Risk Bearing and Use of Fee-for-Service Billing Among Accountable Care Organizations

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Objectives: To determine the willingness of accountable care organizations (ACOs) to bear financial risk for the healthcare they provide.

Design and Methods: Structured interviews conducted between January and June 2012 with 57 ACOs led by hospitals and physician groups located throughout the United States. Findings are based on the 38 ACOs that were actively providing care under an ACO payment arrangement at the time of the interview.

Results: Among these ACOs, 71% cover a portion of their ACO population with contracts that put the ACOs at some financial risk, while 45% have risk-based contracts for their entire ACO population. Payments based on fee-for-service (FFS) billing still dominate, as 92% of ACOs use FFS-based billing for at least a portion of their ACO population and 71% are fully reimbursed using FFS-based billing.

Conclusions: Under the auspices of an ACO, providers are accepting some financial risk for their accountable care patient population. There is still strong reliance on FFS-based billing methods as providers experiment with different payment models.

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For author information and disclosures, see end of text.

Accountable care organizations (ACOs) have become part of the American health system lexicon with active backing from Medicare[1] and adoption by the private sector.[2] They have been tabbed as a means to improve the value of healthcare by improving the experience of care, improving population health, and lowering health costs.[3] Whether they will succeed at these goals remains to be determined, but a small number of providers have begun to actively experiment in accountable care.

Since late 2010 we have been tracking the accountable care movement and have identified, to date, 428 organizations that are currently either operating as ACOs or are in the process of adopting accountable care. In tracking these entities, we use a broad definition and include organizations that self-identify as being an ACO and those that may choose a different name but seek the goals of accountable care[3] and oversee the provision of health services delivered to a defined population with financial responsibility for that care. ACOs on this master list are identified via, among other means, press reports, news articles, government announcements, conferences, personal and industry interviews, and other public records.[2] While the number of ACOs indicates strong interest in accountable care, it still represents a small minority of providers within the United States. To better understand what accountable care means for these organizations and the patients they serve, we are conducting interviews with these ACOs to gain insight into how they are becoming "accountable," what risk they are bearing, how they are coordinating care, and how they are measuring and seeking to improve quality.

Design and Methods

From January to June 2012, our team conducted structured interviews[4] with 57 ACOs from across the United States that are engaged with public or private payers in accountable care programs, drawn from a sample (at that time) of 221 ACOs. This series of interviews represents the first round of an ongoing study and includes 45 hospital system–led ACOs and 12 physician group–led ACOs.[5] Of those interviewed, 49 percent are participating in the Medicare Shared Savings Program (MSSP) or Medicare Pioneer ACO initiatives, with the remainder involved in ACOs with private payers and/or Medicaid pro-

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Take-Away Points

Provides an overview of how accountable care organizations (ACOs) are experimenting with risk-bearing reimbursement agreements.

- ACOs are willing to bear some risk for a portion of the care they provide.
- Movement toward more risk will be slow as ACOs develop needed skill sets to better manage risk; the movement will not mimic the rush to capitation in the 1990s.
- ACO reimbursement models largely rely on fee-for-service billing.

grams; 68 percent of the MSSP/Pioneer ACOs also have private or Medicaid contracts. At the time of the interview, 67 percent of these ACOs were operational (meaning they were already accepting payments under their ACO contract) and 25 percent more expected to be operational within a year. The results of this paper are limited to the 38 operational ACOs which comprise 28 led by hospital groups and 10 led by physician groups.

Interviews with ACOs consisted of interviewers asking structured questions where specific pieces of information were sought, which was followed by qualitative discussions of the responses. The questions relevant to this study are as follows:

(1) How far away is your ACO from being fully operational (ie, formally providing care to ACO patients) [currently operational, 1 year, 2-4 years, 5+ years, don't know]?

(2) What is the nature of your payment arrangement with participating [providers/payers] [fee-for-service, episodic bundled payment/DRG, capitation, shared savings (upside only), shared savings (up and downside), other]?

(3) What is the ballpark mix of the ACO's covered lives by payer [commercially insured %, Medicare %, Medicaid %, Medicare Advantage %, other %]?

(4) How many individual patients are served by the ACO?

ACO Patient Populations

An important distinction for ACOs is the difference between the ACO population and the total patient population. The ACO population includes all individuals whose care is reimbursed under an ACO payment arrangement. In addition to their ACO population, all of these providers have non-ACO patients that they still serve. One weakness of this study is that we were not able to consistently collect the size of the non-ACO population. Among ACOs where we did collect data on the size of the total patient population, there is a considerable range of the ACO population as a percent of the total patient population, ranging from very small (less than 5%) to a majority of patients (greater than 50%), with smaller values being much more common. The results in this study, then, are limited to the ACO patient population.

The population of patients covered by ACOs varied considerably, with 26 percent of ACOs only working with a fee-for-service (FFS) Medicare or Medicare Advantage population, 21 percent only working with commercially insured patients, and 8 percent only working with their state Medicaid population. Eight percent of ACOs had contracts in place covering all major payer types (Medicare, Medicare Advantage, commercial, and Medicaid). Within these groupings, covering some commercial patients or Medicare Advantage patients within the ACO does not mean the ACO covers all commercial or Medicare Advantage patients, as providers must individually negotiate with each payer. **Table 1** contains information on the percent of ACOs that cover various populations under their accountable care contracts. The "Other" category includes populations such as Tricare, self-pay, and the provider's own employees.

ACO Payment Arrangements

ACOs have multiple types of payment arrangements, with many (42 percent) being reimbursed for their ACO population in 2 or more ways. Types of payment arrangements include (1) capitation (global payments for all the healthcare needs of the covered population); (2) bundled payments (fixed payments for episodes of care); (3) shared savings (using FFS payments as a basis, but with retrospective adjustments if the total annual cost for a population is more or less than certain thresholds), which can be broken down into 2-sided risk contracts (where providers are required to repay a portion of any cost overage but will share in "savings" if the population cost is lower than expected) and upside-only contracts (where the provider will only share any savings); and (4) pay for performance (P4P) variants (where providers are paid based on FFS but can receive bonus payments or increases in their base fee schedule conditioned on reaching performance benchmarks). **Table 2** contains information on the percent of ACOs that have entered into different categories of payment arrangements. We did not consistently track the percent of the ACO population that was covered by each type of payment arrangement.

We consider providers to be accepting "risk-based" payments if they could potentially lose or be required to repay money, which includes payment types 1, 2, and 3. The amount of risk varies based on the type of payment. We define FFS-based billing as those models that are reliant on traditional FFS coding and billing and include types 3, 4, and 5. Shared savings with 2-sided risk is both a risk-based model because the provider can be required to repay some of the population's costs and an FFS-based billing model because it relies on traditional FFS billing practices before the annual adjustment.

Table 1. Percent of Accountable Care Organizations With Various Covered Populations

	Commercial Insurance	FFS Medicare	Medicare Advantage	Medicaid	Other
Hospital System (n = 28)	53.6%	46.4%	25.0%	39.3%	7.1%
Physician Group (n = 10)	70.0%	50.0%	40.0%	50.0%	20.0%
Overall (n = 38)	57.9%	47.4%	28.9%	42.1%	10.5%

FFS indicates fee-for-service.

Capitation represents providers bearing full financial risk for the care of a population. While 24 percent of ACOs cover some portion of their ACO population with a capitation arrangement, only 1 ACO covers its entire ACO population under a capitated global payment arrangement. Some providers view capitation as the ultimate goal of accountable care and are actively preparing for it while others have taken more of a "wait and see" approach to evaluate whether narrow network capitation is the ultimate outcome of the accountable care movement or if a different, hybrid payment model will evolve.

As a way to prepare for more risk, some providers are experimenting with episodic bundling where they receive a capitated payment for specific procedures or episodes of care. Bundled payments do represent full risk, but are limited in time and scope. By choosing service lines where they are confident they can be profitable, providers justify the added expense of implementing the necessary infrastructure to expand their risk. Other providers are experimenting with bundled payments on a small scale as a way to learn about accountable care with minimal financial risk while laying the groundwork for potential future ACO efforts. Still others have consciously avoided bundled payments because they lack the technology to accurately measure the cost of providing a bundle of services.

Shared savings, consisting of 2-sided risk and upside-only payments, is the most common payment approach, with 79 percent of ACOs participating in 1 or both forms. Under a shared savings model, providers are able to continue to operate under FFS billing but with retrospective adjustments if total cost differs from a predetermined baseline. This allows providers to maintain their existing billing practices and focus their attention on efforts to lower costs, such as through care coordination. Two-sided shared savings accounts for less provider risk than capitation because any cost overages are shared with the payer, but the upside benefit is similarly limited. While most providers with shared savings arrangements agreed to take on downside risk, 21 percent have only agreed to upside payments. These ACOs with upside-only contracts recognize that they will likely be forced to bear some financial risk in the future, probably by agreeing to downside shared savings risk. This emphasis on shared savings models, though, is viewed by many of these providers as a temporary measure as the system moves toward some other, longer-term model. The vision of what the ultimate model is varies considerably among providers.

Payment approaches based on P4P payments represent the most basic foray into accountable care and are the first step toward other payment models.[6] These payment models, which vary significantly, encourage certain results by modifying the FFS pay schedule or paying bonuses based on achieving measured outcomes or reaching performance targets, but do not dramatically disrupt the existing FFS payment system. Eight percent of ACOs use only a payment arrangement based on P4P, and some reliance on this payment model was due to the inability or unwillingness of payers to enter into other agreements.

ACO Risk Bearing

We classified 3 payment types as risk-bearing arrangements (meaning the provider could potentially lose or be required to repay money): capitation, bundling, and 2-sided shared savings, with capitation and bundling representing full provider risk for the defined care and shared savings representing shared risk between the provider and payer. Of the ACOs we interviewed, 71 percent have some risk-bearing arrangement while 45 percent have only risk-bearing arrangements covering their ACO population. Only 8 percent of ACOs, though, cover their entire ACO population with the full-risk capitated or bundled payments. Of ACOs that bear risk, 81% share some of that risk with payers. Most ACOs that are experimenting with capitation and bundled payments limit those arrangements to just a subset of their ACO population which, in turn, is only a subset of their total patient population. While providers are experimenting with risk-based contracts, the lessons of the managed care movement of the 1990s are still very fresh in the minds of many ACO leaders, and few organizations are willing to dive into full-risk payment arrangements for their entire patient population headfirst.

ACO Use of FFS Billing With Risk-Based Payments

We defined FFS-based payments as those that rely on classic FFS- and relative value unit (RVU)-based reimbursement which allow providers to use existing billing infrastructure while experimenting with accountable care. Both varieties of shared

Table 2. Percent of Accountable Care Organizations With Various Payment Arrangements

	Capitation	Bundled Payments	Shared Savings (Upside and Downside)	Shared Savings (Upside Only)	Pay-for-Performance Variants
Hospital System (n = 28)	17.9%	14.3%	64.3%	35.7%	32.1%
Physician Group (n = 10)	40.0%	0.0%	40.0%	40.0%	40.0%
Overall (n = 38)	23.7%	10.5%	57.9%	36.8%	34.2%

savings payments rely on FFS billing and payments and then reconcile the population's cost at the end of the accounting period. Similarly, the models based on P4P utilize existing FFS billing methods and modify the reimbursement factors for individual providers or add bonus payments. Only the capitation and bundled payments represent departures from FFS billing, as they consist of a single payment for all the care provided (capitation) or all the care related to a single episode of care (bundling). For their ACO population, 92 percent of ACOs still rely on FFS-based billing for a portion of their ACO payments and 71 percent use only FFS-based billing. Many ACOs have plans to adopt some of these new billing approaches, but implementing new reimbursement models can be slow and complex.[7]

ACO leaders, almost universally, recognize the need for financial risk to be coupled with reimbursement that does not emphasize volume. Providers, though, are hesitant to drop their FFS reimbursement models, which incent higher volumes of care,[8] even while experimenting with accountable care contracts. Shared savings with downside risk, the most common payment arrangement (58% of ACOs), represents a good middle ground for many providers to experiment with bearing risk while simultaneously maintaining their FFS-based billing systems. In this way, if their ACO proves workable, they can move to new billing models, and if the ACO fails, they can easily return to the world of traditional FFS reimbursement. Adopting some risk-based contracts while maintaining FFS payment contracts helps minimize provider risk but also poses a major challenge for ACOs as they attempt to move to value-based accountable care while maintaining short-term viability in a volume-based FFS world.

The Future of ACOs

The development of the accountable care movement will be determined by early results. The majority of ACOs are using shared savings models, and most are committed to evaluating their financial returns for 2 to 3 years before moving away from these payment arrangements. ACO leaders speak of a desire to improve the value they provide, but they are hesitant to adopt any wholesale movement away from FFS-based billing as they are not fully convinced that full provider risk and capitation/bundling is the inevitable conclusion of the accountable care movement. In the short term, however, providers are continuing to experiment with new payment models and new approaches to providing and coordinating care. The end result of the ACO movement, particularly relating to provider risk and reimbursement, is still undecided, but the consensus among these organizations is that the value-based focus of accountable care is here to stay.

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