New health care model saving money, report says

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A new model of health care run by doctors and hospitals is growing and saving money in the taxpayer-funded Medicare program, according to a new report from the federal government. However, experts say most patients still don't understand how an Accountable Care Organization works.

And while early data shows financial improvements, experts say it's too early to know the long-term financial impact.

The organizations are networks of doctors, hospitals and other providers who coordinate care in an effort to keep patients out of the hospital. They have become more common as the federal government shifts from a Medicare model that rewards volume to one that creates incentives for quality outcomes, such fewer infections and a reduction in unnecessary tests.

The programs are difficult for doctors and patients to understand, but their impact is real. For example, when a patient undergoes knee replacement surgery, they likely see their primary care doctor, orthopedic doctor, surgeon, visit a rehab facility and attend physical therapy. All of those providers work for different entities, so the federal government uses various incentives so the providers will communicate more effectively with the hope that the patient will get better care at a lower cost.

There are now roughly 420 such organizations in the Medicare program

serving 7.8 million patients, with more expected to enter the market in January. The Obama administration is aiming to have alternative programs like Accountable Care Organizations account for 50 percent of Medicare reimbursements by 2018.

The organizations can receive bonuses if they create savings above a certain threshold. Twenty so-called Pioneer ACOs and 333 so-called Medicare Shared Shavings Program ACOs generated more than $411 million in savings in 2014. Nearly 100 ACOs also saved enough money to get a piece of more than $422 million, according to a recent report from the Centers for Medicare and Medicaid Services.

However, three out of four Affordable Care Organizations did not reduce spending enough to earn bonuses, according to the report released late last month from the Centers for Medicare and Medicaid Services. And at least five of them generated losses.

"ACOs haven't taken a big step backward, but they haven't taken a leap forward. They've been holding steady. They've grown, but their savings have been the same proportionately with roughly 1 out of 4 saving money," said Kavita Patel, a fellow in economics study at the nonprofit independent Brookings Institution.

The organizations can choose to operate at varying levels of risk, on one end, higher potential bonuses also means increased liability for losses; at the other, they can be shielded from losses but sacrifice bonuses. Only a few agreed to take on the highest risk; the challenge is getting others to take on greater risk, Patel said.

"There were a lot of ACOs that lost money, but they didn't pay anything back ... but that can't go on forever," Patel said.

Twenty-nine percent of the 55 million Medicare patients in the U.S. are

covered by private insurers through Medicare Advantage. The rest remain in the traditional fee-for-service coverage that federal health officials want to change. However, those in ACOs lack clarity on how the organizations work, experts say.

"Patients and physicians don't really have any kind of handle on their role in any of it, especially patients," said Patel, who is also a primary care doctor in Baltimore.

Currently, the federal government assigns Medicare beneficiaries to Affordable Care Organizations. But starting next year, a test program will be allowed to recruit patients directly, just as insurance companies do.

"We all have more work to do so beneficiaries understand what it means to be in an ACO," said Sean Cavanaugh, a Medicare deputy administrator. "But we know patients in ACOs report they're receiving better care in ACOs, even if they don't fully understand the concept."