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Questions and Answers on Accountable Care Organizations (ACOs)

What is an Accountable Care Organization?

An ACO is a network of doctors and hospitals that shares responsibility for providing care to patients. In the Patient Protection and Affordable Care Act (ACA), an ACO would agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.

Think of an ACO like buying a television. A TV manufacturer like Sony may contract with many suppliers to build sets. Like Sony does for TVs, 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 today is that patients are getting each part of their health care separately. People want to buy individual circuit boards, not a whole TV.

When will ACOs begin operating?

The ACO initiative is scheduled to launch in January 2012, but the race to form ACOs has already begun. Hospitals, physician practices and insurers across the country, from New Hampshire to Arizona, are announcing their plans to form ACOs, not only for Medicare beneficiaries but for patients with private insurance as well. Some groups have already created what they call ACOs.

Why did Congress include ACOs in the ACA?

As lawmakers search 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.

The aim of ACOs is to make providers jointly accountable for the health of their patients, giving them strong incentives to cooperate and save money by avoiding unnecessary tests and procedures.

Are providers at risk of losing money?

For ACOs to work they'd have to seamlessly share information. Those that save money while also meeting quality targets would keep a portion of the savings. But some providers could also be at risk of losing money. HHS estimates that ACOs could save Medicare up to \$960 million in the first three years. That's far less than one percent of Medicare spending during that period. If the program is successful, it can be expanded by the Secretary of Health and Human Services.

How would ACOs be paid?

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

If an ACO is not able to save money, it would 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 they don't meet performance and savings benchmarks. The law also gives regulators the ability to devise other payment methods, which would likely ask ACOs to bear more risk. For example, an ACO could be paid a flat fee for each patient it cares for.

How would an ACO be different for patients?

Primary care doctors who are part of an ACO would be required to tell their patients. But although physicians will likely want to refer patients to hospitals and specialists within the ACO network, patients would still be free to see doctors of their choice outside the network without paying more. ACOs also will be under pressure to provide high quality care because if they don't meet standards, they won't get to share in any savings – and could lose their contracts.

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

Hospitals, primary care providers and other physicians are in charge of an ACO, but insurers can also play a role.

Some regions of the country, including parts of California, already have large multispecialty physician groups that may become an ACO on their own, likely by networking with neighboring hospitals.

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 required by an ACO.

Some of the largest health insurers in the country, including Humana, United Healthcare and Cigna, already have announced plans to form their own ACOs for the private market. Insurers say they are essential to the success of an ACOs because they track and collect that 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, but there are some critical differences – notably, an ACO patient is not required to stay in the provider network.

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.

What can go wrong?

ACOs are not a panacea. ACO has become the three-letter health acronym of the year, if not the decade. The health industry tends to operate with kind of a herd behavior, rushing to implement an idea without working through the detailed business questions of how they'll work.

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.

While ACOs could accelerate consolidations, it has already become a powerful and pervasive trend in the way providers look at improving their delivery systems.

Are there any possible legal concerns?

Doctors, hospitals and others in the health care industry have raised concerns that ACOs could run afoul of antitrust and anti-fraud laws, which try to limit market power that drives up prices and stifles competition. One concern is that ACOs, particularly those in rural markets, could grow so large that they would employ the majority of providers in a region.

To help providers avoid legal problems, the U.S. Justice Department's antitrust division has provided an expedited antitrust review process for these new doctor-hospital partnership.

What does this all mean for the behavioral healthcare community?

- For many behavioral healthcare providers, partnering with ACOs will mean honing significant new skills and capacities. It is critically important that behavioral health providers assess their current ability to qualify for participation in these efforts and address the gaps they find.
- As SBHAs begin to chart a course toward ACOs, they should keep in mind that behavioral health providers are often starting their journey from a different point of origin than their

medical counterparts. Behavioral health providers are often under-resourced and under-capitalized compared to other providers like hospitals. Behavioral health is going to require some special handling and it behooves primary care, hospitals, integrated delivery systems and health plans to help them keep pace.

- While it's true that all interested parties – behavioral health providers included – need to be able to carry their own weight in business terms, any ACO that fails to properly include behavioral health providers is destined to continue struggling with a significant share of otherwise unmitigated chronic care costs so the value proposition should be clear.