

The Evolving Role of ACOs in Reforming Health Care

By [Rob Schile](#)

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Definition

By definition, an accountable care organization (ACO) is a group of health care providers that work together to manage and coordinate care for a defined patient population. As part of managing and coordinating care, the ACO also accepts responsibility for improving the quality of care provided, while reducing costs at the same time.

ACOs can be a combination of several different types of providers that are not part of a single health system “family.” In other words, they can be separate corporations working together to achieve the same goal: improving health care quality and cutting costs.

ACO requirements in the health reform act

Given the potential role, ACOs could play in health care reform, the *Patient Protection and Affordable Care Act* (commonly referred to as the health reform act or PPACA) contains some key provisions for them. They are outlined under the “Shared Savings Program,” which is scheduled to begin no later than January 1, 2012. The noteworthy requirements for ACOs include:



General PPACA Requirements for ACOs

Eligibility	<ul style="list-style-type: none"> Eligible professionals include group practices, individual practices, hospitals, and other types of providers and suppliers. “Professional” is defined as a physician or practitioner.
Accountability	<ul style="list-style-type: none"> These organizations must be willing to become accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries assigned to it.
Agreement Length	<ul style="list-style-type: none"> To participate, ACOs are required to enter into at least a three-year agreement.
Entity/Leadership Structure	<ul style="list-style-type: none"> The formation of a legal structure that enables the ACO to receive and distribute shared savings payments is a requirement. A leadership/management structure must be in place.
Medicare Beneficiaries	<ul style="list-style-type: none"> Fee-for-service beneficiaries will be assigned to an ACO based on methodology determined by the Secretary of the United States Department of Health and Human Services (HHS), with a minimum number of 5,000. ACOs must have a sufficient amount of primary care professionals

	to cover beneficiaries assigned.
Defined Quality and Care Processes	<ul style="list-style-type: none"> • Processes must be defined to: <ul style="list-style-type: none"> – Promote evidenced-based medicine and patient engagement – Report on quality and cost measures, and – Coordinate care.

Additional PPACA Requirements for ACOs

Quality and Reporting	<ul style="list-style-type: none"> • The secretary of HHS will define measures of quality, which will include clinical processes and outcomes, patient caregiver experience of care, and utilization rates. • The secretary of HHS will determine the reporting manner for specified measures. • Quality performance measures will be: <ul style="list-style-type: none"> – Defined – Over time, performance expectations will be increased, and – New measures will be developed.
Payment for Services	<ul style="list-style-type: none"> • Payments will continue to be made under the fee-for-service program, but ACOs that meet quality performance and cost standards will be eligible to share in the savings generated.
Savings Requirements and Benchmark Determination	<ul style="list-style-type: none"> • The secretary of HHS will determine the percentage reduction in Medicare per beneficiary costs, and establish this as the benchmark for ACO performance. • The benchmark will be estimated for each agreement period using the most recent available three years of per-beneficiary expenditures for Part A and B services for Medicare fee-for-service beneficiaries. • Benchmarks will be adjusted for characteristics of beneficiaries, and they will be updated by projected national per capita growth for Parts A and B services.
Payments for Shared Savings	<ul style="list-style-type: none"> • If the ACO has quality and cost performance at the expected level established by the secretary of HHS, it will be eligible to receive a

percent of the savings.

- The percent to be distributed will be determined by the secretary of HHS.

How ACOs are expected to differ from HMOs and PPOs

To some, the concept of an ACO sounds very familiar to the health maintenance organization (HMO) and preferred provider organization (PPO) days of the 1990s, which reflects the last time a significant push was made to reform the health care delivery system. During this time period, many believed reform initiatives would push providers into capitated payment contracts with third-party payers. In an effort to preserve revenue streams, many providers attempted to protect or expand market share through acquisitions, specifically of physician/primary care practices. In the past, many of these acquisitions were over priced and led to lack of patient choice, reductions in quality and access, and by many accounts, a massive failure of the delivery system.

The concept of an ACO is very different, because it is intended first to focus on providers, and not the insurance companies. Secondly, the ACO concept will be aimed at the entire delivery system and not just the payment stream associated with it. Key elements are below:

- Providers will not be placed at financial risk, but will be able to share in financial incentives if they are able to improve quality and reduce costs.
- Participation in an ACO is currently open to all provider types. Although, there is some debate about who or what entity should be the leader of the ACO, the model is designed to bring providers from the full continuum of care together in a collaborative working environment.
- Technology has advanced considerably since the HMO days, but all providers may not have the capabilities to utilize it. However, the technology exists to assist with elevated levels of collaboration by enabling ACO participants to link together and share critical patient clinical information.
- The state of health care in America has evolved to a point where the vast majority, if not all providers, believe change needs to take place. Because of this belief, there is a greater willingness to work for change to improve quality and reduce costs.

Many are optimistic about the role ACOs can play in improving the health care delivery system. In its June 2009 report to Congress, MedPAC said, “ACOs could prove to be an important catalyst for delivery system reform by creating incentives for increased organization and joint decision making.”

Key success factors for ACOs and unanswered questions

The definition of an ACO is understandable; however, how they’ll operate remains an elusive concept. It’s difficult to comprehend how different providers with their own missions, visions, and leadership teams will come together to function as a single unified structure without walls.

While many people expect ACOs will play a significant role in improving the American health system, there are a lot of unanswered questions. Despite the unknowns, we believe there are some essential characteristics each ACO will need to be successful:

Strong, visionary leadership

It is easy to understand how an ACO could be effective in a large, multi-specialty health system. It becomes difficult to grasp when thinking of it in a non-urban area. Communities with multiple providers would be expected to come together in a form of an organization without walls. This group would potentially consist of several primary care

physicians, the local hospital, multi-specialty physicians, long-term care professionals, community health providers, and others. Typically, these organizations have vastly different visions, strategies, and operating principles.

How can health care professionals in these settings come together and work collegially to be successful in a common goal when in some cases, the success of the ACO may not equate to success for their own organization? To work through this and stay focused on the ultimate goals for the ACO, strong and visionary leadership will be a pre-requisite. Success will demand a leader capable of encouraging this group of non-related providers to put their own interests aside, for the betterment of the larger cause. From a historical standpoint in health care, the ability to put one's own interests aside for the benefit of others has not been a common or typical occurrence.

Significant technology investments

There will need to be a significant investment in technology for the participants of an ACO to understand if it is effectively managing a patient population. For example, care coordination among the providers in the ACO will be critical. For this to efficiently take place, these providers will need to be linked together clinically to readily share patient information.



ACOs will also need technology to report and monitor patient satisfaction, clinical quality outcomes, and financial indicators, such as cost-per beneficiary, budget forecasting, etc. For the ACO to succeed, this type of information must be readily accessible, reliable from an accuracy standpoint, and usable by management. While this technology would most likely exist in the marketplace, the big questions are:

- Who or what entity would be responsible for the capital investment given the ACO is a group of non-related providers?
- How will this responsibility be divided up among the participating providers?
- Who or what entity will take responsibility for day-to-day operations and management of the information stream?

These will be crucial planning issues all non-related ACOs will have to address in the early stages of formation.

Project and change management capabilities

An underlying notion of the ACO concept is that change will be necessary in the delivery of care to reduce costs and improve quality. When thinking of an ACO comprised of multiple non-related organizations, it would appear implementing change across this group of providers would be a difficult task and one that would require skilled expertise in this area. Implementing change will require gaining credibility and buy-in from constituents. Being able to accomplish the level of necessary effectiveness in change management (among a group of providers that inherently lack trust of one another) would seem to be a significant challenge for those who are willing to take it on. As big as the challenge may be, the ability to identify and implement change in care delivery is a critical operating theory of the ACO, and the underlying key to capturing the anticipated benefits expected of them.

Accountability for care of a patient population

A main consideration in identifying the patient population an ACO is accountable for is whether or not there should be specific identification of those patients. In “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” published by *HealthAffairs*, Elliott Fisher and colleagues identified that patients who receive care from specific physician groups tended to flow to or “cluster” to particular hospitals. Because of this patient flow, it is felt by many that within the health care delivery system, there already exists a sort of virtual assignment of patients to a particular group of providers within geographic regions.

The effectiveness of this accountability for certain populations will ultimately depend on how patients view the ACO model of delivery. Consumer choice will be at the heart of this decision. If patients feel their choices are constricted, quality is inferior, and they are not able to establish relationships with their providers, they'll be less apt to remain part of the virtual assignment.

Finally, what types of providers belong to the ACO will need to be considered. To support the full continuum, an ACO must be made up of primary care physicians, specialists, hospital services, mental health, long-term care, etc. In addition, it may be necessary to consider having other third-party payers participate.

Shared incentives and revenue streams

Providers that are part of an ACO are encouraged to elevate collaboration in care coordination and determine best practices to reduce utilization and ultimately cost. If successful, the ACO would then share, on a percentage basis, in the savings and distribute these savings to participating providers.

Extensive work would be necessary to understand the current costs of a specific patient population and how they could be projected forward to establish the base-line cost to compare against. A lot of effort would also need to go into understanding how to best maintain or improve quality, including the current base-line quality performance. Then, specific quality indicators would need to be established to measure and monitor going forward. Patient experience and satisfaction must also be measured.



Whether or not the potential for shared incentives will equal or exceed the lost revenues that result from reductions in utilization is concerning. Additionally, providers from multiple organizations have worries revolving around how these shared savings will be distributed and how each individual provider ensures they receive their fair share.

Will a group of non-related providers be willing to watch their own revenue streams deteriorate while at the same time, they are making capital investments to fund health information technology (HIT) for the ACO—a move that could potentially shift reimbursement to other providers participating in the ACO due to changes in care delivery that demonstrate improved quality, reduced costs, and enhanced patient experience? While this may prove beneficial for the overall health care delivery system and the ACO, it would seem this is a considerable challenge participating providers would have to address.

Industry professionals are also asking if enough impact can be made through just Medicare beneficiaries alone, or if other payers will have to participate in the ACO? If the ACO model holds as much promise as anticipated, it would appear that all payers should participate, along with Medicare. True shared savings and cost reductions would then potentially rise to a level that would create attractive incentive opportunities for all providers.

Sufficiency of size

To make an impact on costs and performance measurement, ACOs must have a large enough patient base. Section 3022 of the PPACA defines sufficient base as 5,000 Medicare beneficiaries. In “Fostering Accountable Health Care: Moving Forward in Medicare,” published by *HealthAffairs*, Elliot Fisher and colleagues recognized that the minimum number of beneficiaries may be dependent on payers involved and identified the following:

- Medicare 5,000
- Medicaid 10,000
- Commercial 15,000

Even though Medicare represents a large portion of the industry, to truly affect the global cost of health care, multiple payers would have to agree to participate in an ACO. Separating patients by payer and creating care protocols tailored for only specific payers would create significant administration complexities, which would prove to be burdensome. Another consideration is if providers would view the incentive of shared savings sufficient with Medicare alone or would it take other payers to encourage broader participation?

If more payers participated, additional pressures would be put on the technical expertise of the ACO by demanding it have access to contract negotiation expertise or each payer would have to be a participant. Either option poses its own set of challenges to overcome.

Conclusion

As with other elements of health care reform, many questions remain unanswered to date, including how ACOs will be developed, structured, and operated. The above items are representative of just a few complex issues that will need to be addressed to ensure success of the ACO concept.

Many of these questions will be resolved over time by providers willing to take the lead on forming ACOs, and ultimately resolving them on their own. Others will be resolved as the secretary of HHS fills in the details assigned to that office through the PPACA. Underlying the resolution to these questions and operating processes, is the true value and impact ACOs can potentially make on the health care delivery system, and whether they'll be able to live up to expectations. This too will take time to understand, and one can only hope that the leadership, vision, and perseverance of providers across the country will be strong enough to deliver the anticipated benefit. The alternative will be a return to the disaster of the 1990s, which many would readily admit our health care system can ill afford.