Issues, Ideas & Actions

Useful Information from Ryun, Givens & Company

Accountable Care Organizations • Issue V

Ryun, Givens & Company, P.L.C.

Accountable Care

Organizations

Health care reform and the Affordable Care Act are creating a lot of change.

Part of that change is the formation of Accountable Care Organizations (ACOs). These are groups of physicians, medical providers, or hospitals from different areas of medicine that come together with the goal of improving the quality of care and reducing costs.

Why Accountable Care Organizations?

ACOs emerge from the recognition that the current medical system:

- Offers fragmented services across providers, i.e. the absence of coordinated care
- Pays for units of service rather than outcomes
- Holds no one organization or individual responsible for either the quality of care or the cost of care provided

The purpose of ACOs are:

- Bring providers together under a single organization
- Create incentives for them to coordinate care
- Improve quality and lower costs

Those who argue in favor of ACOs believe that they will change both the culture and practice patterns of providers. As those changes are institutionalized, all payers and all patients will benefit from the delivery of higher quality, lower costs, and better integrated services.

What is an ACO?

There are numerous definitions of ACOs, but they are generally thought of as collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals and others around the ability to receive shared-saving bonuses from a payer by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients.

Their essential elements are:

- Bringing together and integrating, either actually or virtually, a broad range of providers across care settings
- Emphasizing primary care
- Achieving savings through integrated care
- Savings are shared by payers and providers
- Savings are *not* at the expense of quality
- Providers are responsible for:
  - Improving quality
  - Reducing costs

◦Improvements are measured across a specific population

The emphasis within ACOs is on physicians rather than insurers or hospitals. This is due to the fact that physicians "control" approximately 87% of all personal health spending.

Who Forms ACOs ?

The idea is that leaders in the provider community will come together to form an ACO. The ACO will then solicit other providers in the community to voluntarily join the ACO to improve the quality of care provided and share in the resulting savings.

The enactment of the Affordable Care Act thus encourages all providers to position themselves relative to newly formed ACOs.

ACOs have the potential to alter the influence of primary care physicians, specialist physicians, hospitals, and payers have on one another.

Motivation to participate in ACOs includes:

- A sincere desire to improve quality of care and reduce costs
- A desire to protect their place in the market
- To ensure that they have a role in any collective decision
- To share in cost savings
- To protect their autonomy

At of the release of this edition, over half of newly formed ACOs were formed by physician groups.

Here is a link to Accountable Care Organizations by State: http://www.aapmr.org/practice/PracticeMgmt/ModelsOfCare/Pages/Accountable-Care-Organizations-Listed-by-State.aspx

Existing Accountable Care Organizations

ACOs are modeled on organizations that are seen as quality leaders in health care, such

as:

- Kaiser Permanente
- The Mayo Clinic
- The Cleveland Clinic
- Geisinger Health System

These organizations generally have staff models where physicians are the employees of the health care organization. There are also others, such as HealthCare Partners Medical Group that have both an employee staff model as well as an affiliated independent physician association.

All are considered to be integrated providers and they are paid in a variety of ways, including:

- Fee-for-service
- Capitation
- Pay-for-performance

How are ACOs Supposed to Work?

ACOs maintain three types of relationships:

- The ACO and payers (Medicare, Medicaid, private insurance)
- The ACO and a defined population of patients (Insured)
- The ACO and the providers

ACO and Payers Relationship

An ACO's principal function is to take responsibility for some or all of the medical care delivered to a population of patients. In

order to do so, it is assumed that the ACO will contract with payers on behalf of its affiliated providers. The ACO will not get to pick and choose individual patients from within the defined population based on health status. The ACO and payer need to agree on the following:

- The historic cost of care for this population (the benchmark)
- A formula to calculate anticipated changes in health care costs, due to factors such as increases in medical care costs, aging, or in health status
- A targeted savings rate that will trigger payments to the ACO
- A certain quality measure that the ACO will need to meet

ACO and the Insured

One attractive feature of ACOs is that they are not designed to place a new entity between providers and patients since patients continue to deal with the health care system through their regular sources of care. The provider has a relationship with the ACO and the ACO has a relationship with the payer.

Critics of this model point out that any cost savings are shared between the payer and the ACO. They argue that any savings should be shared with the patient/consumer.

ACO and Providers

While there is no requirement that any provider affiliate with an ACO, any relationship between an ACO and its providers more than likely will be governed by a contract that specifies the obligations of both parties and how providers share in any savings.

There can be multiple ACOs in a community and conceivably a provider could be a member of one with respect to the practice's Medicare beneficiaries and a member of another for their Medicaid beneficiaries and/or private insured.

It's assumed that the ACO will be composed of providers that tend to refer to one another (either admitting to the same hospital or referring to a common set of specialists). To generate shared savings, the ACO and affiliated providers can seek to:

- Reduce unnecessary or duplicate services
- Develop or adopt existing care protocols to improve coordination of care and disease management, increase preventive services, and encourage early diagnosis
- Improve information flows within the ACO
- Promote lower-cost options
- Benefit from economies of scale in the purchase of goods and services
- Reduce preventable emergency department visits and re-hospitalizations
- Coordinate the purchase and use of expensive equipment
- Coordinate the hiring of some specialists to optimize organization efficiency

ACOs aim to improve care and lower costs. There are several that have already been established. It's likely that more will emerge due to inevitable changes from the Affordable Care Act and the evolving status of health care reform.

If you'd like to discuss the establishment of ACOs, please call Whitney Tucker at 515-225-3141 or email sgivens@ryungivens.com.

Check out our website www.ryungivens.com/News for more editions of *Issues, Ideas & Actions*!

Ryun, Givens & Company, P.L.C.