



2009 ISSUE BRIEF

ACCOUNTABLE CARE ORGANIZATIONS: LYNCHPIN FOR REFORM

Position

As part of health reform, and in moving Medicare to becoming a value-based purchaser of services, one of the first changes undertaken should be the creation of community-based accountability for health care services. Our current system of health care delivery does not adequately hold providers accountable for the care they provide, nor for providing the full spectrum of care.

Creating accountability is impossible until we transform the current volume-based system into one that pays providers based on outcomes or value. Once a link has been made between compensation and results, provider accountability will grow. To promote accountability, and build on the practice patterns of a majority of physicians, AMGA supports the creation of organized systems of care often referred to as accountable care organizations (ACOs).

ACOs could serve as the underpinning of several facets of health care reform: They are a vehicle for fostering accountability for quality and costs of care; present an opportunity for payment reform; and lend themselves in application to “fixing” the flawed Sustainable Growth Rate Formula (SGR). ACOs can serve as a lynchpin for reform.

Community Based Accountability for Health Care Services

AMGA defines an ACO as an entity that has physician leadership and internal structures, methods and systems for measuring, assessing and advancing the effectiveness and efficiency of patient care; providing a longitudinal, coordinated continuum of health care services, crossing provider settings and that is willing to be held accountable for the clinical results to the communities served. Accountable care organizations or systems have goals of fostering accountability for quality and costs of care, over time, for the community of patients served.¹ Entities, including and encompassing, either by ownership or by “virtual” networking, suitable attributes of size, scope, infrastructure, governance, etc., may qualify as ACOs. Multi-specialty medical group practices, integrated health care delivery systems, and other organized systems of care are examples of ACOs.

Opportunity for Payment Reform: Take It National Now

ACOs present an opportunity to blend delivery, accountability and payment reforms. Many issues need to be resolved to accomplish proper alignment of payments and responsibilities for ACOs. A model is already in place, the Medicare Physician Group Practice (PGP) Demonstration method, which is essentially an “off the shelf” system by which multi-specialty groups/organized systems of care could be reimbursed, while being held accountable for the quality of care delivered and resources used.

The improvements in care coordination, quality of care, and financial savings demonstrated in this CMS project are impressive and compelling: In performance year one there were impressive quality improvements and savings of \$9.5 million to the Medicare program. Year two saw even greater quality gains and savings of \$17.4 million. There is no reason to think that results from years three and four will show anything other than further progress on both fronts. The findings are significant enough to warrant implementation of this reimbursement model on a national basis as soon as practicable, but with some changes in the methodologies used from lessons learned in the project (drop the 2% eligibility floor; raise



the cap on bonuses to 15% to make participation attractive; factor in and reimburse for start-up costs; change the comparison basis to a national measure; attribute patients prospectively; provide feedback reports in a timely fashion, etc.).

There are currently many groups that would qualify to participate based on the existing participation criteria. There are many smaller groups and “virtual” entities which, by virtue of electronic connections, have the capabilities to participate. If incentives were properly structured, they would stimulate smaller groups to coalesce, to evolve the model of health care delivery to greater integration and efficiency. Other ACOs might be “virtual” groups, physician networks, aligned by contractual and infrastructural arrangements; hospitals with employed physicians; physician hospital organizations; extended hospital staffs, etc.

Conclusion

Congress should create accountable care organizations which will lend themselves to achieving several important public policy objectives to improve the value (quality and costs) of care provided to Medicare patients. Some ACOs already exist and others can be created based upon existing structures, linkages, and affiliations to be found in the health care delivery system. Accountability for health care services in Medicare is an idea whose time has come.

¹ Accountable Care Systems (ACS) referred to by Stephen M. Shortell, PhD, MBA, MPH, and Lawrence P. Casalino, MD, PhD, in their article published in JAMA, July 2, 2008 (Volume 300, No. 1), pp. 95-97, titled: *Health Care Reform Requires Accountable Care Systems*, are defined as “... an entity that can implement organized processes for improving the quality and controlling the costs of care and be held accountable for the results. These entities also might be called accountable care organizations, but the term system is preferred because systems of care must be established to assume responsibility for patients across providers (eg, physicians, nurse practitioners, other clinicians, etc) and settings (eg, hospitals, nursing homes, etc) over time. An ACS may be made up of several or many accountable care organizations covering the continuum of care (ie, outpatient, in-patient, home health, rehabilitation, long-term, and palliative care). We suggest 5 different ACS models:

1. Multispecialty group practice,
2. hospital medical staff organization,
3. Physician hospital organization (PHO),
4. interdependent physician organization,
5. and health plan–provider organization or network.”

MedPAC discusses accountable care organizations in its June 2008 Report to Congress, pages 16-17. The text is reproduced below. There is considerable congruence between an ACO and the Shortell/Casalino descriptions of an ACS.

“Concept 3: Accountable care organizations

The goal of an ACO is to promote accountability for quality and resource use over an extended period of time for a population of patients. Under an ACO, physicians and other providers are encouraged to work together and improve care coordination. Over time, such organizations might control growth in the volume of services provided and improve the quality of their services. This concept could complement medical homes, which in some cases may be too small to support full accountability, and hospital–physician bundling, which creates no incentive to control the volume of initial admissions.

Some existing multispecialty group practices and integrated delivery systems (hospital and physician organizations) might already function as ACOs and could test the concept by volunteering to be accountable for a patient population and be rewarded on their performance. Performance could be measured against the group’s baseline for resource use as is done in the physician group practice demonstration.”