

MMA ISSUE BRIEF: ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

What is an ACO?

It depends; an accountable care organization (ACO) can mean different things to different people. Part of the confusion can be attributed to how the term is used. Some think of ACOs as a specific organizational structure, while others equate them with specific payment mechanisms such as shared savings models or quasi-capitated models that place providers (i.e., the ACO) at financial risk for the care provided. The concept has garnered significant attention as a promising element of health care reform, even though there is no clear and common definition for ACOs or specific evidence of their success. In general, however, an ACO can be defined as a group of health care providers, either formally or informally aligned, that accepts accountability for the cost and quality of care delivered to a defined population.

The term is attributed to Dartmouth physician and researcher Elliott Fisher, M.D. In a 2007 *Health Affairs* article, Fisher and colleagues described an approach to improving quality and reducing waste by “fostering shared accountability” for the cost and quality of care among all providers involved in that care. In particular, Fisher suggested the development of empirically defined “virtual” organizations “comprised of local hospitals and the physicians who work within and around them,” also referred to as the “extended hospital medical staff.”ⁱ

The ACO concept has evolved over time and several subsequent papers and related writings have been published. It is useful to note that three essential characteristics of ACOs have been described by Devers and Berenson (Urban Institute):ⁱⁱ

1. Ability to provide and manage care across the continuum and across settings of care.
2. Ability to prospectively plan budgets and resource needs.
3. Sufficient size to support valid performance measurement

Why all the interest?

The three dominant forces driving interest in ACOs are cost, quality, and the related financial incentives.

The rising cost of health care has everyone searching for innovative solutions for how to bend the cost curve. Similarly, evidence of underperformance in quality and efficiency of care delivered, much of which can be attributed to fragmented or poorly coordinated care for patients with complex or chronic illnesses,ⁱⁱⁱ have led to calls for greater collaboration among care providers. In addition, both physicians and purchasers of care have questioned the feasibility of realizing cost savings and quality improvement given the incentives associated with current models of paying for care. The predominant fee-for-service payment mechanism does not, for example, reward providers for keeping patients healthy or out of the hospital and it encourages utilization of care. Proponents of ACOs suggest that all of these challenges – costs, quality, and payment incentives – can be addressed by holding ACO providers accountable for the cost and quality of care in exchange for payment models that can incent efficient and effective care delivery. Developing the specific mechanisms to create accountability and modify payment incentives is a complex undertaking, however.

What is an ACO accountable for?

Conceptually, an ACO would be accountable for some defined and measurable amount of both the cost and quality of care delivered. In return for greater levels of accountability, the ACO would have access to new models of payment. Large and formally integrated ACOs may have the capacity to accept accountability for a broad range of services and, in turn, may be able to accept risk-based payment models. Other ACOs may have more limited capacity and may only be able to assume accountability for a narrow range of services, such as care coordination. The capacity and organization of ACOs will depend on numerous factors including the level of financial and clinical integration of the ACO. Informal or virtual organizations, as supported by some, will likely encounter legal barriers in trying to accept and distribute payments among unaffiliated providers.

What role do payers play?

For an ACO to successfully improve the quality of care delivered and to reduce costs, health care payers must

be willing to support the model with enrollees and new methods of payment. The Medicare Payment Advisory Commission (MedPAC) has noted that in order for an ACO to align its clinical and operational decision-making, which is particularly important for partial or global capitation models, ACOs will need to have a large or overwhelming proportion of its patients included.^{iv} Fisher and colleagues have suggested a minimum of 5,000 Medicare enrollees per ACO to ensure a statistically stable number of lives for measurement purposes.^v Efforts to align measurement and payment models, however, may encounter practical as well as legal barriers.

How are patients involved?

One of the key issues to be addressed in ACO development is whether patients will be given the option of enrolling in a particular ACO or whether they will be assigned, or attributed, to one. In its recommendations for Medicare ACO development, MedPAC calls for attribution of patients to ACOs based on the primary care physician who provides the plurality of a patient's office visits.^{vi} Patient acceptance of the ACO model, however, may be very important, particularly if ACOs are to avoid the public backlash associated with the HMOs of the 1990s, namely restricted provider networks and perceptions of financially-based stinting of care.

What are the main criticisms of ACOs?

One of the most common criticisms of ACOs is that they are simply a return to the capitation model of the 1990s that some consider "a colossal and expensive failure."^{vii} Minnesota's experience in trying to create Integrated Service Networks (ISNs) in the mid-1990s bears some resemblance to current ACO efforts. From a practical perspective, sound risk adjustment mechanisms, used to adjust for differences in the relative medical risk of ACO enrollees, will be essential to protect ACOs and to prevent ACOs from cherry-picking only healthy patients. Despite real advances in risk adjustment methodologies, they "were developed for research or quality reporting purposes" not for rate setting.^{viii} There are also questions as to whether current quality metrics are sufficient to monitor ACO performance and to ensure that financial pressures do not result in the withholding of appropriate care. How ACOs could be formed in rural or sparsely populated areas is another significant question, as is management of care obtained by patients outside of the ACO. Furthermore, some have questioned whether interest in ACO development will simply result in more large, integrated provider practices that will use their

significant market power to leverage payments that could blunt any potential cost savings.^{ix} Finally, some of the expected functions of ACOs blur the lines between care delivery and insurance functions. The distinction between insurance risk and performance risk is important, not only to ensure adequate payment rates, but also to determine the application of solvency and other insurance regulations to ACOs.

How does the Affordable Care Act (federal health reform) address ACOs?

The Patient Protection and Affordable Care Act (ACA) directs the Centers for Medicare and Medicaid Services (CMS) to establish a variety of demonstration projects to test and evaluate new Medicare delivery and payment models, including medical homes, bundled payments, and accountable care organizations.

By January 2012, CMS is required to develop an ACO demonstration project with the goal of promoting population accountability, coordinating items and services under Medicare Parts A (hospital services) and B (physician services), and encouraging investment in infrastructure and redesigned care processes. Participation in the ACO project is voluntary by providers, but to be eligible an ACO must assume accountability for the quality, cost, and overall care of fee-for-service beneficiaries assigned to it; agree to participate for three years (and not otherwise participate in any other Medicare or Medicaid shared-savings demonstrations); have a legal structure that allows receipt and distribution of payments to providers and suppliers; have a sufficient number of primary care providers to care for the no-less-than 5,000 Medicare beneficiaries assigned to it; have a clinical and administrative leadership and management structure; and have defined processes to provide evidence-based medicine, report on quality and cost measures, and coordinate care.

The law gives CMS discretion in terms of how payment to ACOs could be structured and could include partial capitation, which may be limited to highly integrated provider systems and those capable of bearing risk, or shared savings, in which case fee-for-service payments would continue but the ACO would share a portion of any savings achieved in excess of a defined spending benchmark.

The ACA also authorized the creation of ACOs for the Medicaid population. In particular, the law calls for the creation of a Pediatric ACO Demonstration Project whereby pediatric Medicaid providers could be designated as ACOs and receive incentive payments

similar to those intended under the Medicare demonstration. In addition, the law establishes a Medicaid Global Payment System Demonstration Project under which safety net hospital systems would be paid using a global payment system.

What's happening in Minnesota?

Medicaid

The 2010 Legislature adopted language calling on the Minnesota Department of Human Services to “develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed upon total cost of care or risk-gain sharing payment arrangement.”^x The demonstration project is intended for Medical Assistance and MinnesotaCare enrollees and is expected to begin July 1, 2011. Specific implementation details, such as about the quality and cost metrics and method of payment, have yet to be determined.

Private Payers

There are some emerging ACO-type models developing in Minnesota, particularly among some providers and commercial insurers. For example, Fairview Health Services and Medica announced a new partnership in July 2009 whereby Fairview could earn “performance-based payments tied to improvements in clinical quality and to managing the

total cost of patient care.”^{xi} Similarly, the Northwest Metro Alliance, a collaboration between Mercy Hospital, Allina Medical Clinic, HealthPartners Medical Group, and HealthPartners Health Plan, has established a shared savings model for care focused on the triple aim of improving population health, improving patient experience, and reducing spending.^{xii}

Other

Minnesota's health care home model has many features that may be essential to the success of any ACO, namely care coordination, disease management, and enhanced communication. Given the time and processes associated with building the model across Minnesota suggests that further delivery and payment reforms will take time and patience.

What's Next?

The future of ACOs in Minnesota is somewhat unclear, although interest in the topic appears quite high. It is not known if such interest will translate into further actions at this time or if further signals from Medicare and/or Medicaid are needed first. Minnesota policy makers remain interested in achieving greater predictability and control of state health spending and ACOs have attracted their attention. The formidable and real implementation questions associated with ACOs, however, suggest that a tempered and thoughtful approach is needed to avoid unintended consequences and to avoid mistakes of the past.

ⁱ Fisher, Elliott, Douglas Staiger, Julie Bynum, and Daniel Gottlieb. "Creating Accountable Care Organizations: The Extended Hospital Medical Staff." *Health Affairs* 26, no. 1 (2007): w44-w57.

ⁱⁱ Devers, Kelly, and Robert Berenson. "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" The Urban Institute | Research of Record. <http://www.urban.org/url.cfm?ID=411975> (accessed March 15, 2010).

ⁱⁱⁱ See, for example: IOM, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001); E.A. Coleman and R.A. Berenson, "Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care," *Annals of Internal Medicine* 141, no. 7 (2004): 533–536; and E.A. Coleman et al., "Posthospital Medication Discrepancies: Prevalence and Contributing Factors," *Archives of Internal Medicine* 165, no. 16 (2005): 1842–1847.

^{iv} Chapter 2: "Accountable Care Organizations." *Report to the Congress: Improving Incentives in the Medicare Program*. Washington DC: Medicare Payment Advisory Commission, 2009. 39-58.

^v Fisher, Elliott, Mark McClellan, John Bertko, Steven Lieberman, Julie Lee, Julie Lewis, and Jonathan Skinner. "Fostering Accountable Health Care: Moving Forward in Medicare." *Health Affairs Web Exclusive*, January 27, 2009: w219-w231.

^{vi} Ibid.

^{vii} Jeff Goldsmith, Ph.D. "The Accountable Care Organization: Not Ready for Prime Time." *Health Affairs Blog*, August 17, 2009.

^{viii} Harold D. Miller. "Creating Accountable Care Organizations in Massachusetts." *Massachusetts Hospital Association*, November 2009 (citing Society of Actuaries. *A Comparative Analysis of Claims-Based Tools for Health Risk Assessment*. 2009).

^{ix} Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper. "Unchecked Provider Clout In California Foreshadows Challenges To Health Reform." *Health Affairs* 29(4), April 2010; 699-705.

^x MN Session Laws 2010, 1st Special Session, Article 16, Sect. 19, M.S. § 256B.0755.

^{xi} "Fairview and Medica sign contract that addresses health care cost, quality." Press release, July 24, 2009 (accessed at http://www.fairview.org/About_Fairview/Newsroom/c_659762.asp).

^{xii} "Evolving to Value Payment." Meg Hasbrouck, VP of Payer Relations and Contracting, Allina Health System. Presentation to September 8, 2010 Health Care Access Commission Payment Reform Work Group.