

# Accountable Care Organizations

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## INTRODUCTION

Accountable care organizations (ACOs) consist of a range of health care service providers under a single umbrella organization. This may involve a variety of configurations, but all ACOs should have a strong base in primary care. Payers, such as Medicaid and Medicare, pay the ACO to be accountable for the health, and for containing the cost of health care, for a defined population of patients. ACOs are willing to assume this task because they are rewarded for cost savings achieved through better coordinated care. By working together, providers within an ACO can manage a patient's chronic conditions effectively and efficiently. This "whole system" coordination may save the system money, promotes accountability among all providers and improves the patient's experience. The hope is that ACOs will lead to a more rational use of services and improved health for patients.

ACOs accomplish this through payment reforms that reward providers who implement delivery system changes that reduce fragmented care. An ACO may contain costs by paying for "better" health care—that is, more primary care and chronic disease management, fewer redundant and expensive tests, and fewer preventable hospital readmissions. The current fragmented system, on the other hand, tends to reward volume and discourage collaboration among providers.

Section 3022 of the Affordable Care Act requires the federal Department of Health and Human Services to establish the Medicare Shared Savings Program, which encourages development of ACOs among Medicare providers.<sup>1</sup> The Congressional Budget Office estimated that potential savings to Medicare from use of ACOs could amount to \$5.3 billion between 2010 and 2019, although net savings would not begin to be realized until 2013.<sup>2</sup> Medicare, however, is not the only payer considering ACOs for possible cost containment—both the private market and Medicaid programs are investigating ACOs. In some states—including Colorado, Massachusetts, Minnesota, North Carolina, Oregon, Vermont and Washington—Medicaid ACOs already are being developed.

Legislatures play two important roles—lawmakers and health care purchasers—in establishing ACOs. These two roles require legislators to examine the effects of the ACO model to determine its potential savings to the health care system, its possible effect on markets, its applicability to rural areas and the overall effect on patient care. This brief addresses the basic questions about what ACOs are, how they may contain costs, why providers would (or would not) participate, the market concerns surrounding ACOs, research results about their effectiveness and additional policy considerations for states. This brief also highlights some lessons learned from the Medicare Shared Savings Program to date.



## WHAT IS AN ACO?

### *ACO 101*

While the term ACO is used often, there is no single definition and many forms of the ACO model exist. According to most definitions, however, certain prerequisites include the following.<sup>3</sup>

- Payment reform that promotes value and shares the savings with all participating providers.
- The ability to collect and analyze both quality and cost data in “real” time.
- Performance measurements that allow for accountability in quality and cost for a defined population.
- Mechanisms to implement delivery system changes.

Policymakers can think of an ACO as a “medical neighborhood,” where all providers—from the primary care doctor, to the specialist, to the hospital—have a stake in improving the health of patients and containing costs. Since ACOs are accountable for the health of a population, they must offer patients all necessary health services under the ACO umbrella. As both payer and lawmaker, legislatures may be responsible or delegate responsibility for establishing what may be defined as necessary health services. Once that is defined, legislatures may want to create regulations or other mechanisms to ensure that ACOs do not limit consumer access to these services.

### HOW ACOs CONTAIN COSTS

The ACO promise to contain costs for the state rests in the ACO assuming the risk for the

patients served—however, this will prove successful over the long-term for states only if the ACO is able to manage that risk and to share in savings. ACOs contain costs by creating incentives for their providers that ensure patients obtain the proper level of care, at the right time and in the right setting. To achieve this, payments to providers must be tied to specific quality measures (value-based purchasing), and system-wide risks and rewards must be shared (shared-saving programs) with and among providers.

### *VALUE-BASED PURCHASING*

Value-based purchasing, a concept that links payments directly to the quality of care provided, is a strategy that rewards providers for delivering high-quality, efficient clinical care, rather than simply paying for the number of procedures. This is widely seen as the first step to aligning incentives within an ACO. In theory, value-based purchasing brings together information about the quality of health care, such as patient health status, with data on health care spending.

Using these data, payers can focus on reducing inappropriate care and waste by identifying and rewarding the best-performing providers. This differs from “gate-keeping,” or efforts to negotiate price discounts, which reduce costs but do not focus on patient care and health status. According to the Agency for Healthcare Research and Quality (AHRQ), the key elements of value-based purchasing include:<sup>4</sup>

- Contracts that delineate the responsibilities of both the payer and the providers;
- Information to support management of purchasing activities;

- Quality management to foster continuous improvements in health care, purchasing and delivery of health care services; and
- Incentives to encourage and reward desired practices by providers and consumers.

Under the ACO model, value-based purchasing goes a step further with shared savings and, in some cases, shared risks with providers.

### *SHARED RISKS AND REWARDS*

Shared-saving programs allow providers to keep a portion of the money that is “saved” due to more efficient and effective care, so long as they meet quality standards. In some cases, providers also can be assessed a fee for cost overrides or failure to meet quality measures. According to the Dartmouth Institute for Health Policy and Clinical Practice and the Engelberg Center for Health Care Reform at the Brookings Institution, shared-savings payment models, implemented as part of an ACO, will benefit patients, payers and providers.<sup>5</sup>

Shared savings models have some possible shortcomings, however; costs must go down for an ACO to receive any increase in payment, despite the fact that an ACO cannot control all costs, such as inflation. The model may require providers to make an up-front investment in their practice—such as hiring case managers and improving health information technology capabilities. Some critics suggest that these care-changing investments may be made years before the practice can share in the savings and realize a return on its investment. Others are concerned the model itself may not be sustainable. Once costs are reduced, there is less to be “saved,” since shared savings payments may

disappear, while the costs of reaching quality benchmarks will remain.

## **INCENTIVES FOR PROVIDERS TO PARTICIPATE IN AN ACO**

Maintaining market-share and possible cost savings are significant motivating factors for an organization to become an ACO, as are improving the quality of care for and health of their patients. Provider groups and others, however, have voiced concern about the economics and complexity of ACOs. Some are concerned that, if not regulated correctly, ACOs may create too much financial risk for provider groups and, at the same time, may not adequately consider patients’ varying needs for care. For example, if a provider caseload includes many poor elderly patients with multiple chronic conditions their possible costs savings and quality markers may be different than a provider serving relatively healthy moms and kids.

## **ACO MARKET CONCERNS**

ACOs are founded on the premise that the best way to reduce costs and improve quality is to encourage greater collaboration among health care providers. Such a model, however, could potentially result in greater consolidation and coordination in the health care sector. This consolidation can run afoul of anti-trust laws, complicating states’ efforts to support the establishment of ACOs. Another concern is that a few highly integrated systems could capture a large share of the market, increasing their bargaining power and reducing the potential for savings.

The Department of Justice (DOJ) and the Federal Trade Commission (FTC) developed rules to address concerns that ACOs would improperly collude or exercise market power. In conjunction with release of the final rules for the Shared Savings Program, the two agencies have issued a joint Proposed Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program or Antitrust Policy Statement. Under the proposed antitrust policy statement, the agencies propose to establish various levels of antitrust scrutiny, depending upon the specific ACO arrangement.

## RESULTS OF EVIDENCE-BASED RESEARCH

Very few peer-reviewed evaluations of ACOs are available, and those that do exist have mixed results. This is particularly true of Medicaid-based ACOs because the few currently in operation have not had sufficient time to generate data. According to the 2010 NCSL report, *Containing Health Costs and Improving Efficiency: An Analysis of State Options: Accountable Care Organizations*, several studies have found that more fully integrated ACOs provide higher-quality, more efficient care than smaller, more loosely organized ones.

## ADDITIONAL POLICY CONSIDERATIONS

### ACO 201

Legislatures that are examining ACOs as both payers—for Medicaid and state employees—and as lawmakers, will consider many other issues as described in this brief. The following

additional considerations also may surface in the ACO discussion.

- What governance structure is needed for an ACO that serves Medicaid patients?
- What changes need to be made in current legislation to support development of ACOs?
- How can the state ensure that integration of services provided in an ACO is clinical and not only administrative?
- Should states require ACOs to maintain minimum payment thresholds or cost-based reimbursements for safety-net providers?
- Should safety-net providers be eligible for “up-front” payments to help them offset the cost of improving their delivery systems?
- What is the appropriate definition of “access to necessary services” that an ACO must maintain to participate in shared-savings programs? Are these services the same in all regions of the state?
- Should there be a minimum number of patients within each ACO, referred to as a minimum threshold, to ensure market stability?
- What special considerations might be made for rural hospitals, rural health clinics, or Federally Qualified Health Centers?
- When do ACOs become risk-bearing organizations that need to be regulated?

## MEDICARE SHARED SAVINGS PROGRAM

In October 2011, the Centers for Medicare and Medicaid Services (CMS) finalized the rule on Section 3022 of the Affordable Care Act. This rule contains provisions relating to Medicare payments to providers of services and suppliers participating in Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program. The final rule:

- Defines an ACO as a group of providers and suppliers of services that work together to coordinate care.
- Requires each ACO to establish a governing body that includes providers and patients.
- Establishes quality performance measures and defines a process to link quality to financial benchmarks.
- Sets a minimum threshold or “size” standard of 5,000 beneficiaries.
- Requires providers to notify beneficiaries that they are participating in an ACO. Beneficiaries also must be notified that their claims data are shared within the ACO.
- Outlines procedures for compliance monitoring and termination of ACO status in the case of non-compliance.

## WHAT STATES CAN LEARN FROM MEDICARE SHARED SAVINGS

Below are some changes CMS made to the proposed shared-savings rules in response to public feedback that may be of interest to state policymakers who support creation of ACOs.

- Quality performance measures should be streamlined and simple. CMS reduced the number of quality measures upon which ACOs would need to report from 65 to 33. If an ACO falls below this quality standard, it is placed on a corrective action plan.
- Take action to reduce administrative burden when possible. To reduce burden on ACOs, CMS allowed ACO providers to use existing information technology tools. To relieve the burden for small and rural ACOs, CMS requires only that clinical management and oversight be managed by a senior-level medical director who is one of the ACO physicians; it does not require additional qualifications for the medical director.
- Policymakers may want to include innovative ways to address the up-front investment requirement for providers.
- CMS intends to coordinate closely with antitrust agencies throughout the application process and operation of the Shared Savings Program to ensure that program implementation does not adversely affect competition.

**Sources:** U.S. Department of Health and Human Services, *Shared Savings Program*, Centers on Medicare and Medicaid (May 2012). <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/index.html?redirect=/sharesavingsprogram/>; Final Rule Fact Sheet (Simplified Explanations): [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO\\_Summary\\_Factsheet\\_ICN907404.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf); Table Summary of changes from Proposed to Final: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/Downloads/Appendix-ACO-Table.pdf>; <http://healthaffairs.org/blog/2011/03/31/accountable-care-organizations-a-framework-for-evaluating-proposed-rules/>.

## NOTES

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