

Summary

Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?

Timely Analysis of Immediate Health Policy Issues

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Introduction

One of the major issues being debated in current health reform discussions is how to slow rising health care costs and still achieve quality health care for patients. Policy-makers have discussed accountable care organizations (ACOs) as tools to slow rising health care costs and to improve quality in both the traditional Medicare program and in private insurance programs. A new policy brief released today by the Urban Institute and the Robert Wood Johnson Foundation provides a comprehensive look at ACOs.

The following is a brief summary of the areas covered in the policy brief, which covers:

- The definition of an ACO
- Design issues that still need to be tested and resolved
- Implementation challenges
- Reasons for skepticism.

What is an ACO?

An ACO is a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population.

The goal of the ACO is to deliver coordinated and efficient care. ACOs that achieve quality and cost targets will receive some sort of financial bonus, and under some approaches, those that fail will be subject to a financial penalty. In order to meet the requirements of this

type of incentive system, an ACO needs to be able to:

- Care for patients across the continuum of care, in different institutional settings.
- Plan, prospectively, for its budgets and resource needs.
- Support comprehensive, valid and reliable measurement of its performance.

What is new about the ACO concept and proposals?

ACOs make the people and organizations that actually provide care accountable for the quality and the cost of that care. Previous health reform initiatives involved insurers and made them ultimately accountable. The concept driving ACOs is that it is providers, not insurers, who are best placed to make the changes that will address the cost and quality problems resulting from the U.S.'s current system of fragmented care, variation in practice patterns and volume-based payment systems.

Current proposals for ACOs allow great flexibility in both the types of organizations that could serve as an ACO and the methods by which providers would be paid. This flexibility allows local markets to develop ACO organizational models and payment approaches that match the nature, strengths and weaknesses of those local markets – making it more likely that the ACO will work.

Five issues under discussion

Although authors and legislative proposals describe the broad outlines of the ACO concept, policy-makers are debating many specific program options and design features. Decisions about these options and features will affect:

- The shape of the ACO program.
- Its implementation: scale, pace, challenges, and necessary supports.
- Short and long-term outcomes in cost reduction and quality improvement.

Five key issues are being discussed:

1. How ACOs will be designed.
2. Whether provider participation will be voluntary or mandatory.
3. How patients will be brought into an ACO.
4. What provider payment method should be used.
5. How quality will be assessed.

ACO design questions

Legislative proposals in the House and Senate define ACOs quite broadly, primarily because there is no consensus over a number of design issues, suggesting the need for testing various ACO approaches. Design questions under discussion include:

- Must an ACO be physician-led? Physician decisions drive most health care services (and costs), so certainly physicians must actively



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engage with the ACO, but independent and small group practices may not be large enough to be held accountable for the quality and cost of care across the continuum of care.

- What other types of provider organizations may or must be included? Should hospital participation be mandatory? Can collaboration between physicians and hospitals be achieved in most communities?
- What specific ACO qualifying criteria should govern participation? Should there be size or structural minimum requirements? Can the concept of a “virtual ACO” in a local delivery system be sustained?
- Do patient-centered medical homes complement, or conflict with, ACOs?

Voluntary or mandatory provider participation

On the one hand, voluntary ACO programs offered by established organizations might initially have a higher likelihood of success and require fewer resources to administer its impact on health care delivery across the country. On the other hand, a mandatory program, that is, based on assigning providers to an ACO based on patterns of care available from claims data analysis, while challenging to administer – would have broader scope and offer greater potential for generating savings and improving quality – assuming providers prove willing to alter practice patterns on a broad scale.

Patient participation: passive or active?

Should patients elect to participate in an ACO or should they be assigned based upon their patterns of care? Should their freedom of choice be limited or influenced in any way? In order for ACOs to be successful, patients will need to be confident that the ACO program

will support what they value in health care: strong relationships with their health professionals, sufficient freedom of choice of provider, and access to the health care services that they and their physicians determine they need, consistent with evidence-based medicine. If patients come to view ACOs as solely a cost-control measure, political support for the concept will likely evaporate.

Provider payment methods and financial incentives

The current House legislative proposals propose two very different types of ACO payment methods for Medicare: a shared savings program (SSP) based on fee-for-service payments, and partial capitation – based on what some call population-based payment (PBP). The legislation calls for each to be pilot-tested. As with other elements of ACO design, there are strongly held differences of opinion on which approach is likely to be more successful and under what circumstances.

Assessing quality

As already emphasized, ACOs seek to improve value, that is, the relationship of quality to cost, so both costs of care and the quality of care need to be measured. Possible methods for measuring quality have been proposed: perhaps a weighted single score, or performance on a proven set of quality indicators. But the specific measures have not yet been defined.

Also, the ACO will need to be able to assess its overall quality, rather than the quality of individual physicians or other providers. This will require measures that capture issues in care coordination across providers; issues that an ACO (as opposed to individual physician practices) actually could work to improve. A benefit to measuring quality at the ACO-level is that enough data will be available to have statistical validity.

Implementation challenges

There are additional issues involved in the implementation of ACOs that go beyond the specifics of any given program. The two most critical involve:

- **The participation of, and impact on, private payers.** Do ACOs provide potential value for self-funded employers and commercial insurers, as well as for the Medicare program? Some purchasers and plans are concerned that the enhanced collaboration between physicians and hospitals within a geographic area could increase providers’ market power and result in higher costs to payers.
- **New roles and responsibilities for providers and for government agencies.** ACOs are a new type of organization, and will require provider organizations to develop new skills: skills to support both the development of new ways of providing care and the ongoing operation and management of the new entities. ACOs will need the capacity to support cultural change, teamwork, health information technology, and care management process redesign and improvement, while also strengthening managerial and physician leadership.

Reasons for skepticism

As ACOs have drawn increased attention, some experts have highlighted reasons why the concept is not likely to succeed. They assert:

- Previous attempts to manage care, via risk-bearing provider organizations that imposed restrictions on patients’ freedom of choice, failed miserably, due both to the serious problems of execution that plagued these organizations and also to employers and patients ultimately preferring open panels managed by health insurers to closed panels managed by providers.

- The ACO model that is receiving the most attention now – the shared saving payment approach that does not restrict patient choice or require any providers to take financial risks – also is inherently flawed. In many medical markets, the physician community has drawn away from the hospital and functions increasingly independently on a day-to-day basis. The weak financial incentives in the SSP payment model will not bring together these increasingly independent professionals.

Conclusion

The way health care is currently paid for in the United States, especially in the traditional, fee-for-service Medicare program, does not support coordinated care and the establishment of a delivery system with appropriate capacity and utilization. Proposals for ACOs seek to address this situation.

Many important questions remain, however, as to exactly how ACOs should be structured, given the culture of health care, existing legal requirements, political realities and the legacy of previous attempts at payment reform.

Lessons from previous reform efforts can help resolve the legal and regulatory issues ACOs face and provide insight into the trade-offs among program options. Current legislative proposals envision pilot tests of the ACO concept, ensuring that Medicare policy-makers will be able to learn from experience and make program modifications as necessary. In such a scenario, the potential benefits of ACOs surely outweigh the risks; the concept deserves a chance, although expectations of immediate success should be tempered.

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