Accountable Care Organizations – An Overview

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With the advent of health care reform, one of the topics generating a great deal of discussion among providers is delivery system change—specifically, Accountable Care Organizations (ACOs). This article is intended to answer several critical questions regarding ACOs.

1. What are the common definitions and models of an ACO?
2. What ACO provisions are included in the recently enacted law?
3. What are key considerations in becoming an ACO?

Reform includes several provisions aimed at "bending the health care cost curve." These include attempts to address cost shifting due to covering the uninsured; promoting improved quality (and cost reduction) through value-based purchasing, nonpayment for certain readmissions, and hospital-acquired conditions; and slowing cost increases through payment changes. These provisions are not likely to provide the necessary impact. There are two primary methods to bring health care costs down, and they both relate to utilization. Less must be utilized during each episode of care, and unnecessary episodes of care must be avoided altogether. The challenge is to achieve these goals while maintaining quality. These seemingly paradoxical goals can be achieved, but they require a significant shift in health care delivery—away from the current fee for service model that encourages utilization and does not provide incentives for wellness, prevention, or even cost reduction. Given the size of the health care industry, a drastic change in delivery and payment is not feasible overnight. However, the law has numerous demonstration projects that provide a mechanism for providers to begin to build the capabilities necessary to succeed in a new delivery system where current incentives are modified and cost, potentially, can be addressed.

What is an Accountable Care Organization?

The Accountable Care Organization is one of the delivery system demonstration projects available to providers under reform. Conceptually, an ACO is a provider-based organization that coordinates care for a set population in order to both deliver quality care (and prevention) and control costs. The promise of an ACO is that these two factors—quality and cost—balance. While the idea holds promise, it is relatively new and definitions are still evolving.

At the most basic level, an ACO begins with primary care physicians. Much like a medical home, these primary care physicians are responsible for coordinating the care of a set population of patients. Payment is provided in a variety of methods; the primary care physicians may receive normal fee for service payments with the ability to share savings or they may receive comprehensive (risk adjusted) payments for each person within their covered population. While an ACO may choose to accept insurance risk, the primary risk most ACOs will accept is based upon performance and cost. In our basic ACO, the primary care physicians will utilize relationships with specialists, hospitals, and other providers. In the simple form, the ACO will look to work with those providers who offer higher quality and lower cost care. The "primary care only" ACO is able to target cost reductions related to prevention, appropriate use of tests and referrals, and preventable hospital activity. Note that it is essential for an ACO (particularly one that is primary care only) to have a sufficient population. The new law sets the floor at 5,000 Medicare lives. Others have suggested minimum levels of 4,000 to 10,000. Why the minimums? These larger populations help to both mitigate cost risk and ensure that observed quality outcomes are valid.

The next iteration of an ACO adds major specialists to the organization. These specialists will share in savings or the global payment. The benefit to adding specialists is that—for major specialties—the specialist is incented to work to improve outcomes and look for more efficient delivery of care.

Taking this logic further, an ACO can also include a hospital. With a hospital on board, the ACO can target better care of complex patients and can look to streamline critical patient processes. The challenge, which will be addressed later, is how an ACO with a hospital can agree to share savings or payments.

Finally, an ACO, if focused geographically, can be expanded to include community health resources. Coordinating health resources at the community level can help extend prevention and support services.

The bottom line is that an ACO can exist in many forms. The examples above describe the types of providers involved. Other variations can be geographic, membership, and payer based. One community can have multiple ACOs or one ACO can span multiple communities. As described above, an ACO can be financed with fee for service plus shared savings, risk adjusted comprehensive payments, or if it can manage, full capitation. Membership (which population receives care from the ACO) can be assigned or voluntary. In short, we'll likely be able to say that if you've seen one ACO, you've seen one ACO.

As mentioned earlier, a common definition issue with ACOs is to confuse them with medical homes. Certainly there are similarities and many medical homes will have the ability to become an ACO. An ACO differs from a medical home in that it is explicitly accountable for cost in addition to quality and the ACO may include nonprimary care members. There is overlap, and it should be noted that for a primary care-oriented organization, a medical home could be a good first step to becoming an ACO.

Capitation must also be addressed. As a comment, we often hear that an ACO is simply a new name for a capitated HMO. These new models are not simply "back to the future." In the 90s, the promise of managed care never emerged- capitated HMOs we really "managed

cost" organizations that profited from both rationing of care and shifting insurance risk to providers. So, how does an ACO differ from a capitated HMO? Three primary differences occur: 1) an ACO is accountable for quality as well as cost through effective coordinated care, as mentioned earlier; 2) risk is typically limited to cost and performance not actuarial risk; and 3) an ACO is provider centric not insurer based. Similar to the medical home discussion above, there might be an instance where an ACO decides to take on full actuarial risk and become a provider-based HMO, but this is not expected.

The Current Law

With so many different definitions, does reform help to narrow down the options? Yes and no.

What is defined? The ACO must have a covered population of at least 5,000 Medicare lives (the primary care physicians participating must cover at least 5,000 Medicare members). The organization must also be structured to share savings, and those savings are based upon actual fee for service claims versus the projected fee for service costs for the ACO population. The ACO must agree to participate for at least three years. The program will begin by January 2012.

Many key details fall under the "TBD" or "The Secretary shall define" category. This includes specific reporting, quality measurement, and shared savings details.

As far as participants, there is wide latitude under the law:

- ACO professionals in group practice arrangements.
- Networks of individual practices of ACO professionals.
- Partnerships or joint venture arrangements between hospitals and ACO professionals.
- Hospitals employing ACO professionals.
- Such other groups of providers of services and suppliers as the Secretary determines appropriate.

The lack of details may be a blessing in disguise since most providers will want to wait for full definition before committing to participate in the pilot.

What Are Key Considerations in Becoming an ACO?

Any organization thinking of becoming an ACO must consider three things:

1. Major requirements
2. Risks
3. Implications of action (or not acting)

The requirements can be grouped into financial, customer, process, infrastructure, and culture. The following checklist identifies those areas critical to success:

Financial

- Ability to manage financial risk
- Ability to understand costs of key processes across multiple provider settings

Customer

- Sufficient Medicare lives (i.e., Does the organization have 5,000 or more Medicare lives that will participate?)
- Ability to contract with other major payers

Processes

- Patient-centered processes
- Patient education and self-management
- Effective quality and cost improvement
- Clinical coordination among providers

Infrastructure

- Clinical integration – technology to collect necessary information
- Technology to coordinate patient care
- Performance management tools that can cross multiple organizations
- Alignment between providers

Culture

- Teamwork among ALL members (Is the group a collection of providers or truly one organization?)
- Clear leadership
- Accountability

From the list above, two aspects are critical—culture and technology. An ACO must have the technology to work together, but it must also be able to work together. This suggests two successful types of organizations (at least in the short term)—those with access to capital and those with a history and shared culture. This may point initially to existing physician groups or integrated delivery systems. Others may be able to work toward becoming ACOs, but investments are needed to get there.

From a risk standpoint, the most important issues involve payment and relationships. From a payment perspective, a prospective ACO should only take on the risk it can realistically manage. If starting with the pilot models, risk is minimal. Should the organization fail to achieve savings, it still receives fee for service payments as before (but no shared savings bonus). If engaging in any type of comprehensive payment, risk grows and the ACO could end up losing significantly. The other aspect of payment is the potential for conflicting payment systems. The ACO may be successful managing Medicare patients, but if other payers continue to pay under the status quo, the organization will lose revenue as its utilization is likely to decrease (or it is ineffective in managing two standards). As indicated above, a success factor involves expanding the payers participating in the ACO.

The other major risk is relationships—those with other providers. As an ACO begins, the initial incentives of primary care versus specialists and hospitals are not aligned. An ACO can make money by reducing utilization (balanced with quality). However, for an ACO to make money, specialists and hospitals will lose volume and

revenue. Should the specialists and hospital not be part of the ACO, there will be no shared savings. This certainly can set up the feeling of competition. Adding specialists and hospitals to the ACO can open the door to aligning actions through shared savings, but how can the organization distribute savings or payments? There is potential for conflict among the members. An integrated organization may be better situated as all members of the ACO are under common ownership and governance.

So, given the risks and major investments required, should a provider consider becoming an ACO? The answer is a conditional yes. Over time, the market may move toward systems in which an ACO structure is essential, but that time is not going to happen overnight, and very few organizations have the capabilities to become an ACO overnight. Instead, an organization should establish a long-term "transformation plan" and start to make the investments necessary to succeed as an ACO—culture, technology, management, information, etc. These are the investments that will be necessary to survive or succeed in the future regardless of the actual market structure.

Many of the necessary ACO success factors will come about only through learning. This should be built into an organization's transformation plan. It can use the next few years and reform opportunities to begin working on these factors while managing its risk. For example, if an organization has all the necessary provider components and a majority of the success factors stated above, it could consider the Medicare ACO pilot. If, though, an organization is like most others in the country, it needs to identify other opportunities to drive learning. For a primary care-based organization, invest in medical home capabilities. For hospitals and specialists, look first at managing and coordinating episodes of care potentially through another pilot program—bundled payments.

This is a high-level roadmap. In future articles, we will drill down into specifics. But it is important that these ideas be addressed in this overview. The market will change. We may not know the speed at which this change will come, but it is coming. Every organization is better off trying to control at least some portion of its destiny; if it does not, the market will manage it instead.

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