What are Accountable Care Organizations and how could they improve health care quality?

Takeaways:

- An accountable care organization (ACO) is a group of health care providers (for example, primary care physicians, specialists and hospitals) operating as a single entity with collective responsibility for patient care.
- An ACO is a mechanism to encourage providers to better coordinate services for a group of patients, with the goals of delivering high-quality care while holding down costs.
- ACOs represent a significant shift from a health care payment system that largely rewards volume, rather than value, of services.

Overview

Most private health insurers and public insurance programs pay for health care on what is known as a fee-for-service basis. This means doctors, hospitals and other providers are paid separately for each distinct service—each office visit, each blood draw or each surgery—through a system that rewards providers for the quantity of care they provide instead of the quality of care. Experts believe this incentive system is, in part, responsible for the fragmented nature of our health care model and drives unnecessary services and high costs.

Under the ACO concept, health care providers are organized into teams that together are responsible for the health of a given population and the cost of providing its care. The theory behind ACOs is that well-coordinated care can improve overall health and health care quality while decreasing duplication of services, reducing risks of errors and complications, and lowering costs.

ACOs can work with public or private insurers, and some have already formed in the private sector. But the greatest attention has arisen from Medicare’s attempt to bend the cost curve by fostering ACOs under the Medicare Shared Savings Program created by the 2010 Affordable Care Act. ACOs that meet certain quality performance requirements would share in any money they save Medicare, called shared savings. In some cases, ACOs would also face financial penalties if they do not meet their savings goals.

HOW ACOS CAN DRIVE CHANGE

During the debate over the Affordable Care Act, ACOs emerged as a leading model to transform health care delivery.

- An ACO could be operated by health systems, health plans, hospitals, large physician practices or other medical service organizations. Under Medicare rules, an ACO would manage the needs of a minimum of 5,000 Medicare beneficiaries for at least three years. Beneficiaries would be preliminarily assigned to an ACO at the beginning of the year based on...
where they receive primary care services. At the end of the year, each ACO will receive the final roster of beneficiaries that have been assigned to it by the Centers for Medicare & Medicaid Services (CMS). This hybrid assignment process is designed to provide ACOs with enough information to begin redesigning care processes, while at the same time encouraging ACOs to improve quality and efficiency for all patients, and not just those enrolled in the ACO.¹

- **The ACO model integrates health care delivery with the goal of improving patient health and care coordination across all settings.** ACOs accept responsibility for “population health,” which means not just taking care of people when they are sick, but also keeping them healthy. When they are sick, ACOs are responsible for managing the critical transitions between care locations, including physicians’ offices, outpatient surgery centers, hospitals, rehabilitation facilities and nursing homes. For instance, patients who transition from hospital to home with an insufficient understanding of the necessary follow-up care for their condition often end up back in the hospital for the same issue. With better management of that transition, patients may understand their follow-up care better and be more likely to visit a primary care doctor or specialist when they should, which can help them stay healthier and avoid complications that could result in a costly readmission.

- **The ACO model centralizes crucial aspects of health care delivery.** Providers in ACOs will have access to centralized information portals with comprehensive patient information. As a result, patients are less likely to receive redundant care such as duplicative diagnostic tests. The model also centralizes the disbursement of payments to providers for episodes of coordinated care, such as a surgery, dialysis or oncology treatment. This means, for example, that the total reimbursement of a surgery patient’s care would be distributed among all physicians and the hospital and rehabilitation facility where he or she is treated before, during and after the surgery.

- **CMS’s final Medicare rules would incentivize ACOs to follow proven practices.** Medicare would monitor whether ACOs follow practices shown to improve care and track incidents where patients are exposed to harm. ACOs would receive financial incentives to follow evidenced-based practices that keep people healthier.

- **ACOs that fail to meet quality and cost-savings targets would face financial penalties.** Medicare would penalize certain ACOs that do not reach their target savings, but it would allow all ACOs to share in the savings if targets are met. To be eligible, ACOs would need to meet national quality standards in four key areas: patient experience of care, care coordination/patient safety, preventive health and caring for at-risk populations.²

The ACO model has emerged as one of the most widely discussed approaches for improving the quality of health care that Americans receive while slowing the growth of costs.³ The Affordable Care Act calls for ACOs to launch in 2012. CMS finalized its rules for ACO creation and incentives in October 2011. Many hospitals, physician practices and insurers across the country are already working to build their networks.

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