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Accountable Care: Will it Transform Health Care Delivery?

By Allan B. Goldstein, MD, MPH

What is an Accountable Care Organization?

The Patient Protection and Affordable Care Act describes an Accountable Care Organization (ACO) as a group of providers of services and suppliers "willing to become accountable for the quality, cost, and overall care of the Medicare beneficiaries assigned to it." Additional characteristics of the ACO include a formal legal structure with shared governance; appropriate leadership and management structure; processes to promote evidence-based medicine, patient engagement, and care coordination; mechanisms to report on quality, patient experience, and cost measures; and creation of an environment of patient-centeredness.[1]

Although other ACO definitions and descriptions have been formulated, the common denominator is that *provider groups* working together will be *accountable* for a *defined population* and employ *measurable outcomes* as criteria.[2] The accountable care model takes many of the disparate threads of health care reform and weaves them into an integrated fabric. From another perspective, accountable care may be viewed as a health care delivery model that optimally employs standardized processes and tools, measurement, and information-driven improvement to achieve its goals. Because a broad range of delivery systems meet these requirements, the ACO structure allows for both flexibility and diversity in delivery system design as we learn more about this model and refine it based on experience.

Key Organizational Competencies

Organizations may need a tool to help them understand what it means to be an ACO, as well as to evaluate the status of their current operational capabilities and to identify the gaps they must fill to qualify as an ACO. One such benchmarking tool, developed by Premier Inc., has established 6 key organizational competencies required to perform the functions of an ACO (Premier Accountable Care Organization Capabilities Framework Assessment Tool, unpublished data, 2011). These core competencies are shown in Figure 1.

Each component is divided into *Capabilities* and subdivided into *Operating Activities*, each of which constitutes a discrete core competency the organization must develop to become an ACO. With more than 150 operating activities (Premier Accountable Care Organization Capabilities Framework Assessment Tool, unpublished data, 2011), the task of organizational transformation to an ACO will be a prodigious undertaking.

Figure 1. The Accountable Care Organization: Conceptual Architecture

Core Components:

- People-Centered Foundation
- Health Home
- High-Value Network
- Population Health Data Management
- ACO Leadership
- Payor Partnerships

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Figure 1 provides a visual representation of the relationships among these key components as interpreted by Premier's Accountable Care Collaborative.

Regulatory Constraints

On March 31, 2011, the Centers for Medicare and Medicaid Services

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(CMS) published proposed rules for Medicare contracting with ACOs.[3] Following receipt of extensive feedback from a broad range of stakeholders regarding the regulatory constraints imposed by the proposed rules, CMS published final rules governing the implementation of the Medicare Shared Savings Program (MSSP) on November 2, 2011.[4] Four requirements in the final rules represent significant obstacles to provider entities that are considering creating ACOs to serve the Medicare population.

First, CMS acknowledged that provisions of the Physician Self-Referral Law, the Federal antikickback statute, and the civil monetary penalties law "may impede development of some of the innovative integrated-care models envisioned by the" MSSP.[5] In conjunction with the Office of the Inspector General, CMS established 5 unique waiver requirements covering a variety of arrangements that ACOs might need to undertake in order to be successful at carrying out the MSSP.[6]

The Internal Revenue Service has provided guidance for 501(c)(3) not-for-profit corporations that participate in the MSSP through an ACO, enumerating those circumstances under which the not-for-profit entity could avoid impermissible inurement or private benefit that would adversely impact its status.[7] Organizations forming ACOs also must satisfy state anticompetitive rules. Creating a legal and governance structure that conforms to all the regulatory requirements will be a challenging early step for prospective ACOs.

Second, beneficiary assignment for the MSSP will be retrospective based on the "plurality of their primary care services during the performance year."[8] CMS acknowledges the challenges this creates for the prospective ACO that must develop and implement a population management strategy for a population that is defined after the fact.

Third, in response to extensive comments and criticism of the proposed quality reporting requirements, the final rule requires ACOs to report on 33 quality measures (instead of 65) spanning 4 quality domains (patient/caregiver experience of care, care coordination/patient safety, preventive health, and at-risk populations).[8] Although this reduction in the number of reportable quality measures (and employment of nationally endorsed measures already in use) mitigates the magnitude of the data collection and reporting requirement for ACOs, 33 measures represent a significant administrative burden for most organizations. In addition, there is concern that ACOs will manage to the metrics rather than focusing on other meaningful process improvements that may not impact the metrics.

Fourth, ACO receipt of shared savings is subject to meeting quality performance targets and exceeding a minimum savings rate of 2.0%-3.9% below the applicable benchmark. The ACO will be eligible for a maximum shared savings rate of 50% (1-sided model) or 60% (2-sided model). Calculation of benchmarks and actual payments from CMS will be subject to a variety of adjustments that may make cash flow projections difficult.[9]

Organizations will be required to make substantial up-front investments to create the requisite ACO infrastructure. However, it may be several years before the ACO generates savings and it remains unclear if the savings realized will be adequate to repay the initial investment, motivate behavior change by providers, or create a sustainable business model.

Critical Challenges to Accountable Care Deployment

In many localities, the hospital is the only care delivery entity with the organizational and financial resources to develop an ACO. Hospitals have been acquiring primary care and select specialty practices at an accelerated rate over the last several years. Collaborations between hospitals and physicians have a troubled history marked by mistrust and competition for lucrative services.[10] Converting physicians to hospital/health system employees does not obviate the need to align physicians' goals with those of their new employers and to make necessary attitudinal and behavioral changes. Many physicians may fear their loss of autonomy, and resist efforts to standardize care delivery processes and measure performance against objective metrics. Overcoming such resistance will be essential to ACO success.

Establishing the infrastructure necessary to support an accountable care delivery system will require considerable capital investment. CMS has estimated the initial ACO development investment at $1.8 million, but the American Hospital Association estimates that $5.3 to $12.0 million will be needed, depending on system size and complexity.[11] These figures do not include the ongoing cost of ACO operations, which is estimated at $6.3 to $14.1 million annually. These costs will be incurred regardless of the ACO's success or its ability to earn shared savings. Despite such substantial investment, organizations have no guarantee that there will be a return on investment or that accountable care represents a sustainable, long-term business model.

Accountable care will challenge the basic tenets of today's health care system. Although providers are currently paid on a piecework basis, they can expect numerous efforts to foster alternative payment mechanisms. Long viewed as a major revenue generator for the delivery system, the hospital will become a cost center, as will all other care delivery settings. Hospitals will become the focus of intense efforts to eliminate waste and duplication with the goal of maximizing system efficiency and value.

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Transforming to an accountable delivery system will not occur at a fixed point in time. Rather, it will occur over an as yet undetermined span of time. During this transition phase, providers will be operating in a care delivery environment with a split personality. Managing through that transition will be one of the most difficult challenges for future ACOs.

Opportunities for Early Success

The Health Home represents a major innovative advance in primary care and is a foundational prerequisite for a successful ACO. Despite significant energy and resources currently dedicated to Health Home deployment, these transformed practices still represent a small fraction of the primary care delivery system. ACO deployment can facilitate and support the rapid expansion and adoption of Health Homes, resulting in higher quality, patient-centered care. Embedding case management services within the Health Home and concentrating efforts on the sickest patients will improve coordination of patient services and reduce costs.[12] In addition, coordinating care transitions can dramatically reduce hospital readmissions.

A corollary to ACO implementation is the commitment to make clinical quality improvement part of the organization's core business strategy. Reduction of unwanted variation in physicians' practices is an excellent place to begin these efforts. By selecting high-volume, high-cost treatments and focusing on care delivery processes, the organization can embed evidence-based clinical practice guidelines into the flow of clinical activities. With 20 years of experience using this model, Intermountain Healthcare estimates that it can reduce clinical costs by 6%-10% while improving clinical outcomes.[13] Once physicians are provided with relevant, actionable information and see the impact of process improvement activities, they will drive most of the changes themselves. Process improvement has been shown to reduce the frequency of adverse events and avoidable deaths in the hospital.[14]

Potential Downstream Consequences of Adopting Accountable Care

Many changes will occur in the health care landscape over the next 10 years. The adoption of ACOs is expected to accelerate the pace at which these changes take place.

In the future, US health care will be dominated by competing, vertically integrated delivery systems comprising a diverse group of provider stakeholders and, potentially, insurers. The integrated delivery system will be a risk-taking entity accountable for a defined population of patients. Customer service will be a foundational element of the delivery system and critical to its success. System performance will be measured using broadly accepted cost, quality, and patient experience metrics.

The Health Home will be the system point of entry and the center for care delivery and coordination. Disease and case management services will emanate from the Health Home. Primary care practices will be larger and linked into self-managing networks. Non-affiliated solo and small group practices will not be financially viable business options. An increasing percentage of patient encounters will be provided by e-visits, group visits, and in the home setting.

Reimbursement systems that align incentives and reward performance will predominate. Fee-for-service reimbursement will be the exception rather than the norm.

Medical schools and hospitals will recalibrate projected manpower needs (both the number and type of practitioners), training, and deployment. Inpatient facilities will have fewer beds, a higher proportion of which will provide intensive care.

Those insurance companies that have not partnered or merged with an integrated delivery system will focus on core competencies of marketing and claims processing. Some will become vendors for other services such as disease and case management or actuarial services.

Currently, accountable care is the vehicle driving these changes. However, if ACOs fail to meet the challenge, other economic, demographic, and governmental forces will step in. In any event, transformation of the American health care delivery system is inevitable.

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