



Becoming Accountable — Opportunities and Obstacles for ACOs

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The Patient Protection and Affordable Care Act (ACA) requires the secretary of health and human services to establish a program within Medicare in which savings from efficient, high-value

care are shared with accountable care organizations (ACOs). No demonstration project, this is the start of an ongoing way of paying for care; the program is to be launched in January 2012. The concept is appealing, but right now ACOs don't exist, and regulations regarding qualification as an ACO have not yet been published. Much needs to be done to make this new approach to payment and delivery a reality.

In principle, ACOs will efficiently deliver the measurably high-quality care offered by integrated health maintenance organizations (HMOs) without the "lock-in" that many Medicare beneficiaries abhor. Most HMOs are built on an insurance "chassis"

— a state-regulated, risk-bearing entity that contracts with various providers. In some cases, the insuring entity contracts exclusively with a single provider group, but most HMOs contract with many providers who see patients from multiple health plans and are paid on a fee-for-service basis — which gives them an incentive to provide more services. Because it would be too time-consuming for individual physicians to negotiate separate arrangements with each HMO in their region, most clinicians rely on fee for service. (Because of their size, hospitals are better able to negotiate different payment approaches.) The default fee structure is some multiplier of the amounts in the

Medicare fee schedule, and there are no incentives for exploring alternatives to face-to-face visits, improving quality so as to reduce the volume of required services, or coordinating with other providers.

In contrast, ACOs begin not with insurance but with a collection of providers (physicians and facilities) who come together and accept internal payment arrangements that facilitate the provision of efficient, high-quality care. If the ACO does well, the savings it achieves can be shared among the providers or pumped back into the provision of high-value care.

Enrollment contracts allow insurers to know what patient population they are responsible for. An HMO typically allows its members to obtain services only from its contracted providers. The primary ACO model discussed in the ACA does not require enrollment: patients are

attributed to the ACO on the basis of their patterns of service use. That is, if a patient typically sees a primary care physician who belongs to an ACO, all of that patient's care is attributed to that ACO. If the costs incurred by the ACO's "attributees" are sufficiently below Medicare's spending projections for that population, the ACO shares in the savings realized by Medicare; if the costs are too high, the ACO loses nothing.

Fisher et al. have described an attribution rule whereby Medicare beneficiaries are assigned to their primary care provider and then to unique physician-hospital networks,¹ but it is unclear whether those networks approximate prospective ACOs. ACOs must be able to collect information on the quality of care, create new incentives, and accept and distribute bonus payments. Building these capabilities will entail substantial up-front costs for new legal entities, information systems, and other infrastructure. Large multispecialty groups are well positioned to take on these responsibilities, but most primary care physicians are not² — nor are all primary care practitioners likely to be invited into, or want to participate in, an ACO. A simple geographic model for attribution that may work in rural areas would be less desirable in urban areas. Moreover, it may be important to create multiple ACOs in a given region to allay antitrust concerns.³

The ACO concept calls for each primary care practitioner to be part of only one ACO. The key question will be which patients should be attributed to each ACO. Rules based on who provides the majority of a patient's primary care visits are

appealing — but problematic when applied to patients who make few visits to their primary care physician, either because they are healthy (and thus incur fewer costs) or because they are quite ill and primarily see specialists (and thus are good candidates for better care coordination). Attribution will be further complicated by the need to consider reasonable patterns of patient visits. For instance, a patient who evenly divides his or her visits between two job-sharing clinicians may have more continuity of care than one who sees a single clinician 60% of the time and six other primary care providers 40% of the time — especially if there is no integrated medical record. The nature of the attribution rules that are ultimately implemented will have enormous implications for ACOs' care-management approaches and their likelihood of success.

The ACA focuses on accountability for costs under Medicare Parts A and B. Being accountable for that much care may be so daunting that few entities will choose to become ACOs. Hospitals receive fixed payments for diagnosis-related groups under Part B, but Medicare also reimburses them for part of the costs of very expensive cases. Holding an ACO fully accountable for such outlier cases may add too much uncontrollable risk. In addition, a New Hampshire ACO may feel comfortable being held accountable for care delivered in its region but not for services its patients receive while they winter in Florida.

Some ACOs, however, may want more accountability than is currently envisioned. Well-coordinated, continuous care involves effective drug management, so ACOs may want more control

over formularies, which restrict treatment options and may influence adherence. Providers in ACOs should also be able to participate in innovations related to care after discharge, care coordination, and end-of-life care, although they shouldn't be paid twice for the same efforts.

The ACA requires that ACOs have good information systems to report quality measures to the Centers for Medicare and Medicaid Services (CMS). But Medicare's own information must also be shared efficiently and rapidly. Unlike HMOs, which limit members to receiving nearly all their care through a given health plan, ACOs must be permeable, yet they are held accountable for services obtained from outside providers. The lack of information on such "outside use" results in economic risk for the ACO and may lead to clinical harm, so Medicare must make data available rapidly. Even if ACOs are not held accountable for costs for Medicare Part D, the CMS should encourage the sharing of data on filled prescriptions to facilitate improvements in care.

More urgently, unless the CMS provides those organizations considering ACO status with the data they need for planning, the concept may never be effectively implemented. Providers forming ACOs will want to know how much care their patients receive elsewhere, for instance, and whether such services are concentrated in a small number of providers who might be invited to join the ACO. To be successful, ACOs must slow the rate of growth of costs for their own patients. Areas with high Medicare costs have the greatest potential for eliminating unnecessary care

but often have the least organization and infrastructure in place. Low-cost areas have already squeezed out some of the waste but still need to restructure their incentives for providers.

ACOs won't bear the risk of higher-than-expected costs. They will, however, bear the up-front costs of organizational and cultural change, reaping rewards only if quality is sufficiently high and costs sufficiently low. It will be challenging for providers to create ACOs. The CMS can reduce the uncertainty associated with implementation by providing com-

prehensive data for planning and by making the operational rules for ACOs somewhat flexible.

Our fee-for-service system doesn't provide incentives for high-quality care at reasonable cost. Although ACO structures will be superimposed on Medicare's fee-for-service model, the approaches ACOs develop for compensating providers hold potential for enhancing the efficiency of U.S. health care — improving outcomes using fewer resources than our system currently consumes.

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Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Creating Accountable Care Organizations



A video is available at NEJM.org

Under the Affordable Care Act, Medicare will launch a Shared Savings Program for groups of health care providers and hospitals that join forces to take responsibility for the “quality, cost, and overall care” of a population of patients. What will these accountable care organizations (ACOs) look like? What are the best pathways and likely hurdles to achieving ACO status? What are the expected benefits for clinicians and their patients? On September 27, 2010, experts Lawrence Casalino, Elliott Fisher, and Gail Wilensky addressed these and other questions about the move toward ACOs in a roundtable discussion moderated by NEJM Associate Editor Thomas H. Lee.

Low-Cost Lessons from Grand Junction, Colorado

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In August 2009, President Barack Obama traveled to Grand Junction, Colorado, touting that community's health care system as a model for the provision of low-cost, high-quality care. According to the Dartmouth Atlas of Health Care, average per capita Medicare spending in Grand Junction was \$6,599 in 2007 — 24% lower than the national average and 60% be-

low high-cost Miami. In 2005, Grand Junction had only 60% as many coronary-artery bypass surgeries in its Medicare population as the national average, 55% as many inpatient coronary angiography procedures, and 61% as many inpatient days during the last 2 years of life. Moreover, Grand Junction scored above the national average on a number of

measurements of preventive care, diabetes, asthma, and other quality metrics.

Although the Dartmouth Atlas has been criticized for failing to adjust for regional price variation and differences in health status in various populations,¹ three independent observations confirm that Grand Junction provides low-cost health care. First, a 2009