Published in final edited form as:

N Engl J Med. 2017 November 09; 377(19): 1809–1811. doi:10.1056/NEJMp1709197.

Explaining sluggish savings under accountable care

Valerie A. Lewis^{*},

The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth, 1 Medical Center Drive, Level 5 WTRB, Lebanon, NH 03766

Elliott S. Fisher, and

The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth

Carrie H. Colla

The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth

Despite aggressive targets set by Medicare for spread of value-based payment and agreement on the importance of delivery system reform, progress toward slowed spending growth and a transformed delivery system has been slow. Accountable care organizations (ACOs) are a prime example: nearly 1,000 organizations operate as ACOs, but ACOs are generating modest savings. Even in the third year of Medicare ACO contracts, fewer than half of ACOs received a bonus. To guide policy and help providers succeed it would be useful to understand: why are so few ACOs achieving savings? Data-driven empirical work on ACO performance has yielded few insights into specific characteristics of ACOs that lead to success.¹ We believe now is a good time to take stock of ACO organizational types and consider what economic and organizational literature might have to say about the ACO experiment.

ACOs are remarkably diverse. To spur innovation and encourage participation, Medicare sets few constraints on ACO forms. As a result, participating organizations include both long-standing integrated systems and more recently formed entities, such as hospitals and private practices that came together to pursue ACO contracts.² Understanding this diversity – and associated variation in performance – may provide insight into how to accelerate improvement.

We paired data from the Centers for Medicare and Medicaid Services with the National Survey of ACOs to compare performance in the first three years of ACO contracts across three types of ACOs: integrated delivery systems, outpatient physician practice ACOs, and coalitions of independent hospitals and practices (Figure 1). In the first year of ACO contracts, each group began with approximately 30% of ACOs receiving bonuses. After that, trends diverge. Among integrated delivery systems, this percentage remains unchanged over the three years. Among hospital coalitions, the proportion is steady in year two but jumps to

^{*}corresponding author: valerie.a.lewis@dartmouth.edu.

47% in year three. Among physician group ACOs, the percentage achieving savings steadily increases to 43% in year two and 51% in year three.

What might explain these differences? A myriad of context-specific factors explain individual ACO performance, but overall, few characteristics have been shown to systematically explain ACO performance.¹ Here, we refrain from analysis of factors associated with each type of ACO. Instead, we focus on four crosscutting explanations for why ACOs may not achieve bonuses more quickly, two economic and two organizational (Table 1) and how they may explain these divergent trends. Economic explanations emphasize the breadth and depth of financial incentives in ACO programs, whereas organizational explanations emphasize organizational processes and complexity.

Economists worry about weak incentives. In the Medicare Shared Savings Program, nearly all participants opted to receive a bonus if they generate savings, but bear no responsibility for losses. Transitioning providers to downside risk may result in greater behavior change and savings, although literature on this is mixed.^{3,4} A second explanation suggests that having more patients in ACO-like contracts may strengthen incentives. Providers with few patients under ACO-like contracts face a problem colloquially described as “having a foot in two canoes.” Initiatives that generate savings in ACO patients will reduce income in fee-for-service patients, a situation that led some integrated networks to fail during the managed care era.⁴ Until providers reach a tipping point in patients under risk-based contracts, it will be hard for ACO contracts to generate substantial savings.

We believe all ACOs would benefit from having more patients under ACO-like contracts, and we routinely hear this when we speak with providers. Economic explanations about downside risk may help explain the performance of integrated delivery systems. The inertia associated with existing, complex systems could require stronger financial incentives to change the organization’s behavior, discussed more below in the context of organizational complexity. In contrast, the increasing proportion of physician groups and hospital coalition ACOs achieving savings over time suggests that downside risk may not be necessary for these types of ACOs to generate cost savings given enough lead time.

Economic explanations suggest that the key issue is motivation: providers know how to save money, but need financial motivation to change behavior. An alternate set of explanations draw on organizational theory and literature:^{4,5} providers either don’t know how to achieve savings (at least at first), or providers must work on other things before they can implement necessary change to save money. These hypotheses could explain the more rapid savings among ACOs that are not integrated delivery systems.

One organizational explanation is about knowledge: independent physician practices with little knowledge of new care models who enter an ACO may have a few ideas about how to save money, but need time to work out what to do and how to do it. They may need to explore care management models or learn evidence on improving care transitions. This explanation may particularly fit outpatient physician practice ACOs and some hospital coalition ACOs new to the game, so to speak.

An additional organizational explanation is that the complexity of ACO organizations could be important. First, most ACOs are not pre-existing organizations, but collections of independent providers pursuing an ACO together, such as a community hospital and local private practice physicians newly partnered.² These new organizations must accomplish a great deal of foundational work, such as forming a board; determining how to share bonuses; and completing tasks that require internal coordination, such as reporting. They then must agree upon and implement a joint strategy to pursue cost savings. In these ACOs, we expect that progress on generating savings may be delayed because setting up a functional ACO will initially require attention and effort. This may explain why hospital coalition ACOs remain stagnant in year two, but experience an increase in the proportion receiving savings in year three.

Second, organizational complexity likely challenges integrated systems. While all ACOs face the problem of overcoming ingrained practices among clinicians, the large, complex, and diverse networks of providers in an integrated delivery system present an additional challenge to clinical transformation. Overcoming the inertia in these large systems may be metaphorically like turning a large battleship. In contrast, outpatient physician practice ACOs are small in size and simple in organizational structure, likely making them nimble and able to more quickly implement (or discard) new initiatives -- and generate savings. Newly formed coalition ACOs must spend time developing organizational infrastructure, but these new organizations are not encumbered by existing organizational processes and behaviors.

Together, this set of explanations argue for a nuanced approach to encourage, motivate, and reward providers. For all providers, moving a greater share of patients to value-based payment may support care transformation efforts and remove barriers of conflicting incentives. For larger, integrated systems, increasing the breadth of incentives could be coupled with stronger incentives through a more rapid transition to downside risk. Shifting to risk too quickly for newly formed ACOs, however, could backfire: among a subset of ACOs, allowing enough time may be critical, so providers can settle into new organizational forms and develop and implement strategies in a deliberate and thoughtful manner. ACOs are as diverse as the U.S. health care system, and saving money in health care is notoriously hard. Developing policy approaches that accommodate this diversity through both careful incentives and deliberate patience will be important for payment and delivery reform to achieve its potential.

References

1. Ouayogodé MH, Colla CH, Lewis VA. Determinants of success in Shared Savings Programs: An analysis of ACO and market characteristics. *Healthcare*. Sep.2016 doi: 10.1016/j.hjdsi.2016.08.002
2. Lewis VA, Tierney KI, Colla CH, Shortell SM. The new frontier of strategic alliances in health care: New partnerships under accountable care organizations. *Soc Sci Med*. 2017; doi: 10.1016/j.socscimed.2017.04.054
3. Hellinger FJ. The impact of financial incentives on physician behavior in managed care plans: a review of the evidence. *Med Care Res Rev MCRR*. 1996; 53(3):294–314. DOI: 10.1177/107755879605300305 [PubMed: 10159930]

4. Burns LR, Pauly MV. Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s. *Health Aff (Millwood)*. 2012; 31(11):2407–2416. DOI: 10.1377/hlthaff.2011.0675 [PubMed: 23129670]
5. Burns LR, Goldsmith JC, Sen A. Horizontal and vertical integration of physicians: a tale of two tails. *Adv Health Care Manag*. 2013; 15:39–117. [PubMed: 24749213]

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Figure 1. Proportion of ACOs achieving shared savings under Medicare ACO programs in the first three years of payment contracts indicate divergent trends across types of ACOs

Note: Data from the CMS public release file and the National Survey of ACOs (NSACO).

N=137; cohort consistent across years. NSACO response rate 71% among eligible ACOs in this analysis. Integrated systems are those ACOs who responded affirmatively to a survey question asking if the ACO is an integrated delivery system. Physician group ACOs are ACOs with only physician groups (e.g. no hospital, post-acute care, or other provider types in the ACO). Hospital coalition ACOs are ACOs that are not integrated delivery systems that include a hospital. Mean number of clinicians is the total full time equivalent primary care and specialty clinicians participating in the ACO, as reported on the NSACO. Proportion of ACOs achieving savings comes from CMS publically available data on ACOs achieving savings.

Table 1

Explanations for why Medicare ACO programs are producing limited savings and analysis of which frame may apply to each type of ACO

Analytic frame	Specific description of the problem	Problem applicable to type of ACO		
		Integrated systems	Hospital coalitions	Outpatient medical groups
<i>Economic</i>				
Depth of incentives	Financial incentives are too weak to meaningfully change provider behavior, both in amount of savings providers can earn and lack of downside risk in contracts	Yes	No	No
Breadth of incentives	With only a small proportion of patients under value based payment, providers cannot truly transform care delivery in any comprehensive way	Yes	Yes	Yes
<i>Organizational</i>				
Depth of experience	Providers with little knowledge of new care models require time to figure out how to do it	No	Yes	Yes
Breadth and complexity of provider organizations	For ACOs that are not pre-existing organizations, a great deal of foundational work must be spent to form and govern the ACO	No	Yes	Depends *
	Very large organizations have higher levels of organizational inertia that make major changes to care delivery difficult	Yes	Depends *	No

Notes:

* These are marked “depends” because some of the ACOs in the group may be pre-existing and others not, or some may be larger than others.