

Accountable Care Organizations: The Case Is (Relatively) Strong but the Jury Is Out

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THREE THINGS ARE CLEAR: 1) THE FEDERAL GOVERNMENT wants to simultaneously increase healthcare coverage, limit cost increases, and improve quality; 2) greater integration among physicians and between physicians and hospitals is in everyone's future; and 3) accountable care organizations show promise, but widespread adoption will encounter a number of obstacles.

ACO Background

Circa 2003, the Council of Accountable Physician Practices, consisting of 34 of the nation's largest multi-specialty group practices (e.g., Permanente, Mayo, and Geisinger) was formed. Because most either owned or were closely affiliated with a hospital(s), they were referred to as integrated delivery networks (IDNs), and analyses indicated they generally outperformed other providers. It seemed logical to replicate IDNs in other settings but most of the nation's hospitals and physicians were anything but integrated. Researchers, however, discovered that 70 percent of patient care occurs in a "local, natural referral network." In other words, a virtual IDN existed—what is now called an accountable care organization (an entity clinically and fiscally accountable for the entire continuum of care for a given population of patients).

CMS seized on this research and Section 3022 of the PPACA specified that aspiring ACOs must:

- Have a legal structure for receiving and distributing shared savings.
- Have appropriate clinical and administrative systems in place.
- Commit to at least a three-year participation agreement.
- Accept assignment of $\geq 5,000$ Medicare beneficiaries.
- Have sufficient primary care physicians to cover the beneficiaries.
- Demonstrate establishment of quality and care coordination processes.
- Have patient-centered processes that meet specified criteria.
- Demonstrate an ability to meet specified reporting requirements.

ACOs will be rewarded financially for meeting certain cost and quality goals through one of three payment options:

1. **Shared savings:** providers who perform well against projected targets will have an opportunity to share in the savings (no downside risk to providers).
2. **Symmetric:** providers have a greater shared savings upside in return for accepting downside risk.
3. **Partial capitation:** providers have an even greater financial upside potential in return for accepting greater risk; primarily in the form of primary care capitation.

There are four models providers can utilize to structure their ACO. Two include hospitals as partners with physicians: IDN and physician-hospital organization; two do not: multi-specialty group and independent practice association. The argument for inclusion of a hospital is based on the availability of capital, management, and information technology.

Obstacles Boards Should Consider

There are at least four major, external impediments that healthcare leaders should keep an eye on.

Evolving legislation: the PPACA makes it clear that healthcare reform in general and ACOs in particular are in an embryonic stage. Additional ACO regulations are expected in the fall of 2010 and other key initiatives will be clarified over the next four to five years.

Population: the legislation requires an ACO to have a minimum of 5,000 Medicare beneficiaries. Acceptance of a shared-savings contract for such a small population may be relatively risk-free; taking on the risk associated with capitation may be ill advised.

Legal considerations: it has been estimated that it takes more than 10 years for federal law to catch up with the realities of market evolution. Whether or not that is true, there are a number of potential legal constraints to ACO formulation: antitrust considerations; fraud and abuse; tax-exemption issues; and state laws concerned with licensing, corporate practice of medicine, credentialing, malpractice, and insurance regulation.

Electronic medical record: for two decades, the promise of connectivity and interoperability among diverse providers has remained elusive. Even hospitals as independent entities have a long way to go.

Internally, there are a number of questions directors, executives, and physician leaders should address together:

1. **Core business:** 75 percent of healthcare costs are related to chronic illness; does your core business focus need to change?
2. **Culture:** providers are accustomed to focusing on transactional activities that emphasize independent, event-based decision making. Successful ACOs will transition to relational approaches where care is coordinated across a continuum. How will you move from a siloed to a team approach?
3. **Physician engagement:** physicians are under enormous financial and regulatory pressure that can strain relationships with hospitals. What processes will you use to engage physicians in an effort to move forward together?
4. **Outcomes:** there will be a demand for providers to demonstrate the ability to provide safe, quality care in a cost-effective manner. Where does your hospital stand today and what steps are you taking to continuously improve?
5. **Finance:** is the upside potential of shared savings worth the effort? Are your hospital and medical staff ready to take on the greater risk associated with symmetric payment and/or partial capitation?



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