; it includes multiple types of organizations operating under many different payment arrangements. While the MSSP is the most publicized incarnation of ACOs, many other public and private models exist, with many different approaches to achieving the common goals.

ACO Growth

Since the MSSP round 3 participants began in January 2013, nearly 200 new public and private ACOs have been formed across the country (Chart 1). During that time, physician groups have become the primary sponsor of ACOs, though other organizations, such as non-profit community organizations and practice management companies, have begun to more actively sponsor ACOs (Chart 2).

*Chart 1: Total Accountable Care Organizations; Source: Leavitt Partners Center for Accountable Care Intelligence*

*Chart 2: Total Accountable Care Organizations by Sponsoring Entity; Source: Leavitt Partners Center for Accountable Care Intelligence*
The growth in the total number of ACOs is significant, but that only tells part of the story. While the 123 new MSSP ACOs was the largest single ACO announcement, they only represent 1.5 million of the now 5.3 million Medicare ACO covered lives. Covered lives, which indicate how many people are covered by any ACO contract, are a better representation of the prevalence of the model. Following the announcement of the new MSSP ACOs, the total number of estimated lives in public and private ACOs has risen to 18.2 million.
lives from 13.6 million at the end of 2012 (Chart 3). (This number is lower than some of our previous estimates [9] due to updates in our ACO database — some announced ACO contracts never materialized in 2013 and other ACO-like contracts were determined to not involve a defined population or providers bearing financial responsibility.) While the total number of ACO lives has been increasing, this growth has been relatively modest recently, with only 2.6 million new lives added in the past six months.

Chart 3: Estimated Accountable Care Lives; Source: Leavitt Partners Center for Accountable Care Intelligence

ACO Dispersion

Accountable care organizations have continued to expand throughout the country, though certain regions have significantly more accountable care activity. Following the round 4 announcement, ACOs are now located in all 50 states and the District of Columbia, as determined by location of their hospitals or clinics (Chart 4). California leads all states with 58 ACOs followed by Florida with 55 and Texas with 44. ACOs are primarily local organizations, with 538 having facilities in only one state. At the Hospital Referral Region level (HRR), ACOs now are present through much of the United States, though some regions, primarily rural areas in the northern Great Plains and Southeast still have limited ACO activity (Chart 5). Los Angeles (26), Boston (23) and Orlando (17) have the most ACOs.

Chart 4: Accountable Care Organizations by State; Source: Leavitt Partners Center for Accountable Care Intelligence

Chart 5: Accountable Care Organizations by Hospital Referral Region; Source: Leavitt Partners Center for Accountable Care Intelligence

While these maps indicate growth of ACOs throughout much of the country, the number of ACOs, again, is of secondary importance to the number of covered lives. Using clinic locations and hospital service areas we have approximated ACO penetration [13] by region...
(Charts 6 and 7). One state, Oregon, due to the movement of its Medicaid population toward accountable care arrangements, has the largest percent of its population covered by ACOs (27 percent), while eight other states (Alaska, Iowa, Massachusetts, Maine, New Hampshire, Rhode Island, Utah and Vermont) have more than 10 percent of their population covered by ACOs. Nationally, approximately 6 percent of the population is estimated to be enrolled in an ACO.

*Chart 6: Estimated Accountable Care Organization Covered Lives by State; Source: Leavitt Partners Center for Accountable Care Intelligence*

[14]

*Chart 7: Estimated Accountable Care Organization Covered Lives by Hospital Referral Region; Source: Leavitt Partners Center for Accountable Care Intelligence*

[15]

**Looking Ahead**

The accountable care movement, and ACOs in particular, represent the "[volume to value](http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/print)" transition that has been the long-term objective of many policymakers. Meaningful changes in health care delivery often proceed at a glacial pace; incremental changes, however, will continue to occur throughout the country as individual hospital systems, physician groups, and health insurers make advancements toward achieving the triple aim. During the upcoming year a number of factors could significantly impact how the accountable care movement progress.
ACO Results. CMS began releasing very preliminary results of ACO performance in 2013, including results from the first year [17] of the Pioneer ACOs. In 2014, many of the earliest ACOs will begin to show results. The importance of these initial results cannot be understated. Many organizations that have considered pursuing accountable care contracts are eager to observe how their peer institutions perform. Consistently positive results will help these organizations that are sitting on the sidelines to decide to move toward value-based payments. Conversely, consistently negative, or even ambiguous, results will not only discourage potential ACOs from forming, but will lead to existing ACOs abandoning their current value-based contracts.

Potentially more important than the general results are the results from specific organizations. ACOs are based around organizations of varying size and complexity. An ACO based around a large, integrated hospital system that shows success does little to inspire confidence, or provide a roadmap, for a small physician group. Organizations that are considering accountable care will be best helped by seeing success in similar organizations. The majority of participants in the MSSP are smaller physician groups and for the program’s ongoing success, viable models of achieving savings for physician groups will need to be demonstrated.

Political Changes. One of the biggest ongoing issues for physicians is the sustainable growth rate [18] (SGR). In late 2013, a bipartisan proposal [19] to replace the SGR worked its way through congress, though it has not yet been passed. A significant component of the proposed legislation was strong encouragement (a 5 percent Medicare payment increase) for providers to accept risk-based payments. While the draft language states that requiring these risk-based payments wouldn’t begin until 2016, the prospect of this would encourage many more organizations to prepare to become ACOs in the short term. Additionally, such a
substantial bonus would offset some of the initial fear of bearing risk. If similar legislation is passed in 2014, expect a broader acceptance of ACO and ACO-like contracts going forward.

**State Medicaid Activity.** While federal legislation has the ability to encourage long-term adoption of risk-based contracts, states have the ability to encourage greater shorter-term adoption through their state Medicaid programs. States such as Oregon and Utah, which have both formally embraced the ACO/Medicaid concept, have some of the highest penetrations of ACO covered lives due to these Medicaid lives.

As states proceed with Medicaid expansion under the Affordable Care Act, the ACO model, with providers bearing financial risk for some of the enrollees’ care while meeting quality benchmarks, will be an enticing option. For states that are still considering expanding their Medicaid programs, ACOs may be seen as a way of limiting state risk enough that full expansion or partial expansion through a waiver will become politically favorable.

**Consumer Preference.** A final area to pay attention to is how ACOs fare in the eyes of individual patients. While ACO agreements are currently blended into existing contractual relationships between payers and providers, they may be viewed more of a differentiator going forward. Large employers may start to favor ACO-based plans because of the expected savings and care coordination which should limit absenteeism. In relation to the health insurance marketplaces, ACO-based plans may become favored by individual purchasers due to their lower price (as a result of their generally narrower networks).

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