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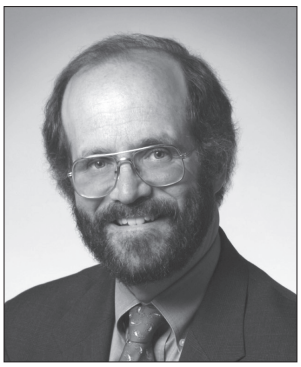

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Accountable Care Organizations:

What are they? Where are they coming from? Where will they lead?

Jonathan Jaffery, MD; Robert N. Golden, MD

Accountable Care Organizations (ACOs) are receiving an increasing amount of attention, yet remain shrouded in mystery for many physicians and their patients. "No different from an HMO," say some. "The answer to misaligned incentives inherent in the fee-for-service system," say others, while a few compare an ACO to the Loch Ness Monster—everyone knows what it looks like, but no one has actually seen one.

Created under Section 3022 of the Affordable Care Act (ACA), the Medicare Shared Savings Program is a voluntary mechanism through which providers can contract with the Center for Medicare and Medicaid Services (CMS) to provide high-quality, cost-effective care to Medicare fee-for-service beneficiaries.

While the ACA clearly remains a political lightning rod, the ACO program has nonpartisan roots. In fact, Section 502 of the Patients' Choice Act of 2009 (HR 2520 and S1099), a bill introduced in the 111th Congress by Representative Paul Ryan (R-Wis) and Senator Thomas Coburn, MD (R-Okla), would have authorized a Medicare ACO Demonstration Program that is remarkably similar in design to the actual legislation adopted in the ACA.

But what is an ACO? In some ways, the description is straightforward. An ACO is a group of providers who agree to accept responsibility for overall quality and cost of the Medicare fee-for-service beneficiaries for whom they provide care. This "group" includes primary care physicians, at a minimum, but also may include specialists, hospitals, and other types of providers.

In the Medicare Shared Savings Program, quality is measured by 33 metrics defined by the Centers for Medicare and Medicaid Services (CMS), and cost is defined as the total cost of care to CMS. This last factor is key, and it points to a fundamental change from the status quo. Under this model, providers are at risk for all of the health care costs of their patients, not simply the costs for the services that they, themselves, provide. Throughout the contract period, CMS continues to pay fee-for-service claims as usual, but if the average total cost of care is less than projected, the ACO can share in a percentage of the savings.

Why would providers choose to join this program? One reason is to prepare for the future. While fee-for-service reimbursement, which rewards a high volume of activity irrespective of quality or overall costs, has been the predominant payment mechanism for years, payers (including the government, commercial insurers, employers, and individual consumers) increasingly are insisting on value-based payments, which reward the highest quality and service and the lowest costs. While some may prefer the traditional payment system, most experts believe that maintaining the status quo is not a viable, long-term option. Early movement toward and engagement in value-based care may create the differential advantage that helps providers remain competitive in the marketplace.

Perhaps more importantly, this is an opportunity to add new capabilities to our practices. While critics of our country's health care system

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often emphasize discrete problem areas—such as inappropriate emergency department use, low generic prescription drug utilization, and redundant high-cost imaging studies—that hopefully are isolated and uncommon, some fundamental changes in how we approach health care delivery are necessary and underway.

The US health care system provides some of the best acute episodic and high-end specialty care in the world, but care coordination—especially for high-risk patients with chronic diseases or combinations of medical diseases, behavioral health issues and substance abuse—is largely lacking. Emerging payment mechanisms, such as ACOs, allow providers to invest in resources and activities that provide the full spectrum of care to their patients and re-orient their practices toward managing populations.

We know that employing nurses and social workers to help with care management can provide better patient-centered care while reducing avoidable high-cost health care utilization for some high-risk patients. However, this costly investment results in decreased downstream revenue under the fee-for-service reimbursement model. By creating incentives to invest in care coordination services, shared savings models or other risk-sharing payment mechanisms, providers can make these fundamental changes to their practices without putting themselves out of business.

At UW Health, we think these investments are both the smart thing and the right thing to do. In 2012, UW Health established its own ACO (UW Health ACO, Inc) and—following a successful application in the most recent round of CMS competition—it now is an official Medicare Shared Savings Program.

To prepare for the launch of our ACO and for the "brave new world" of health care delivery, we restructured our primary care compensation models away from a system that rewards only volume of service, to a panel-based plan that encourages optimizing care for a population. We are deploying a new care model that we hope will deliver the most effective and efficient care for patients and populations, without requiring their physical presence in the clinic for all services. Additionally, we are hiring a cadre of nurses and social workers who will coordinate and manage care for patients with complex, chronic diseases and high-risk social needs.

Of course, no one knows exactly what the future holds. But, currently, a number of new value-based payment mechanisms, including ACOs, are being tested. We predict that some of these will prove successful, others will fail to achieve their goals, and newer models will evolve. The importance lies not in any individual pilot, program, or payment mechanism, but rather in the hope that this evolutionary process will lead to a sustainable approach for providing the highest-quality, most cost-effective care to the patients and populations whom we serve.

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