Accountable Care Organizations: Providing Quality Healthcare in an Integrated System

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I. INTRODUCTION

A new era of health care has arrived with the passing of the Patient Protection and Affordable Care Act (PPACA), and one of major goals of health care reform is to furnish integrated, quality health care in a cost-effective manner.¹ The United States’ current health care structure incentivizes the provision of providing more services because doctors are paid on a fee-for-service basis.² For example, on the Medicare Physician Fee Schedule, a physician receives payment for each procedure performed.³ Medicare Part A reimburses hospitals via the Inpatient Prospective Payment System for Diagnosis Related Groups (DRG) under which a hospital receives prospectively determined, fixed payment for all hospital items and services provided to a Medicare beneficiary during his or her inpatient stay or outpatient service.⁴ This structure understandably incentivizes hospitals to control costs. Consequently, this creates a disconnect between hospitals and physicians and leads to a fragmented system, decreased quality, and unsustainable spending.⁵ Different providers who see the same patient rarely synchronize the care they provide with other physicians, which leads to repetitive and inconsistent treatments.⁶

³ Gail R. Wilensky, Reforming Medicare’s Physician Payment System, 7 NEW ENG. J. MED. 653, 654 (Feb. 12 2009).
⁴ Id. at 653.
⁵ See Catherine Arnst, The Hospital, Your Care Coordinator, U.S. NEWS & WORLD REP., JULY 2010, at 2; PREMIER, INC., supra note 1, at 1.
⁶ Merlis, supra note 2, at 1.
bend this cost curve, health care will account for almost one-fifth of the nation’s GDP by 2019.7

CMS believes that the implementation of Accountable Care Organizations (ACO) will lower the cost of health care, while maximizing the value of health services provided to patients.8 The PPACA defines an ACO as “an organization of health care providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries enrolled in the traditional fee-for-service program who are assigned to it.”9 Providers who work within an ACO will now be paid for the quality of services they provide instead of the quantity of services provided.10 Additionally, a quality-driven system incentivizes a greater degree of integration among providers by encouraging them to work together to enhance their patients’ well-being and achieve quality measurements.11

The idea of accountable care organizations originated in 2005 when CMS introduced the concept as a way to promote integration while avoiding the past problems of HMOs.12 Because healthcare providers participating in HMOs were reimbursed using a capitation payment system where providers received a fixed monthly payment for each enrollee, the focus of HMOs was on providing care without going above a “fixed financial ceiling.”13 Consequently, the concern was not that providers were incentivized to provide too many services, but that they were instead denying care in order to save money.14

In response to these problems, CMS initiated the Physician Group Practice (PGP) demonstration where physicians could qualify for bonus payments if they met certain quality standards and reduced costs.15 When health care reform discussions began in 2008, lawmakers were contemplating ways providers could offer efficient and effective care to their patients, and they then looked to the PGP demonstration and decided that ACOs should be included in the final piece of legislation based on the success of these

8. STEPHEN WOOD, INGENIX CONSULTING, CREATING AN ACCOUNTABLE CARE ORGANIZATION 1 (Apr. 2010) www.ingenixconsulting.com/content/
10. See PREMIER, INC., supra note 1, at 1.
11. Id.
12. See Merlis, supra note 2, at 2; Premier, Inc., supra note 1, at 2.
15. PREMIER, INC., supra note 1, at 2.
demonstrations.\textsuperscript{16}

This article will focus on what an ACO entails, what it looks to accomplish,\textsuperscript{17} and what health care delivery systems can now do to become a successful ACO.\textsuperscript{18}

II. WHAT IS AN ACCOUNTABLE CARE ORGANIZATION UNDER PPACA AND WHAT DOES IT SEEK TO ACCOMPLISH?

Accountable care organizations are a part of the Medicare Shared Savings Program under PPACA because of their cost-effective techniques coupled with their desire to promote quality patient outcomes.\textsuperscript{19} PPACA limits the ACO program to Medicare, but private plans will also be able to work with Medicare-eligible ACOs.\textsuperscript{20} There is still a lack of specificity in the law, and details of exactly how an ACO will operate continue to evolve.\textsuperscript{21} CMS issued proposed regulations at the end of March 2011 that outlined the key components of ACOs, and the criteria organizations must meet to become eligible under Medicare’s Shared Savings Program.\textsuperscript{22}

There are, however, certain statutory requirements that provider organizations must abide by to qualify as an ACO.\textsuperscript{23} The provider group must enter into a Provider Agreement with CMS, and in return, they are contracting to:

a) Commit to participate in the ACO program for at least three years
b) Demonstrate that they meet patient centeredness criteria, which will be determined by the Secretary of the Health and Human Services (HHS)
c) Have defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care
d) Have a formal structure to receive and distribute shared savings
e) Have a sufficient number of primary care professionals for the number of assigned beneficiaries, which will be a minimum of 5,000
f) Have a leadership and management structure that includes clinical and administrative systems
g) Provide the Secretary of HHS with requested information, which will

\textsuperscript{16} Id.
\textsuperscript{17} See infra Part II.
\textsuperscript{18} See infra Part III.
\textsuperscript{19} HEALTH L. PRAC. GUIDE § 1:2, at 5 (2nd ed. 2010).
\textsuperscript{20} Fenninger & Riker, supra note 9, at 1.
\textsuperscript{21} See id. at 2.
\textsuperscript{22} Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67 (proposed April 7, 2011).
\textsuperscript{23} See HEALTH L. PRAC. GUIDE, supra note 19, at 5.
be specifically identified by forthcoming regulations.24 Additionally, provider groups electing to form an ACO may consist of many different forms, including: (i) physicians with other professionals in group practices; (ii) physicians and other professionals in networks of practices; (iii) partnerships or joint venture arrangements between hospitals and physicians/professionals; (iv) hospitals employing physicians/professionals; and (v) other forms that the Secretary of HHS may deem appropriate.25 Since the concept is new, different people have entertained numerous ideas regarding how they see an ACO operating, and Exhibit 1 illustrates the type of delivery systems that could become models for ACOs.26

**Exhibit 1**

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<tr>
<th>Delivery Systems That Could Become Accountable Care Organizations</th>
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<td><strong>MODEL</strong></td>
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<td>Integrated Delivery Systems</td>
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<td>Virtual Physician Organizations</td>
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24. *Id.* at 5-6.
Participation in an ACO under PPACA is voluntary, but the provider groups that agree to partake in the program will be eligible to receive a share of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specific benchmark amount. The quality standards for each ACO will be based on the most recent three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The benchmarks will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary of the HHS, and restructured by the estimated absolute amount of growth in national per capita expenditures for Part A and B. Yet, ACOs will not be penalized if they fail to meet certain benchmarks. This provision is set out to encourage a greater degree of provider integration since all caregivers will aspire to work together to improve quality and efficiency in order to receive financial incentives and not fear any repercussions.

In spite of these savings, many hospitals and physicians benefit immensely from providing a high volume of services to their patients, particularly in specialty areas, and without facing any consequences, these providers may not find that a form of shared savings is enough to offset the profits that they would be losing. Additionally, it can be difficult to change a physician’s mindset, which has always focused on volume to now concentrate on quality. Many providers fear change, and without CMS issuing any

repercussions, they may find it easier to keep working without implementing these quality standards into their practice.\(^{34}\)

However, reimbursement rates are declining under the fee-for-service system, so this provision encourages providers to supply quality care in order to mitigate negative financial losses.\(^{35}\) The reduction of compensation under FFS will hopefully serve as determent to providers who still wish to issue a high volume of services for their patients without considering the quality of care they are providing.\(^{36}\)

Additionally, CMS will appoint beneficiaries to certain ACOs, but beneficiaries will not know that they are a part an ACO.\(^{37}\) In addition, this assignment will not affect their guaranteed benefits or choice of doctors.\(^ {38}\) The law does not specify how a beneficiary will be assigned to an ACO, but the CMS has implied that it may place beneficiaries in an ACO if he or she receives the majority of his or her primary care from an ACO physician.\(^{39}\) As HHS begins the rulemaking process to provide greater clarification for potential ACOs, the understanding that all conditions and specifications implemented in the future will revolve around the goal of health care providers supplying quality, integrated care in a cost-effective manner will guide the process.\(^{40}\)

III. WHAT CAN HEALTH CARE DELIVERY SYSTEMS DO NOW TO BECOME A SUCCESSFUL ACCOUNTABLE CARE ORGANIZATION?

A. Assess Your Viability

Before deciding to become an ACO, an organization must first assess whether they have the required skills needed to succeed as an accountable care organization.\(^{41}\) The organization must research what resources are necessary to become a profitable ACO, and they need to plan how they will obtain these resources.\(^{42}\) Forming an ACO takes a considerable amount of capital, both financial and human, and the organization needs to

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34. See Riegel & Tung, supra note 33, at 6.
35. Id.
36. See id.
37. Id.
38. Id.
40. See Fenninger & Riker, supra note 9, at 1.
41. Wood, supra note 8, at 1.
realize where they stand and the operational changes that will be required of them in order to improve their healthcare efficiency.43

Furthermore, in order for a health care delivery system to provide efficient and effective care as an ACO, it must strive to meet certain identified objectives, such as clinical processes and outcomes of care, patient experience, and utilization of services.44 The basis of an ACO rests on performance measurements.45 Therefore, the organization must examine problematic areas specific to their system, and subsequently, outline ways to solve these problems.46

Moreover, the organization must evaluate its relationship with its physicians.47 Physicians will be the ones ultimately driving this process.48 They are the ones in charge of the patient’s care and determine everything from what treatments the patient are receiving to when the patient will be discharged.49 Hospitals, especially, must work on improving their alignment efforts with physicians.50 Historically, the physician/hospital relationship has been fairly informal in that it has mostly existed through medical staff privileges and referral patterns.51

However, the environment of health care is pushing for a more strategic relationship,52 and in order to succeed as an ACO, hospitals must work to align their incentives with physicians.53 For this to happen, a hospital must get to know the physicians and determine what is most important to them.54 By just learning where their complaints lie can strategically alter the physician/hospital relationship.55 This shows a true commitment to an organization’s relationship with their physicians.56 Additionally, if

43. See id. at 5.
44. PREMIER, INC., supra note 1, at 2.
45. See BARD & NUGENT, supra note 31, at 1.
46. See WOOD, supra note 8, at 1.
47. LINDSEY DUNN, BECKER’S HOSPITAL REVIEW, SHOULD YOUR HOSPITAL DEVELOP OR JOIN AN ACO? 5 QUESTIONS TO ASK 1 (NOV. 9, 2010).
48. WOOD, supra note 8, at 2.
49. WOOD, supra note 8, at 2.
51. Id.
52. Id.
53. MOLLY GAMBLE, BECKER’S HOSPITAL REVIEW, 6 SECRETS FOR BETTER HOSPITAL-PHYSICIAN RELATIONSHIPS 1 (Jan. 18, 2011).
54. Id.
55. Id.
56. Id. at 2.
physicians distrust the organization, they need to get to the root of the problem. In doing so, the organization can alter their strategic plan accordingly in order to raise physician’s satisfaction levels.

B. Establishment of Specific Benchmarks

Second, health care systems looking to form an ACO must establish set performance measurements that will enable them to improve their productivity and overall results. ACOs will be rewarded for value and not volume and, because of this, it is important for a health care system to identify constant measures of success. Providers will most likely use defined quality measures given to them by the CMS, but over time, for best results, they will need to focus their goals around problems that are unique to their area and then identify specific benchmarks that they want to meet.

Meeting benchmarks will determine the success of the ACO. Thus, it is important for these measurements to focus on the issues of better care, reduced per capita costs, and patient experience. To achieve better care for all, providers need to concentrate on six areas: “safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.” Additionally, for providers to decrease costs, they need to identify how they can reduce unnecessary and unjustified medical costs and reduce administration costs through a more streamlined process. Last, providers should determine how to improve population health by looking at ways they can decrease health disparities, improve chronic care management, and improve community health status.

Providers must also be willing to collect data regarding these issues and publicly report their findings. In doing so, providers will be able to identify where their best practices

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58. Id.
60. See id.
61. See Fenninger & Riker, supra note 9, at 4; see also Premier, Inc., supra note 1, at 3.
62. NCQA Public comments, supra note 59, at 4.
64. See NCQA Public comments, supra note 59, at 5.
65. See Silva, supra note 64, at 1.
66. NCQA Public Comments, supra note 59, at 5.
exist. Additionally, they will be able to determine where they can eliminate waste and where their inefficiencies lie.

C. Adoption of a Sophisticated IT System

Third, for providers to meet their specific benchmarks and thereby become a successful ACO, they will need to invest in significant technology. To create a truly integrated system and for providers to coordinate their patients’ care effectively, providers must be linked together clinically to readily share patient information. Moreover, an advanced IT system will allow the provider to better track their quality outcomes and look at statistics to determine problem areas.

Electronic medical records (EMRs) will also be implemented as a part of this initiative, which will allow providers to have immediate access to patients’ records, and will, consequently, lead to less “chart chasing” among providers who may be treating the same patient. Furthermore, providers will be able to access a patient’s information across the entire continuum of care, which will eliminate the need to continually transport records. Consequently, this can also lead to the elimination of duplicate procedures since EMRs allow for the sharing of patient records at all times.

V. CONCLUSION

Health care costs are rising at an unsustainable rate, and the structure of our health care system’s reimbursement formulas has done nothing to bend this cost curve. The prospective payment system used to reimburse hospitals incentivizes the underutilization of services. Whereas physicians are reimbursed using the fee-for-service system, which

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67. See NCQA PUBLIC COMMENTS, supra note 59, at 5.
68. See id.
69. Mark McClellan et al., A National Strategy To Put Accountable Care Into Place, 29 HEALTH AFF. 982, 987 (2010).
70. RIEGEL & TUNG, supra note 33, at 6, 8.
71. GRUBE & KAUFMAN, supra note 42, at 4.
74. See id. at 6.
75. See Premier, Inc., supra note 1, at 1.
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encourages the overutilization of services since a physician is reimbursed for each procedure performed. Therefore, these two diametrically opposed payment systems leave us with a defragmented health care system and misaligned incentives. However, ACOs look to link these two reimbursement schemes in a way that improves the quality of health care services and decreases health care costs.

Despite coming to the realization that providers need to be held accountable for the care they provide, organizations must realize that the transition to an ACO will neither be quick nor effortless. The organizations that make up this integrated system must first assess whether they have the appropriate resources needed to succeed as an ACO. Can they contribute to the growth and help improve the performance of the ACO? Becoming an ACO takes a significant amount of capital, and organizations need to determine where these costs lie and how quickly return on investment will occur.

Lastly, an organization must have strong relationships with physicians who will center around this process of coordinated care. Many believe that ACOs can change our health care system in a way that leads to lower health care costs and higher quality of care, but we must approach this new method of health care delivery with guarded optimism. It holds the promise of increasing patient satisfaction, lowering costs, and improving patient health, but it has yet to be seen if ACOs can live up to their potential.

77. Wilensky, supra note 3, at 654.
78. See McClellan, supra note 70, at 1.
79. Merlis, supra note 2, at 2.
80. WOOD, supra note 8, at 1.
81. Id.
82. Id.
83. Id.
84. WOOD, supra note 8, at 1.
86. Id. at 1.