Accountable Care Organizations
What Is Required to Make Them Work?
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One innovation to improve healthcare is the "Accountable Care Organization" (ACO). The final rules for ACOs have not yet been published. The following is one description of the ACO:

> "…is a local health care organization that is accountable for 100 percent of the expenditures and care of a defined population of patients. Depending on the sponsoring organization, an ACO may include primary care physicians, specialists and, typically, hospitals, that work together to provide evidence-based care in a coordinated model. The three major foci of these organizations are: 1) Organization of all activities and accountability at the local level, 2) Measurement of longitudinal outcomes and costs, 3) Distribution of cost savings to ACO members."

How Do ACOs Differ from Medicare Advantage and Tradition Insurance

Of course, some of ACO functions are like those of traditional insurance. The differences are that Medicare still pays the bills rather than the ACO and Medicare is liable for paying all of costs whether they exceed a budget or an expected expenditure, or not. In "managed care" system and particularly in the case of Medicare Advantage programs, Medicare transfers its risk to the Health Maintenance Organization (HMO) which allows Medicare to budget its cost for each Medicare member. No matter what the actual cost of care is, Medicare will never pay the HMO more than the contracted per member payment.

Traditional insurance defines its risk by contract. Medicare Advantage defines its risk by its "bid," which is a contractual relationship with CMS which defines the benefits in addition to the regular Medicare benefits. In both cases, insurance companies and Medicare Advantage plans have no protection from "down-side" risk, i.e., the potential for the care of a patient or client costing more than what the insurance company is paid.

ACOs differ in that, as it is presently designed, ACO's have no "down-side" risk, i.e., if care costs more than expected, the ACO does not have to fund the additional cost, all the ACO loses is the profit which was only potential. And, as it is presently designed, while there are responsibilities to demonstrate that the ACO is providing traditional Medicare services, there is no requirement, as with Medicare Advantage, for the ACO to provide services in excess of what Medicare provides.

What is required to make ACOs' Work?

ACOs may result in the radical change in healthcare which is hoped for. The probability of this occurring will be increased if the following pitfalls are recognized and avoided.

Revenue-Sharing Model

First, it may be that the highest probability of success may occur in integrated devilry networks such as staff model HMOs. They already have an electronic infrastructure in most instances, which can be adapted to the functions needed for ACO accountability and accounting. In the same way, non-staff model HMOs with strong relationships with Independent Physician Associations (IPAs) may also have an increased probability of success. When the staff model has an ownership interest in hospitals, the potential for success is enhanced significantly. The principle reason for the higher potential of success in these instances is they already have a model for the sharing of revenue and the participants have already accepted the details of that revenue-sharing model. This will be one of the biggest hurdles for other ACOs.

When the participants in an ACO do not have an integrated financial relationship, it will be very difficult to hold the group together once the division of profits begins to take place. Our health care system has placed high value on facility and procedure services and has placed little to no value on comprehensive and coordinated care. There is nothing structurally within the ACO model to date which addresses that dichotomy in anything but a *Laissez-faire* manner. The division of the financial benefits of the ACO may be its Achilles heel.

Herein lies the most challenging task for ACOs determined to succeed. Finding a venue model which equitably shares revenue, valuing elements of care which are not pivotal to ACOs success but which have traditionally been undervalued or unvalued.

Avoiding the Hazard of Involuntary Enrollment

Second, patients who understand the benefits of restricted-access healthcare (managed care) have already elected to join Medicare Advantage programs. One of the trade-off is that for agreeing to see only certain healthcare providers, the patient receives increased benefits and reduced cost. This methodology has increased access to healthcare for many. Others, either because of excellent insurance or personal resources, have rejected that model of care, even though it can be demonstrated that Medicare Advantage is providing excellent care. To involuntarily enroll those who have previously rejected a “managed care” model creates an ethical dilemma.

The ACO can avoid this pitfall by transparently notifying those whose care is to be managed in an ACO. And, the ACO must enroll only those who give prior consent to do so. As with patient-centered medical home, engaging the patient as a partner in preserving American healthcare with improved quality by cost savings is the best solution to this potential hazard. . The involuntary enrollment of patients into ACOs creates a potential legal hazard in the event of an adverse outcome, particularly if the patient wanted to go to one provider and was sent to another. That would probably not be the cause of the negative outcome but the ACO will bear the burden of proving that. The potential hazard is avoided by full disclosure and informed consent.

Hospital Interests and the Potential for a Perverse Effect

Third, one of the principle means of the ACOs creating financial savings will be the using of lower levels of care, i.e., outpatient rather than inpatient services. If hospitals are partners in the ACO, they will recognize that the increased savings often result from decreased utilization of their services and they will expect a significant if not majority share of the profits. In their own defense, hospitals will increase their competition with ambulatory-care providers, both by owning medical practices and by opening their own ambulatory-care centers. The perverse result could be not only increasing competition, which in this unique case might drive up cost, but also make appropriate and beneficial collaboration between hospitals and independent healthcare providers more difficult. Increasing cost savings at the expense of the hospital could also create the situation where essential and expensive care could be limited due to increasing financial pressure on the hospitals.

This hazard and perverse effect can be avoided by dialogue between the ambulatory providers and the hospital. Each must recognize and respect the role of the other. With such dialogue, strategies for quality improvement and cost savings. With ambulatory care providers working with hospitals to improve lengths of stay and thus the effective return on DRGs, to decrease preventable readmissions and to prevent redundant and expensive care, a true collaboration between inpatient and outpatient care can be achieved. This partnership between hospital and healthcare provider can go a long way to avoiding the perverse effect of conflicting interests.

Rebuilding Trust in Healthcare Providers Rather than Technology
Patient-Centered Medical Home

Fourth, in an age where most patients have more confidence and trust in technology – procedures, tests, etc. – than they do in a personal relationship with a healthcare provider, the principle way to decrease the cost of care is to ration care by structurally decreasing access to care. The best way to change that cost curve it to restore patient trust in their healthcare providers where their counsel is sought before a test is ordered. This is the reason why, any ACO which has the least potential for success must be built upon healthcare providers who are not only have the designation but who are also actually functioning in a patient-centered medical home. It is only with compassionate, comprehensive, coordinated and collaborative care that the relationship with provider and patient can recreate the trust bond which supersedes technology in the healthcare-decision-making equation. In that trusting relationship, wise decisions can be made about watchful waiting, appropriate end-of-life care and a balance between life expectance with and without expensive but unhelpful care. Increasingly, we have to wonder if technological advances are actually resulting in a decreased rather than an increased quality of life.

Avoiding Duplication of Infrastructure

Fifth, except in the case of existing staff-model HMOs and/or functioning IPAs, the infrastructure cost of forming and sustaining an ACO is going to much higher than most people think. This cost is going to be incurred without any guarantee of recovery and unless the issues addressed herein are resolved a great deal of infrastructure may be built without benefit in quality or cost of care. Those who wish to pursue the formation of an ACO should consider partnering with those who have a significant infrastructure avoiding the need for duplication.

Annual Reconciliation

Sixth, at present the ACO design is based on an annual reconciliation of cost with the potential for sharing the savings realized. It is highly improbable that that is a sustainable model. It is more likely that the reconciliation will be multi-year with either a gong-forward withhold for past losses or a with hold of earned savings in anticipation of possible adverse results in the future. IBNR is a well-know phrase in healthcare finance. It stands for "incurred but not received" and refers to services which have been provided but for which the bill has not yet been presented. Financial planning for a successful ACO must take into account fluctuations in results. Careful cash management with adequate capitalization initially can help the ACO weather revenue shortfalls and benefit from positive results in the good times. The first step is to anticipate multi-year reconciliation and to build a business model on that expectation.

Benefit to the Patient

Seventh, inherent in this entire discussion is the fact that the ACO is a public-policy initiative which has no inherent value to the patient but only to the ACO and to CMS. The re-organization of healthcare by the ACO is potentially good and the principles of medical home are extremely valuable if incorporated into the ACO model by specific requirement rather than by co-incidence. But, the reality is there is no structural benefit for the patient. This deficient can be resolved by the internal policies of the ACO which concentrates on comprehensive, preventative health with wellness metrics and with coordination of care. In this way, the patient returns to the focus whether or not the ACO "makes money."

ACOs may work and many of us hope they do, but to do so they have to answer these questions before they start.