

## ACCOUNTABLE “CARE ORGANIZATION”

### or “Accountable Care” Organization

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**The Patient Protection and Affordable Care Act (ACA) includes a number of delivery system and payment reform initiatives that hold much promise for bending the cost curve.**

The legislation provides for mandatory programs like value based purchasing, pilot and demonstration programs like bundled payments, and voluntary opportunities like Accountable Care Organizations (ACOs). But, the ACA also provides for a close to unlimited potential for the Center for Medicare and Medicaid Innovation (CMI) to affect both payment and delivery system reform.

The legislation itself offers some prescriptive provisions that limit what a Medicare “shared savings program” ACO can be. At the same time, since passage of the ACA there have been a number of “summits” and conferences to convene payors and providers to discuss the experience of entities which either claim to be ACOs or are pilots working to become ACOs. However, these are not Medicare ACOs under the ACA, because there are no rules for Medicare implementation yet.

In light of this flurry of activity, many providers, in large and small organizations, have been left to wonder what being an ACO means. We suggest that there are two overlapping definitions that confuse most stakeholders and the ambiguity in the definitions may be detrimental to broader efforts to reform payment and the delivery system.

Most payors consider an ACO to be an accountable “Care Organization”: an organization of physicians, hospitals and other members of the delivery system—either legally united as one or virtually linked—but willing to be “accountable” for costs for a defined population. To succeed, that type of Care Organization has to have certain characteristics: It needs to have sufficient numbers and types of care providers to deliver a large scope of services. It needs a certain degree of clinical integration to coordinate care efficiently. It must have agreements in place about how monies get distributed among providers; and it must have sufficient financial reserves to cover the potential medical losses that come with being financially accountable for the medical care of an assigned population.

In many providers’ minds, by contrast, an ACO is an “Accountable Care” organization. It is an organized group of physicians,—either legally united in one or virtually linked— with or without the presence of a hospital or other members of the delivery system, that is willing to optimize its delivery of services so that patients receive high quality and high value care. This idea of “accountable care” requires a system of coordinated and pro-active, evidence-based, measured, patient-centered care. Accountable Care is exemplified not only by the Patient-Centered or Advanced Medical Home concepts, but also as often described in the many reports of successful, high performing, high value provider organizations.<sup>1</sup> In many providers’ minds, the “Accountable Care” organization does not require assumption of financial risk for a population, but rather accountability for the care delivered within a payment model that only puts them at risk for their management of individual patients. In fact, most physicians do not have the tools to understand, monitor and manage total population costs, but they can deliver Accountable Care.

These two concepts of an ACO are not incompatible. In fact, the “Accountable Care” organization will likely be part of any successful accountable “Care Organization.” But the very real implications of these different concepts underscore the importance of definitional clarity. As CMI instigates the implementation of new models, both types of approaches should be tested.



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In moving us away from fee-for-service, CMI-supported payment innovation should encourage the creation of as many modes of “Accountable Care” organizations as possible. The role of these organizations will be to reform the delivery system to better deliver truly accountable, measured, efficient, high quality care. The size of those organizations should vary according to the amount of financial risk they are willing to bear.

New modes of payment, including bundled payments for an episode of care or a bundled budget for clinically integrated care like PROMETHEUS Payment<sup>2</sup>, can support these organizations without giving them full financial risk. The risk in these payment models is limited to the providers’ ability to manage care efficiently for each episode of care. They are not at risk for the incidence of episodes among the assigned patient population. And yet they will become “Accountable Care” organizations as they create the clinically integrated systems of care to manage care effectively, improve financial margins and limit financial risk under such payment mechanisms. In contrast, those accepting global capitation take on a considerable amount of additional financial risk – they become accountable for total population costs, only some of which they can control. The expertise necessary to implement a Care Organization that can succeed are quite different. We have seen the disasters which befall those without such capabilities<sup>3</sup>.

The confounding of these two concepts in the ACA—assumption of financial risk and delivery system reform—seems to have been purposeful so as to avoid addressing head-on the contentious challenge of financial risk transfer to providers. But the result of this avoidance may prove a serious impediment to successful implementation of the Medicare “shared savings program” ACO.

The accountability for care delivery in “Accountable Care” organizations is the stimulus to delivery system reform that will be required to bend the cost curve and improve quality. The financial accountability of accountable “Care Organizations” may be an important model for some aspects of a changed health care system. Both versions of ACOs, clearly distinguished, should be encouraged by CMI.

<sup>1</sup>Minott et al, “The Group Employed Model as a Foundation for Health Care Delivery Reform,” The Commonwealth Fund, Issue Brief (April 2010) [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Apr/1389\\_Minott\\_group\\_employed\\_model\\_hlt\\_reform\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Apr/1389_Minott_group_employed_model_hlt_reform_ib_v2.pdf) (hereafter, “Minott”)

<sup>2</sup>Hussey, et al. “Controlling US Health Care Spending—Separating Promising from Unpromising Approaches.” NEJM 361; 2109-2111, 2009

<sup>3</sup>Engert and Emery, “Integrated Delivery Systems: Non Fait Accompli”, Managed Care Quarterly 1999, 7(1):29-328



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