

Accountable Care Organizations

What are they?

Proposed in 2006ⁱ, ACOs are integrated networks of local providers across the care continuum, including hospitals, physicians and affiliated providers that are paid based on their ability to provide quality care and restrain costs. ACOs share in the savings they generate as a network by coordinating care, reducing overuse or misuse of care, eliminating wasteful duplication of services, and providing wellness programs and patient support. ACOs shift the emphasis from payment for utilization to payment for health outcomes.ⁱⁱ The core of the ACO concept is that the parts work as a coordinated entity in the shared goals of improving both the quality and efficiency of care. ACOs can be fully integrated health systems, such as the Cleveland and Mayo Clinics, or geographically diverse networks of providers connected through contractual relationships, such as Geisinger Health System in Pennsylvania.

The Geisinger system is paid a risk-based flat rate or bundled payment for a growing number of conditions. The rate covers whatever is needed for each patient's episode of care including pre-operative evaluations and work up, hospital and professional fees, routine discharge care and management of any complications arising within 90 days of surgery. Eighteen months after implementing the new pricing and quality program for coronary artery bypass grafts, average length of stay dropped from 6.2 to 5.7 days, 30-day readmissions dropped by 44%, and complications dropped by 21%.ⁱⁱⁱ Because of Geisinger's ability to lower health benefit costs for their employees, one Pennsylvania community's Board of Education was able to give teachers a \$7,000 raise.^{iv}

What are the goals? What problem are they meant to solve?

Too often health care decisions that benefit one provider or payer financially disadvantage another, encouraging decisions based on narrow economic interests rather than savings to the entire system or the needs of patients. Providers have no incentive to reduce duplicate tests and procedures or to coordinate care. ACOs are designed to align incentives across the care continuum to improve the quality and efficiency of care by sharing savings and bonuses with all providers.

How are they different from managed care plans? Hasn't this been tried before?

ACOs differ from managed care plans in several ways. Most treatment decisions are driven by providers, especially physicians, across health care systems. In ACOs, accountability and savings rest with the providers rather than an insurer. The providers who run the ACO also benefit from their investments in quality. Unlike national or statewide managed care plans, ACOs allow for flexible structures in different regions, respecting the unique assets and challenges of local health care markets.

While past efforts to align incentives across health care stakeholders have not been successful, there is optimism that ACOs may be more successful. The health care market has evolved significantly since managed care reforms of the 1990's; providers are more willing to enter into contractual alliances with other providers and institutions. Much has also been learned about how to measure and reward the quality of health care delivered. Payers are investing in effective use of information technology that will facilitate care coordination and efficiency.^v

What are the challenges?

There are several open questions that will affect the success of ACOs, especially in CT. CT physicians are more likely to practice in small groups than physicians in other states; small practices may be more difficult to integrate into ACOs. There are concerns that ACOs will be seen by providers and consumers as a new spin on HMOs and capitated care, which met with significant resistance in the 1990s leading to managed care reform legislation and opening of provider panels. It is critical that ACO payment structures include significant quality and performance incentives to counter any financial incentives to deny care to patients. And while most ACO payment structures adjust for the greater needs of more complex patients, risk adjustment methodologies are still developing. Consolidating providers into large networks raises anti-trust concerns. While ACOs should reduce costs by improving efficiency, increasing market power in negotiations with providers may outweigh those savings. Monitoring of new risk arrangements and enhanced quality monitoring places larger administrative burdens on providers and government regulators.

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May 2010

ⁱ E. Fisher, et. al., Creating Accountable Care Organizations: The Extended Hospital Medical Staff, Health Affairs 26:w44-57, January/February 2007.

ⁱⁱ Reforming Provider Payment: Moving Toward Accountability for Quality and Value, Issue Brief, Dartmouth Institute for Health Policy & Clinical Practice and Engelberg Center for Health Care Reform at Brookings, March 2009.

ⁱⁱⁱ R. Paulus, et. al., Continuous Innovation in Health Care: Implications of the Geisinger Experience, Health Affairs 27:1235-1245, September/October 2008, T. Lee, Pay for Performance, Version 2.0?, New Engl J Med 357:531- 533, Aug 9, 2007, ProvenCare By The Numbers, Geisinger Health System.

^{iv} E. Fisher, Dartmouth Medical School, Families USA conference plenary session, January 2010.

^v M Gold, Accountable Care Organizations: Will They Deliver?, Mathematica Policy Research, January 2010.