

FAQ On ACOs: Accountable Care Organizations, Explained

ACO is the hottest three-letter word in health care

By Jenny Gold, KHN Staff Writer

Aug 23, 2013

One of the main ways the Affordable Care Act seeks to reduce health care costs is by encouraging doctors, hospitals and other health care providers to form networks to coordinate care better, which could keep costs down.

To do that, the law is trying a carrot-and-stick approach in the Medicare program: Accountable Care Organizations. ACOs have become one of the most talked about new ideas in Obamacare. Providers get paid more if they keep their patients well. About four million Medicare beneficiaries are now in an ACO, and, combined with the private sector, more than 428 hospitals have already signed up. An estimated 14 percent of the U.S. population is now being served by an ACO. You may even be in one and not know it.

While ACOs are touted as a way to help fix an inefficient payment system that rewards more, not better, care, some economists warn they could lead to greater consolidation in the health care industry, which could allow some providers to charge more, if they're the only game in town.

Because ACOs are increasingly important, here are some answers to common questions about them:

What is an accountable care organization?

An ACO is a network of doctors and hospitals shares responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. At the heart of each patient's care is a primary care physician.

In Obamacare, each ACO has to manage the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years. Think of it as buying a television, says Harold Miller, president and CEO of the Network for Regional Healthcare Improvement and executive director of the Center for Healthcare Quality & Payment Reform in Pittsburgh. A TV manufacturer like Sony may contract with many suppliers to build sets. Like Sony does for TVs, Miller says, an ACO would bring together the different component parts of care for the patient – primary care, specialists, hospitals, home health care, etc. – and ensure that all of the "parts work well together."

The problem with most health systems today, Miller says, is that patients are getting each part of their health care separately. "People want to buy individual circuit boards, not a whole TV," he says. "If we can show them that the TV works better, maybe they'll buy it," rather than assembling a patchwork of services themselves. "But ACOs will need to prove that the overall health care product they're creating does work better and costs less in order to encourage patients and payers to buy it."

Why did Congress include ACOs in the law?

As lawmakers searched for ways to reduce the national deficit, Medicare is a prime target. With baby boomers entering retirement age, the costs of the program for elderly and disabled Americans are expected to soar.

ACOs make providers jointly accountable for the health of their patients, giving them financial incentives to cooperate and save money by avoiding unnecessary tests and procedures. For ACOs to work, they have to seamlessly share information. Those that save money while also meeting quality targets would keep a portion of the savings. Providers can choose to be at risk of losing money if they want to aim for a bigger reward, or they can enter the program with no risk at all.

In addition, CMS created a second strategy, called the **Pioneer Program**, for high-performing health systems to pocket more of the expected savings in exchange for taking on greater financial risk.

HHS estimates that ACOs could save Medicare up to \$940 million in the first four years. While that's far less than one percent of Medicare spending during that period, if the program is successful, it can be expanded by the federal secretary of health and human services.

How are ACOs paid?

In Medicare's traditional fee-for-service payment system, doctors and hospitals generally are paid for each test and procedure. That drives up costs, experts say. ACOs don't do away with fee for service, but they create savings incentives by offering bonuses when providers keep costs down. Doctors and hospitals have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases. In other words, providers get paid more for keeping their patients healthy and out of the hospital.

If an ACO is unable able to save money, it could be stuck with the costs of investments made to improve care, such as adding new nurse care managers, and also may have to pay a penalty if it doesn't meet performance and savings benchmarks. ACOs sponsored by physicians or rural providers, however, can apply to receive payments in advance to help them build the infrastructure necessary for coordinated care – a concession the Obama administration made after complaints from rural hospitals.

How would an ACO work for a patient?

Doctors and hospitals will likely want to refer patients to hospitals and specialists within the ACO network. But patients would still be free to see doctors of their choice outside the network without paying more. Providers who are part of an ACO are required to alert their patients, who can choose to go to another doctor if they are uncomfortable participating. The patient can decline to have his data shared within the ACO.

Who's in charge — hospitals, doctors or insurers?

ACOs can include hospitals, specialists, post-acute providers and even private companies like Walgreens. The only must-have element in an ACO is primary care physicians, who serve as the linchpin of the program. More than half of the current Medicare ACOs are actually run by physicians and don't even include a hospital partner.

In private ACOs, insurers can also play a role, though they aren't in charge of medical care. Some regions of the country, including parts of California, already had large multi-specialty physician groups become ACOs on their own by networking with neighboring hospitals. "A lot of health care organizations are

going to dust off the existing structures they had in place" says Kelly Devers, a senior fellow at the Urban Institute.

In other regions, large hospital systems are scrambling to buy up physician practices with the goal of becoming ACOs that directly employ the majority of their providers. Because hospitals usually have access to capital, they may have an easier time than doctors in financing the initial investment, for instance to create the electronic record system necessary to track patients.

Some of the largest health insurers in the country, including Humana, United Healthcare and Cigna, are forming their own ACOs for the private market. Insurers say they are essential to the success of an ACO because they track and collect the data on patients that allow systems to track patient care and report on the results.

If I don't like HMOs, why should I consider an ACO?

ACOs may sound a lot like health maintenance organizations. "Some people say ACOs are HMOs in drag," says Devers. But there are some critical differences – notably, an ACO patient is not required to stay in the network.

Steve Lieberman, deputy director for policy and analysis at the National Governors Association, explains that ACOs aim to replicate "the performance of an HMO" in holding down the cost of care while avoiding "the structural features that give the HMO control over [patient] referral patterns," which limited patient options and created a consumer backlash in the 1990s.

In addition, unlike HMOs, the ACOs must meet a long list of quality measures to ensure they are not saving money by stinting on necessary care.

What could go wrong?

Many health care economists fear that the race to form ACOs could have a significant downside: hospital mergers and provider consolidation. As hospitals position themselves to become integrated systems, many are joining forces and purchasing physician practices, leaving fewer independent hospitals and doctors. Greater market share gives these health systems more leverage in negotiations with insurers, which can drive up health costs and limit patient choice.

But Lieberman says while ACOs could accelerate consolidations, it's already "such a powerful and pervasive trend that it's a little like worrying about the calories I get when I eat the maraschino cherry on top of my hot fudge sundae. It's a serious public policy issue with or without ACOs."

Are ACOs the future of health care?

ACOs are already becoming pervasive, but they may be just an interim step on the way to a more efficient American health care system. "ACOs aren't the end game," says Chas Roades, chief research officer at The Advisory Board Company in Washington D.C.

One of the key challenges for hospitals and physicians is that the incentives are to reduce hospital stays, emergency room visits and expensive specialist and testing services—all the ways that hospitals and physicians make money in the current fee-for-service system, explains Roades.

Ultimately, Roades says the goal would be for providers to take on full financial responsibility for caring for a population of patients for a fixed payment, but that will require a transition beyond an ACO.

Recently, nearly a third of the Pioneer ACOs announced they were dropping out of the advanced program, some because they didn't save enough money, though seven are moving into a second Medicare ACO model with less risk of losing money.

But there's reason for hope: All 32 Pioneers succeeded in improving quality and performed better than fee-for-service Medicare in 15 quality measures, according to CMS. And they generated a gross savings of \$87.6 million in the 2012, the first year of the program.