

ACCOUNTABLECAREFACTS.ORG
Accountable Care Organizations:
Frequently Asked Questions and Research Summary
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*While the Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act of 2010 (together commonly referred to as the **Affordable Care Act** or **ACA**), , primarily addresses the need to provide health insurance coverage and consumer protections for millions of uninsured Americans, it also contains many provisions to help stem the rising cost of care and improve the quality of basic health care in America. The initiatives and incentives that the law has put into place for Medicare reflects the recognition that the gaps in quality and unrestrained cost are results of a delivery system and payment methodology that is in need of significant restructuring. Accountable care organizations (ACOs) are one of the many solutions proposed in the ACA. Some solutions proposed in the ACA are the concepts of care coordination and accountable care organizations (ACOs)¹.*

This document seeks to explain what the characteristics of an ACO are according to the law, why ACOs are expected to achieve high quality outcomes while reducing the overall cost of care, what nascent ACO-like arrangements currently exist, and what barriers will hinder formation of such organizations.

Why is healthcare delivery reform as proposed in the Affordable Care Act necessary?

The various delivery-system reform provisions of the Patient Protection and Affordable Care Act (H.R.3590) and the Health Care Education and Reconciliation Act (H.R.4872) – together known as the **Affordable Care Act (ACA)** - strive to achieve the “**Three Part Aim**”: improving the experience of care for individuals, improving the health of populations, and lowering per capita costs. In order to achieve those goals, the existing payment models and health care delivery system need to be reformed.

Despite general public perception,, the healthcare system of the United States does not deliver the best care it can (see **Health Care Facts** on this website). Yet, it is the most expensive healthcare system in the world. The ACA aims to move the healthcare system away from its current episodic, fee-for-service payment approach and towards a coordinated model that is focused on delivering high-quality, low-cost care across the continuum of care. The fee-for-service method of paying for healthcare can create incentives for providers to deliver more care,

¹The term “Accountable Care Organization” was used in the House Tri-Committee Health Reform Bill (HR 3200), and in other proposals and documents from Senate and MedPAC. It was coined by Elliot Fischer et al in their 2006 *Health Affairs* article on **creating Accountable Care Organizations**. However, as **The Urban Institute noted**, “other terms have been used for similar concepts. Specifically, the term accountable care system (ACS) is the term used by Shortell and Casalino (2007; 2008); ‘bonus-eligible organization’ (BEO) is a term sometimes used by the Congressional Budget Office (CBO)²; and accountable care entities (ACE) is a term sometimes used by the Medicare Physician Value-Based Purchasing Program.”

but not necessarily better care. Developing a payment system that rewards quality outcomes and stewardship of healthcare resources is necessary for America to rein in its costs and improve the overall quality of the healthcare system. In addition to changing the method through which providers are paid for healthcare, it is also necessary to reform the way in which that care is delivered, i.e., reforming the delivery system by creating high-performing organizations of physicians and hospitals that use systems of care and information technology to prevent illness, improve access to care, improve safety, and coordinate services—in other words, to become accountable for the quality and cost of American health care.

What is an Accountable Care Organization (ACO)?

The Accountable Care Organization concept is one that is evolving, but generally, an ACO can be defined as a set of health care providers—including primary care physicians, specialists, and hospitals—that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients.

An ACO potentially could be formed around a variety of existing types of provider organizations. Many multispecialty medical groups, physician-hospital organizations (PHO), and organized or integrated delivery systems already function as ACOs or have the management and/or payment structure required to quickly evolve into an ACO. Other provider organizations, such as tightly managed independent practice associations (IPAs), are also likely candidates to become ACOs but some may require more time and/or infrastructure support to provide the care and cost benefits of an ACO.

The Affordable Care Act's most significant contribution to creating ACOs is in the traditional Medicare fee-for-service system. The law includes a provision that allows Medicare to reward healthcare organizations with a share of the savings that would result from improving care quality and reducing the cost for their eligible Medicare populations.. To participate in this **“shared savings program,”** healthcare organizations need to become Accountable Care Organizations (ACOs).

The Centers for Medicare and Medicaid Services (CMS) are currently testing several models of care delivery re-design that aim to improve the efficiency of American healthcare systems, improve quality, and contain costs—in other words, to provide accountable care. These include such initiatives as the Advanced Payment Incentive, Pioneer ACO demonstrations, in addition to the Medicare Shared Savings ACO program.

Private commercial payers, such as Cigna, Anthem, and Aetna are also supporting ACO formation, testing the concept either by aligning incentives with more organized provider groups and health systems in their marketplaces or by purchasing physician groups and providers to attempt to improve care delivery.

These types of insurer-directed payment approaches to care delivery remind many of the HMO movement of the 1990s. Since that time, however, the term HMO has come to mean different things. Today, HMOs generally refer to: 1) Fully integrated delivery systems like Kaiser Permanente, where the insurer, physician groups, and hospitals are part of one integrated

organization, and care is provided to only those who are insured by that organization; and 2) private health-plan products that call themselves HMOs, but are fundamentally only payment contracts with a network of mostly disaggregated physicians and hospitals.

In the former, care and cost can be managed much more effectively because clinical information and care processes are shared and supported by all providers. In the latter, care and cost are less easily managed because the providers are bound only by contractual agreements, not by care processes, shared incentives, or a common mission or shared values. Kaiser Permanente, an HMO, has for many decades delivered strong care coordination and integration of clinical services, care management, and clinical integration systems that many people are looking for in the ACO model. While some HMOs could meet the test of an ACO, not all of them have currently the capability.

Why are Accountable Care Organizations important to achieve improved cost and quality?

The belief is that, if well conceived and implemented, ACOs can achieve both cost and quality improvements because the coordinated and collaborative nature of the delivery system itself is paid for and rewarded for its outcomes, not for its volume of services. Therefore, the structure of an ACO becomes important: experts believe that ACOs must be physician-led, primary care-centered, and patient-focused systems of care. Currently, there are many health care systems of physicians and hospitals that function like ACOs, and the **research conducted on these entities** support the prevailing notion. By encouraging the evolution and growth of ACOs through payment incentives and a favorable regulatory climate, ACOs may be the most promising mechanism to control costs and improve quality and access in the American healthcare system

The ACO concept is one that has been widely discussed among health researchers and pundits. According to the **Commonwealth Fund**, 54 percent of health care opinion leaders believe that ACOs are an effective model for moving the U.S. health care system toward population-based, accountable care. The **Congressional Budget Office** projects that the Shared Savings Program will save the Federal government \$5 billion between 2010–and 2019.

Note that while the government focus on ACOs is within the context of Medicare, the concept applies to all patients covered by all forms of insurance and private-sector insurers are also sponsoring such efforts. If ACO development can extend beyond the Medicare program, the advantages are clear: physicians and other providers will be able to interact with both public and private payers based upon consistent incentives and “rules of the game.” In addition, quality and care coordination will improve for all Americans, irrespective of age or payer.

What are the primary characteristics of an ACO?

The sponsors of this website believe that ACOs should be formed around strong primary care, specialty, and hospital physician-led alliances. Payment by insurers and the government should incentivize cost control and the improvement of care that is delivered within these organizations. In this way, ACOs can be formed that serve all patients equally, not just the people covered by Medicare.

Proponents generally agree that the following characteristics are essential in an ACO delivery model:

1. An ACO should have the capability to manage both the cost and quality of health care services under a range of payment systems, including fee-for-service, episode payments, and full and partial population-based prepayment (capitation).
2. Possession of sufficient infrastructure and management acumen to support comprehensive, valid, and reliable performance measurements; to make internal system improvements in care quality; and to externally report on its performance with regard to cost and quality of care
3. A clear organizational mission and commitment to achieve quality and cost efficiencies; a physician management structure that is supportive of all of the requirements listed above; and a culture that supports and rewards continuous quality improvement
4. The use of health information technology to manage patients across the continuum of care and across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post-acute care.

What is the difference between a medical home and an ACO?

The **Patient-Centered Medical Home** model was proposed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association in 2007. It is, in essence, an enhanced primary care delivery model that strives to achieve better access, coordination of care, prevention, quality, and safety within the primary care practice, and to create a strong partnership between the patient and primary care physician. In the model, payers often reward providers with a per member per month “bonus” for improving primary care services for each patient in the medical home. Like accountable care organizations, the medical home model is referenced many times in current health reform efforts as one way to improve health outcomes through care coordination.

The Accountable Care Organization is also based around a strong primary care core. But ACOs are comprised of many “medical homes”—in other words, many primary care providers and/or practices that work together. Some have even dubbed ACOs the “medical neighborhood.” The difference is that ACOs would be accountable for the cost and quality of care both within and outside of the primary care relationship. As such, ACOs must include specialists and hospitals in order to be able to control costs and improve health outcomes across the entire care continuum. ACOs by nature would be larger than a single medical home or physician’s office. There are many known benefits of the ACO structure over the medical home model, including the ability to better manage the care for a greater population of people with a larger budget. Being able to use the dollars across a wider range of patients and conditions allows for better overall cost management, less variation within the population, and the ability to track and trend for quality.

How many ACOs have been or are being formed across the country?

Over the past few years, the formation of organizations to function as ACOs has increased rapidly. Since there is no formal method to track their development nationally, some consulting groups are attempting to quantify the movement through literature searches and public announcements. As of November 2012, **Leavitt Partners** estimated that there are more than 300 commercial and government-sponsored ACOs around the country. In January 2013, **CMS** announced 106 more organizations will be participating in the Medicare-sponsored ACO programs. A recent study conducted by **Oliver Wyman**, a management consulting firm, estimates that 25 to 31 million Americans are currently receiving health care services from an Accountable Care Organization (ACO) and more than 40% of Americans live in areas with at least one ACO. An ACO is defined in this study as providers participating in a Medicare Pioneer ACO project, Medicare Shared Savings Program, a Medicaid coordinated care initiative, the Medicare Physician Group Practice (PGP) Transition, or in a shared savings/risk arrangement with a commercial payer.

What medical organizations are the most likely types to evolve easily into ACOs?

An ACO could potentially be formed around a variety of existing types of provider organizations. Many multispecialty medical groups, physician-hospital organizations (PHOs), and organized or integrated delivery systems (IDSs) already function as ACOs or have the management and/or payment structure required to quickly evolve into an ACO. Other provider organizations, such as tightly managed independent practice associations (IPAs), are also likely candidates to become ACOs, but some may require more time and/or infrastructure support to provide the care and achieve the cost benefits that are expected of an ACO.

What are the real cost savings that can be anticipated by an ACO and how will they be achieved?

As proposed by the ACA, ACOs would share in the savings to the federal government if they are able to improve quality and reduce healthcare costs under the Medicare fee-for-service Shared Savings Program. The **Congressional Budget Office** projects that this program could save approximately \$5.3 billion over 2010–19. This is only a portion of the savings the CBO projects through implementation of all of the care coordination and insurance provisions of the ACA.

However, the real cost savings of ACOs have yet to be determined. Much will depend on the extent to which ACOs are formed; how effective they are in improving quality and containing costs; whether the Medicare-sponsored program works on a fee-for-service foundation or if the payment model needs to be modified; the capabilities of ACOs of handling different expectations of different payers; etc.

In the end, however, the true *value* of ACOs will be determined not only by cost savings but by assessing improvements in quality while being cost effective.

What are the barriers and challenges such organizations might face?

As recognized by many other industries, “system-ness” in an organization provides consistency of quality and outcomes. This is the operational imperative of any efficient enterprise, but is still sorely lacking in the U.S. healthcare system. Clinical and financial integration and/or alignment will be necessary to achieve the aims of an ACO, but a successful integration cannot occur without a way to systematically provide good medical outcomes. Despite the evidence that the more highly integrated and organized health care systems in this country have proven to be more adept at managing cost and quality, integrated systems of care are not the norm.

Why not? There are many barriers and challenges that have deterred the expansion of integration. Some that face aspiring ACOs include:

1. **Multispecialty group formation:** multispecialty group practice is a necessity to manage care across the continuum, but aligning specialties under a multispecialty group umbrella can be challenging when there are great income disparities between specialties and multiple ways that physicians can be paid.
2. **Size of the patient population:** what size patient population is necessary to produce meaningful outcomes data? The Medicare Shared Savings provision of the ACA proposes a minimum Medicare population of 5,000, but this number may be too small. The consensus is that the larger the population, the easier it is to measure outcomes and manage the costs of care.
3. **Cultural:** does the organization have the patient-focused, physician-led accountable culture that is the common underpinning of the most successful American health care systems? A strong culture of self-reflection and assessment, continuous improvement, and flexibility may be the key differentiating factor between success and failure. Trying to integrate the different business cultures of partnering organizations into one can be a significant barrier.
4. **Resources:** does the organization have the resources (staff, time, money) necessary to carry it through its journey to accountability, which means completely realigning how money flows and services are delivered?
5. **Staffing:** primary care providers are critical to the ACO, yet the specialty-focused structure of the current delivery system has created a dearth of primary care physicians. Finding enough primary care doctors will be a challenge for the nation, as well as individual organizations.
6. **Lack of consistent measures:** Quality measures requested from providers and hospitals by the various payers are often different, presenting resource challenges within the health care organization.
7. **Market-based:** health care markets vary widely, so the organization must carefully consider its current market position and the impact that an ACO transition might have on its business in the short-term and the long-term.
8. **Legal:** there are several legal and regulatory issues that must be addressed to allow for ACO collaboration and integration, the Sherman Act anti-trust laws, anti-kickback laws, and the physician self-referral Stark Laws among them.

The challenges are many. Those provider groups, hospitals, and other medical delivery systems that have not done the work of strengthening their primary care services, who do not manage populations well, have not embarked on clinical integration, and/or have not adopted health care technology to facilitate care delivery while measuring quality will have great hurdles to cross. A highly functioning ACO will not evolve solely through the financial and clinical integration of parts of the delivery system. As CMS works to maximize participation in the Medicare Shared Savings Program (designed to create incentives for the growth of ACOs), it must remember that not any provider organization is well-suited for this model. Moving an organization towards accountability will not only require integrated clinical and financial processes, an investment in technology, and waivers of legal barriers, it will also take time and commitment.

What is the importance of linking of outcomes measures to payments?

In a word, accountability.

For too long, the American healthcare system has not been effective in delivering quality care to all Americans or in managing our healthcare dollars. The healthcare costs for our nation are ever-increasing and our system is the most expensive in the world, yet measures of medical quality indicate that we are not living longer, or healthier, or receiving the best care we can for the dollars we are spending. And one reason why is that the current fragmented, volume-based, system is not accountable to payers or consumers and is unsustainable. The Affordable Care Act recognizes the need for care coordination and accountability. In order to assure accountability, health outcomes and performance measures are needed to assess whether or not payers and consumers are getting value for their health care dollar.

How should quality outcomes be measured?

Outcome measures must reflect the goals that ACOs are being incentivized to achieve. Ideally, these measures should support the Three Part Aim: improved population health, improved patient experience, and lower per capita cost. Additionally, these measures should be standardized, accepted by all payers, and should be reported externally at the practice level, not at the individual physician level.

While ACOs will be rated and rewarded for performance, at present ACOs do not have enough standardized quality-of-care data to generate measures for comparison. The **National Committee for Quality Assurance**, the independent organization that currently reviews and accredits managed care health plans and measures the quality of care offered by these plans, has established an accreditation process for ACOs. In doing so, they recommended that Medicare should create a set of criteria and standards to determine which ACOs have the infrastructure to achieve the goals of the Shared Savings Program, including the ability to collect and aggregate data for measurement. Once that is established, reports on standard performance measures around clinical quality, patient experience, patient-centeredness, and stewardship of resources can be produced and used for benchmarking, evaluation, and payment.

Clinical quality measures could include prevention measures, chronic care measures, acute care measures, an inpatient patient mortality and safety measures (for specific examples, see

measures developed by **NCQA in their work on ACO accreditation** standards). Patient experience and patient-centered care measures could include assessment of culturally competent care, patient satisfaction with access to care and how care was managed and transitioned, assessment of self-care and self-monitoring procedures, and measurements of team-based performance. Cost measures could include chronic care-management resources, inpatient readmissions, inpatient utilization, ER visits, preventable hospitalizations, and utilization of imaging services. Measures that attempt to quantify “value,” i.e., cost in relation to quality, would be particularly useful, particularly as the program attempts to gain consumer understanding and buy-in. The shift that needs to take place with consumers is away from the notion that “more care equals better care” to an acceptance that “accountable care brings value.”

How should the current antitrust and antifraud laws be addressed to clear the way for ACO development?

It is unknown how the implementation of the health-reform law will change the playing field, therefore recommendations about how federal and state laws would need to be reformed are still under development.

However, assuming that Affordable Care Act and the ACO program in particular strive to move the country’s healthcare delivery system toward more collaboration and coordination in order to assume collective accountability, laws affecting the ability of providers to work together will have to be reformed.

The Federal Trade Commission is already aware of the issues in this regard. In **House Subcommittee testimony**, FTC director Richard Feinstein discussed the relationship between competition and antitrust enforcement and the goals of the Affordable Care Act to lower cost and increase quality. In his testimony, he acknowledged that antitrust guidance may be necessary for ACOs as they strive to operate and perform under both the Medicare Shared Savings Program and in the private market. Because the integration of provider organizations will take time and resources, the resulting delivery system needs to be viable in both markets. Therefore, the FTC is exploring whether they can develop “safe harbors” for ACOs, and develop rules for ACOs that will allow the health care community to collaborate but without creating market concentration or fixed prices. There are three principal federal anti-trust statutes that may be restrictive to the evolution of ACOs: Sherman Act 1 (agreements between economic entities that unreasonably restrain trade), Sherman Act 2 (predatory or exclusionary conduct to monopolize), and the Clayton Act 7 (mergers and acquisitions that threaten to lessen competition).

In addition to the antitrust issues, there are several fraud and abuse prohibitions: the anti-kickback rules of CMS; the physician self-referral laws (also known as the Stark Laws); false medical claims enforcement; and the physician incentives provision of the fraud law (also called the civil monetary penalty). These laws are a direct outgrowth of Medicare’s fee-for-service payment methodology.

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