

Accountable Care Organizations

Cost Containment Strategy and Logic

An accountable care organization (ACO) is a local, provider-led entity comprised of a wide range of collaborating providers. ACOs monitor care across multiple or all care settings (e.g., physician practices, clinics and hospitals) and are accountable to health care payers (e.g., Medicaid, Medicare or private insurers) for the overall cost and quality of care for a defined population. They provide an overarching structure for coupling health care delivery system reforms (e.g., medical homes and electronic medical records) and new forms of provider payment (e.g., global and episode-of-care payments) (Figure 1). The ACO concept envisions direct contracting by payers with provider organizations without reliance on a health plan intermediary such as a managed care plan.

In and of themselves, ACOs are not a cost containment strategy. Rather, they are a vehicle for implementing comprehensive payment reform and health care system redesign in order to control the growth in health care costs and obtain better value for each health care dollar.

The following example illustrates how an ACO might work to control health care costs, developed by health policy expert, Steven Shortell. Health care providers sign an agreement to participate with the ACO. Spending targets are set based on past years' data. If total spending comes in under target, providers share the savings. Savings

come from better chronic care management, compliance with preventive care guidelines and better care coordination among ACO providers.

ACOs are a relatively new, largely untested concept. As a result, the exact definition of what constitutes an accountable care organization varies. Common elements and variations in an ACO definition are described below.

Accountable care organizations, a relatively new concept, have not been fully tested. Existing evidence indicates that fully integrated ACOs can provide higher-quality, more efficient care than smaller, more loosely organized ones.

■ According to the Medicare Payment Advisory Commission, "The defining characteristic of ACOs is that a set of physicians and hospitals accept joint responsibility for the quality and cost of care received by the ACO's panel of patients."¹

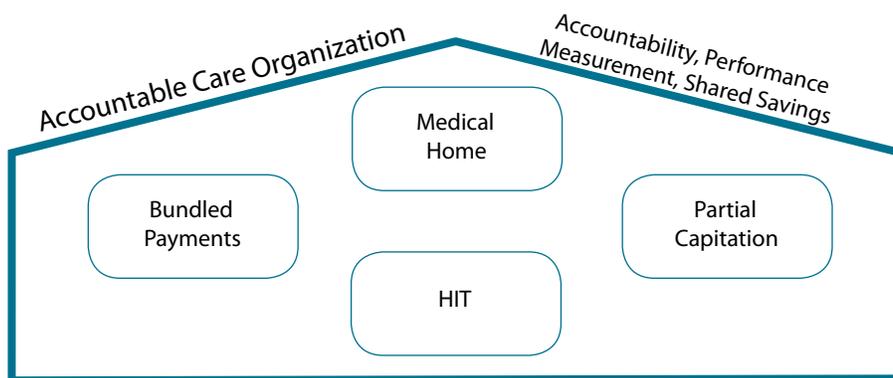
■ ACOs serve a patient population (e.g., Medicaid recipients or health plan enrollees) in a defined medical service area. A medical service area (sometimes called a hospital referral area) includes most or all the health care services needed by patients living in the area. The ACO concept may allow for only one or for several competing ACOs in a medical service area.

■ ACOs receive financial incentives to contain costs and improve quality through the collaborative efforts of the providers in their networks. Incentives are based, in part, on the extent to which providers in the ACO meet or fail to meet efficiency and quality goals. Goals are set by, or negotiated with, payers.

■ ACOs provide support services to providers to help them achieve quality and efficiency goals. Support services include care coordination, health information technology support, performance feedback and assistance with practice redesign.

■ ACOs can include a wide continuum of providers and services in their networks, but usually include at least physicians, specialists and one or more hospitals.

Figure 1. The ACO is the overarching structure within which other reforms can thrive



Source: John Bertko, "Delivery System Reform: Developing Accountable Care Organizations," PowerPoint presentation to the State Quality Improvement Institute meeting, Denver: May 27, 2009; www.academyhealth.org/files/SQII/Bertko.pdf.

■ The ACO itself can be an independent nonprofit organization formed specifically to serve as an ACO, an independent practice association, a multi-specialty group, a hospital-medical staff organization or a physician-hospital organization. It also could be a fully integrated health care system that provides the full range of health care services and employs most or all the physicians in the system. Examples include the Cleveland Clinic in Ohio, the Mayo Clinic based in Rochester, Minn., and Denver Health in Colorado.

■ Under some models, ACOs receive a per-member, per-month fee for overseeing and supporting the care delivered by network providers. In this case, providers often are paid a fee for each service minus an amount withheld that is paid out based on attainment of benchmark goals. Under other models, the ACO may receive a global per-member, per-month payment that it distributes to participating providers to yield the most efficient care overall. Funds are distributed based in part on the costs incurred by each provider and in part on the success of the entire organization in meeting quality and cost goals. In either case, providers in the ACO share some financial risk for meeting or exceeding performance goals across all providers and patients and may earn less if benchmark goals are not met.

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Target of Cost Containment

The primary target of ACOs is lack of accountability for the overall cost and quality of care. ACOs are designed to address fragmentation of care, current financial incentives that encourage clinically unwarranted higher volumes of care and intensity of services, unnecessary growth (e.g., more hospital beds and diagnostic equipment than needed), lack of care coordination, use of higher-cost providers where lower-cost ones (e.g., nurse practitioners) would be as effective, and insufficient attention to ensuring that patients receive timely primary and preventive care. ACOs address these problems by organizing, supporting and paying providers so they have financial incentives and a mutual interest in holding down costs and improving care quality across all providers, for all patients.

The Congressional Budget Office has estimated that potential savings to Medicare from promoting ACOs could amount to \$5.3 billion between 2010 and 2019, although net savings would not begin to be realized until 2013.² The savings would be realized as providers reduce the volume and intensity of services delivered to their patients.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, authorizes Medicaid and Medicare ACO pilot programs. The Medicaid program allows pediatric medical providers organized as ACOs to share in cost savings, effective Jan. 1, 2012, through Dec. 31, 2016 (section 2706). The Medicare pilot program authorizes Medicare providers organized as qualifying ACOs that voluntarily meet quality goals to share the cost savings they achieve with the program, beginning Jan. 1, 2012 (section 3022).

State Examples

■ Vermont enacted legislation in 2009 that included ACO provisions.³ The state's Commission on Health Reform is to convene a work group to support an application by at least one Vermont provider network to participate in a national ACO state learning collaborative. The intent is to implement at least one ACO project in Vermont by July 1, 2010. The legislation addresses possible federal anti-trust issues that may arise when providers join to deal with cost and shared savings issues. The law states the General Assembly's intent to ensure sufficient state involvement in design and implementation of ACOs to comply with federal anti-trust provisions "by replacing competition between payers and others with state regulation and supervision." The law envisions that the state's Medicaid program, Children's Health Insurance Program (CHIP) and Health Access Program could contract with the ACO and recapture a portion of anticipated savings from the state participation.

■ Oregon passed the Healthy Oregon Act in 2007,⁴ which established the Oregon Health Fund Program and directed it to develop a comprehensive health reform plan. The law also established a set of committees to develop recommendations on specific aspects of the plan. The Delivery Systems Committee has developed recommendations concerning accountable care districts. Recommendations call for the state to define accountable care districts "that will allow for meaningful comparisons of quality, utilization and costs between districts" and test new payment models in the accountable districts.

■ A 2008 Massachusetts law required creation of a Special Commission on the Health Care Payment System.⁵ A July 2009 commission report recommended that the state make the transition from the current fee-for-service payment system to global payments⁶ over a period of five years. It also recommended creating an entity to guide implementation of the new payment system. Among other things, the entity would be responsible for defining and establishing risk parameters for ACOs, which will receive and distribute global payments. ACOs will assume risk for clinical and cost performance.

■ Programs in at least two states—Colorado and North Carolina—use networks of providers that, while not true ACOs, have the potential to develop. The programs in both states focus on primary care for Medicaid enrollees and rely on provider-led local networks that are responsible for improving care, quality and efficiency for the patients served by the networks.

• Community Care of North Carolina consists of 14 independent, nonprofit, care-coordination networks.⁷ The regionally organized networks consist of participating physicians that receive per-member, per-month fees for serving as a medical home for Medicaid patients. The networks receive a \$2.50 per-member, per-month fee to coordinate patient care and help primary care providers improve care using local nurses and other case managers.

- The Colorado Accountable Care Collaborative, set to launch in 2010, is designed to be a “primary care-based health care reform for full body, mind and mouth.”⁸ Regional Care Coordination Organizations (RCCOs) will develop and organize the provider network in their regions. They will provide technical assistance on such things as medical home practice redesign and implementation of new health information technologies. They also will help coordinate care and care transitions between health care settings and be accountable for specific population health measures within each region. Each RCCO will be paid a per-member, per-month case management fee. Primary care medical providers that meet medical home standards also will be paid a per-member, per month fee. A portion of total funding will be withheld from the RCCOs and the primary care medical providers to support a potential incentive payment.⁹

- Several states regulate ACO-like entities called provider-sponsored organizations, which accept risk for ensuring that a population of patients receives necessary care. A 1997 study examined how nine states regulate provider-sponsored organizations.¹⁰ It found that some states require HMO licensure if the organization, rather than an insurance plan, is the ultimate bearer of risk or assumes risk beyond that which its providers are licensed to offer themselves (e.g., California, Illinois and Pennsylvania), especially where the organizations receive capitated or global payments. Others require a special license or certificate (e.g., a limited service license in Colorado, a non-profit health corporation license in Texas, and a community integrated service network license in Minnesota).

Non-State Examples

- Patient Choice is a program for self-funded employers in Minnesota, North Dakota and South Dakota. Created by the Buyers Health Care Action Group in 1997, it is operated today by Medica, a large HMO. The Patient Choice Care System Program works with groups of providers (including both hospitals and physicians) called care systems that function like ACOs. Care systems submit bids based on their expected total cost of care for a defined population of patients who have the same benefits. Reimbursement rates are driven by performance on quality measures and the total cost of care, or what has been called “virtual capitation” or “capitation in drag.”¹¹

- In the Physician Group Practice (PGP) Demonstration, a Medicare pilot program started in 2005, 10 large, multi-specialty physician groups receive a share of the savings they achieve in caring for Medicare patients and meeting documented quality improvement targets. Physician groups that are able to meet quality benchmarks and reduce their total expected Medicare spending by more than 2 percent can share in the savings they generate for Medicare. Although the demonstration does not meet all the criteria of a true ACO—for instance, there is no penalty for failure to meet efficiency and quality benchmarks—Medicare plans to expand the PGP model to more closely resemble an ACO pilot program.

- Health systems in five states will be part of an ACO pilot program sponsored by two health policy groups, the Engelberg Center for Health Care Reform at the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. The systems, in Arizona, Iowa, Kentucky, Vermont and Virginia, are scheduled to begin in 2010.

Evidence of Effectiveness

Because it is a relatively new concept that has not been fully tested, there is insufficient evidence to determine the effectiveness of true ACOs in containing costs. According to a recent report to Congress on Medicare, “...any projections of savings from the formation of ACOs are subject to a high degree of uncertainty.”¹² What evidence exists is mixed.

- Evaluations of the early results of several Medicare ACO-like pilot programs have led researchers to different conclusions. Some have reported that the Medicare Physician Group Practice Demonstration described previously has resulted in lower costs and improved quality.¹³ They note that four of 10 demonstration sites had low enough growth in their risk-adjusted costs to qualify for bonuses. In contrast, the Medicare Payment Commission reports that, “It is questionable whether the PGP demonstration has saved money.”¹⁴ The commission notes that, after two years, five of the PGP sites had absolute (non risk-adjusted) cost growth that was materially higher than their comparison groups, four had roughly equal cost growth and only one had lower cost growth.

- During the 1990s, a number of provider-sponsored organizations assumed responsibility from managed care plans for coordinating the care and managing the costs of care for groups of patients. Examples of such organizations included independent practice associations and physician-hospital organizations. Although these arrangements do not exactly match the ACO definition, they bear many similarities. A 2001 study of 64 risk-bearing, provider-sponsored organizations found that some experienced serious financial problems, some were dealing with tension between themselves and hospital partners due to concern about payment adequacy and fairness, and some were simply unable to manage costs.¹⁵ Proponents of ACOs note that many of these problems are being addressed in current models. ACOs receive payments that are risk-adjusted, and they are better equipped to track quality-of-care and costs. They have better data support, their risk assumption is limited to that they directly control, and quality and efficiency incentives are more fine-tuned.

- Experience with the Minnesota Patient Choice system indicates that the program “...has encouraged patients to select more cost-effective providers and has spurred providers to reduce their costs while maintaining or improving quality to attract more consumers.”¹⁶ Although the competing, ACO-like care systems that participate in Patient Choice are not the only factor that accounts for these findings, they appear to contribute significantly.

■ Several studies have found that more fully integrated ACOs provide higher-quality, more efficient care than smaller, more loosely organized ones.¹⁷

Challenges

A number of challenges exist to successful implementation of ACOs. Formation of ACOs may raise anti-trust issues when an ACO dominates the market. The ACO and participating providers must resolve organizational and professional liability arrangements. ACOs must have systems in place to capture, analyze and share clinical information with providers across care settings and to track costs. Payers and ACOs will need to agree on how patients will be assigned to a particular ACO and what happens when patients use a non-ACO provider—is the ACO still accountable for the total costs of that patient's care? Experience suggests it takes many years to establish a successful ACO, particularly where formal arrangements among providers do not already exist. Finally, states will want to decide whether and how to regulate ACOs—at what point do ACOs accept so much risk that they should be regulated as insurers?

Complementary Strategies

ACOs provide an organizational framework for implementing, coordinating and enhancing payment and delivery system reforms. Examples of such reforms include medical homes, episode-of-care and global payments, partial capitation, care coordination, chronic disease management and broad-scale health information technology projects. These are discussed in separate papers in this NCSL cost containment series.

For More Information

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Notes

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2. Randall Brown, *Strategies for Reining in Medicare Spending through Delivery System Reforms: Assessing the Evidence and Opportunities* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, September 2009); <http://www.kff.org/medicare/upload/7984.pdf>.
3. Vt. 2009 Vt. Acts, Act 49.
4. Ore. 2007 Or. Laws, Chap. 697.
5. Mass. 2008 Mass. Acts, Chap. 305.
6. A global payment is a fixed prepayment made to a group of providers or health care system (as opposed to a health care plan) covering most or all the care a patient may need during a specified time period. Global payments usually are made monthly over a year and are paid on a per-patient basis, unlike fee-for service which pays separately for each service. For more information, see the brief in this series on global payments.
7. Community Care of North Carolina website, www.communitycarenc.com.
8. Colorado Department of Health Care Policy and Financing, Accountable Care Collaborative website, <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246?rendermode=preview>. Click on "Questions and Answers about the Accountable Care Collaborative."
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About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

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