

# Radiology in Pioneer Accountable Care Organizations: Much Ado About Nothing?

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Amid the political banter that continues to surround the Patient Protection and Affordable Care Act, or Obamacare, 32 accountable care organizations (ACOs) participating in CMS's Pioneer ACO Model dove in headfirst to see if this new model for aggregating, coordinating, and financing health care accomplishes the stated goals of the Institute for Healthcare Improvement's Triple Aim Initiative [1]: (1) to improve patients' experience of care, (2) to improve population health, and (3) to reduce costs.

One year into the experiment, it turned out that 13 of the 32 had saved enough money to participate in shared savings of \$76 million. Only 2 of the 32 had shared losses, which totaled \$4 million [2]. Nine left the Pioneer ACO Model for the less risky Medicare Shared Savings Program, and 2 left the program entirely. Twenty-three decided to continue participation as Pioneer ACOs for a second year, with both upside and downside risk. The questions for radiologists are: How has imaging fared? And radiologists? The ACR, through its Radiology Integrated Care Network, has been working to answer those questions in an effort to ensure that radiology is well informed and that radiologists are positioned for success [3].

As CMS put forward its request for information regarding the next round of Pioneer ACO recruitment, it allowed radiologists participating in ACOs time to reflect on the experience thus far, allowing the ACR to

provide input on behalf of its members.

As a quick refresher, an ACO is a team of providers that takes on the responsibility of coordinating care for a population and in turn accepts financial risk for providing that care [4]. An ACO participating in the Pioneer ACO Model commits to take on responsibility for all of the care for a population of at least 15,000 Medicare beneficiaries [5]. In exchange, the Pioneer ACO will continue to function in a fee-for-service environment, will share in both upside and downside risk, and will garner a greater proportion of any shared savings, should these be generated by its efforts, than is the case with subsequent ACO models that involve only upside risk.

## MECHANICS

To many, the entire concept may seem esoteric. How is the population defined, and how is day-to-day practice affected? When asked, one of our members, a radiology chair in a large academic department, said that it was simple. The primary care physicians in his organization were able to easily attribute the patients on their Medicare panels. Once the patients were assigned and verified on the basis of Medicare claims data on 50,000 beneficiaries, the institution was in, and radiology was in with it. What was most telling about the remainder of the account was that despite what was touted as a radical change to the

organization of care, the radiologists in the organization did not have to do anything differently.

As radiology group leaders recounted their experiences, a theme emerged that we predicted in our earlier work: the ACOs were heavily focused on primary care and particularly on the coordination of care for the sickest patients. Multiple systems intentionally targeted elderly patients with chronic conditions, in the belief that these patients yielded the greatest opportunities for savings. Two major mechanisms of management seemed to predominate: (1) keep the elderly out of the hospital and at home, managing their delicate balance of nursing care and drugs, and (2) when there are admissions, work to reduce lengths of stay, and readmissions, both of which are major drivers of costs. What was clear, however, was that there was, to that point at least, little to no attention paid to specialty practice. In fact, in most cases, the Pioneer ACOs have not begun to work out metrics as to how the specialties contributed to the savings or to better care.

## SAVINGS

Per the model, during the first 2 years, providers were paid according to the fee-for-service approach, and for nearly every participating ACO radiologist, essentially nothing changed. The participating systems set system-wide targets for spending. One group set 1% savings in the first year (2012) relative to 2011 spending. This group

narrowly beat its target, and thus 50% of the savings was to be returned to the providers. Had they overspent, the money would have been returned to CMS. Although savings were realized for 2012, no funds have trickled back specifically to radiology according to members of the Radiology Integrated Care Network. One potential reason is the belief that the costs associated with administering an ACO outpaced and thus consumed the lion's share of savings.

A second and smaller group told a nearly identical story. A critical difference is that the smaller group has been taking on risk for many years. Still, its savings never trickle to the physicians, as the savings seem to essentially only cover the costs. This group is a smaller ACO and has been providing the same quality care for patients. This example is important, as many argue that the lost expenses of the startup year will be recouped later, but this seems not to be the case.

A system that performed particularly well (in fact, the best) under risk saved \$14 million as a system. That system was told that the specialists took approximately \$600,000 as a whole. Given their academic, salaried model, it was unclear how the radiologists would receive their fair share of the savings. Primary care physicians received the greatest disbursement, \$1.7 million for 24,000 lives.

## QUALITY

It is important to note that although the potential for savings gets the press with regard to ACOs, ACOs theoretically also exist to improve quality. The radiologists in the systems we queried categorically stated that essentially nothing has changed. Most stated that they have not done anything more than what they had already been doing before the Pioneer ACO Model began. These radiology groups seemed to describe themselves as insurance agnostics: always providing quality care

for all patients, regardless of the program or payer. They know that they will eventually have to find a way to demonstrate improvements but as of yet have been unable to. Furthermore, because not all patients are Medicare or ACO beneficiaries, it is possible to compare care and costs between those in the ACO and those who are not. To that point, our respondents stated that they have not seen any major differences between their facilities, which are participating in the Pioneer ACO Model, and non-ACO facilities. We heard that imaging utilization management through the use of clinical decision support has improved the level of appropriate imaging and thus quality but that this was in place before the participation in the Pioneer ACO Model.

## NEXT STEPS: MORE RISK?

Year 3 of the Pioneer ACO Model allows a shift from fee-for-service to a population-based payment model. Despite being a successful vanguard of assumed risk, most of these systems seem to shy away from that conversion. One reason seems to predominate: distribution of funds. Given a lump sum payment if savings are generated, how much should each provider group receive?

Imagine a patient with back pain. In one scenario, that patient may undergo CT, followed by MRI, followed by neurosurgical intervention. In another scenario, a decision support tool may opine that imaging is not considered useful, and the patient would be referred to physical therapy. In a fee-for-service environment, it is clear what each provider should be paid. In a lump-sum-payment or capitated environment, it is much less clear. If the answer is to revert to what would have been paid under the fee-for-service model, then the incentives remain unchanged, obviating the point of changing the system.

Another reason for providers' and health systems' hesitancy to take on more risk is their limited ability to hedge against catastrophic downside. Most have been unable to find or purchase insurance products that will reinsure the system should they take major losses. As it turns out, hospitals and hospital systems may have been built to care for patients, not to bear insurance risk. Although very few hospital institutions have the experience or the resources to become their own insurers, this may be an option for some.

Also of note, because the Medicare Shared Savings Program is the structural foundation of ACOs, is that the shared savings model carries a potential flaw in its benchmarking framework. In short, the 3-year contract terms for current Pioneer ACOs will continually benchmark against their own past performance. The most efficient ACO will certainly make the most savings and ultimately put itself at a disadvantage when, in subsequent contract periods, it may be unable to maintain similar savings [6]. This phenomenon has yet to manifest.

## SO WHAT CAN RADIOLOGISTS LEARN FROM THIS?

ACOs remain in their infancy. Thirty-two started in January 2012, and about a third have subsequently stopped participating. They collectively saved approximately \$147 million [7] for Medicare, which spent \$574.2 billion in the same year [8]. This amounts to approximately 0.02% savings. This is of course a misrepresentation, as those savings should not be attributed across all of Medicare. Another way to calculate the savings is to note the \$240 per member saved by the Pioneer ACOs [9] against the approximately \$11,300 spent per beneficiary, amounting to a 2% savings.

These systems are saving money. How much of that is occurring because of the Pioneer ACO Model

remains to be seen. There are obvious confounders in the analysis. The Pioneer ACOs were chosen because they had already developed systems capable of monitoring a population. Furthermore, the savings occurred in a time of historically low growth rate of Medicare expenditures.

What is clear is that these ACOs have shown enough success that they are not immediately going away. Radiologists have thus far remained largely unscathed in the practice changes surrounding system-wide risk assumption. Someday that will not be true. It is imperative to the future of our specialty that we remain vigilant and participatory in the changes happening around us as we implement the ACR's recommended strategies for successful radiologist participation in ACOs [10]. We must combine traditional services,

including timely and high-quality image interpretation, with new services on the basis of providing cost-effectiveness to the imaging portfolio of ACOs.

## REFERENCES

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