

# From the CEO

## ACOs: Revolutionary Healthcare Model or Repackaging of the Same Old Ideas?

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One of the many controversial elements of the new Health Care Reform legislation is the establishment of Accountable Care Organizations (ACO). With the projected bankruptcy of the Medicare Trust Fund and steeply increasing health care costs overall, a sense of urgency exists to address the areas of cost, quality and efficiency. Some believe that ACOs can successfully improve quality and efficiency while achieving cost savings within the healthcare system.

The literature on ACOs is extensive with policy briefs, personal viewpoints of supporters and detractors, and even implementation manuals for those ready to take the plunge. The discussion here is only a brief overview of some elements of ACOs that may be of interest to CSA members.

Although many authors describe ACOs as models for community health systems and privately insured patients, the new law, including requirements and incentives, address only Medicare beneficiaries in the fee-for-service system. It could be a harbinger of a future of managed care for all Medicare beneficiaries as noted in a reference to “assigning” beneficiaries to ACOs if they do not select one. One element that has not been addressed in the literature is that under the ACO model, Medicare contracts directly with the provider organizations without the reliance on a health plan intermediary.

### Medicare Shared Savings Program

The Patient Protection and Affordable Care Act describes ACOs in Section 3022, entitled “Medicare Shared Savings Program.” Examples of acceptable business models are noted in Section 1889(b):

*“the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:*

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- “(A) ACO professionals in group practice arrangements.*
- “(B) Networks of individual practices of ACO professionals.*
- “(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.*
- “(D) Hospitals employing ACO professionals.*
- “(E) Such other groups of providers of services and suppliers as the Secretary of Health and Human Services determines appropriate.”*

Among the myriad requirements to qualify as an ACO, entities must have a legal structure that is the recipient, manager and distributor of shared savings. They must establish and document quality measures, develop methods of quantifying and reporting clinical processes and outcomes, and report patient and caregiver experience of care, as well as utilization. Many of these factors have been around for years and most continue to defy clear definition and implementation. A simple example is the widespread absence of electronic health records, which continues to be a huge impediment to effective coordination of care.

Payment models for providers include traditional fee-for-service, bundled/episode-of-care payments, and partial or full capitation. However, the new law notes that Medicare payments to the ACOs “shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings...”

ACOs must have a minimum of 5,000 Medicare enrollees, and all benchmarks are measured against that population. Provided that the ACO meets the quality standards (as yet undefined), then the Secretary of Health and Human Services determines the percentage of savings shared with the ACO. Savings are the difference between the estimated per capita cost of care (adjusted for patient characteristics) and actual expenses.

State laws greatly influence the structure of ACOs and how physicians are integrated into the system. Only a handful of states, including California, prohibit lay entities from employing physicians. That doctrine prevents hospitals from requiring hospital-based physicians to become employees.

ACOs may be viewed as an opportunity to reap rewards for managing care across a continuum, from prevention to acute care and caring for those with chronic conditions, providing only necessary care to achieve cost savings, all the while improving quality and patients' experiences. From another vantage point, it raises alarm among some individuals and groups that they might be dominated by hospitals or entities that will exert control over their practices and incomes. While that could happen, it would require the assent of groups or individuals who agree to the conditions and payment methods for their services. Cooperation and coercion, however, bear a strong resemblance where one "partner" has significant clout over others.

While many elements of ACOs are familiar, the time-worn expression "the devil is in the details" reminds us that what sounds good in concept may not be successful in execution. Who controls the dollars is a significant issue that may impede the formation of ACOs or ultimately could mark their demise.

### **CSA Bulletin Cover for Volume 59, Number 4 "Walk Amongst the Oaks"**

The cover photograph of this Bulletin issue was taken in 2008 at the Los Osos Oaks State Natural Reserve located just outside of Los Osos, along the Central Coast of California. The reserve is home to centuries old costal live oak trees. This image was captured with a DSLR in RAW and processed in Photoshop and Silver Efex.

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