

Accountable Care Organizations

Too often health care decisions that benefit one provider or payer financially disadvantage another, encouraging decisions based on narrow economic interests rather than savings to the overall system or the needs of patients. The need to align incentives to promote quality and efficiency are behind the concept of Accountable Care Organizations (ACOs).ⁱ Proposed in 2006ⁱⁱ ACOs are integrated networks of local providers across the care continuum, including hospitals, physicians and affiliated providers that are paid based on their ability to provide quality care and restrain costs. ACOs share in the savings they generate as a network by coordinating care, reducing overuse or misuse of care, eliminating wasteful duplication of services, providing wellness programs, and patient support. ACOs shift the emphasis from payment for utilization to payment for health outcomes.ⁱⁱⁱ ACOs can be fully integrated health systems, such as the Cleveland and Mayo Clinics, or geographically diverse networks of providers connected through contractual relationships, such as Geisinger Health System in Pennsylvania. The core of the ACO concept is that the parts work as a coordinated entity in the shared goals of improving both the quality and efficiency of care. The Congressional Budget Office estimates that creation of ACOs could save Medicare \$5.3 billion in the next ten years even after returning significant savings back to the provider network.^{iv} Medicare savings are estimated at \$300 to 400 per patient per year.^v

ACOs differ from managed care plans in several ways – ACOs do not have to be at financial risk as HMOs are, but can share in the savings resulting from their efforts. Accountability rests with providers and their treatment decisions rather than insurance companies. ACOs also allow for flexible structures in different regions^{vi}.

While past efforts to align incentives across health care stakeholders have not been successful, there is optimism that ACOs may be more successful. The health care market has evolved significantly since managed care reforms of the 1990's with providers more willing to enter into contractual alliances with other providers and institutions. Much has also been learned about how to measure and reward the quality of health care delivered. Payers are investing in effective use of information technology that will facilitate care coordination and efficiency.^{vii}

ⁱ P. Galewitz, ACOs: A Quick Primer, Kaiser Health News, July 17, 2009.

ⁱⁱ E. Fisher, et. al., Creating Accountable Care Organizations: The Extended Hospital Medical Staff, Health Affairs 26:w44-57, January/February 2007.

ⁱⁱⁱ Reforming Provider Payment: Moving Toward Accountability for Quality and Value, Issue Brief, Dartmouth Institute for Health Policy & Clinical Practice and Engelberg Center for Health Care Reform at Brookings, March 2009.

^{iv} Budget Options, Volume 1: Health Care, Congressional Budget Office, December 2008.

^v E. Fisher, et. al., Fostering Accountable Health Care: Moving Forward in Medicare, Health Affairs 28:w219-231, January 2009.

^{vi} What are Accountable Care Organizations?, Healthcare Economist, January 26, 2010; K. Devers and R. Berenson, Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandries?, Urban Institute, October 2009.

^{vii} M Gold, Accountable Care Organizations: Will They Deliver?, Mathematica Policy Research, January 2010.