

Health Care Reform: What Are Accountable Care Organizations

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A component of the Obama Administration's national health care reform legislation that has risen to the headlines recently are "accountable care organizations" ("ACO's").

What are ACO's and what exactly are they intended to do?

To answer these questions, we need to revisit the fundamental assumptions underlying the Obama Administration's national care health reform legislation. The Obama Administration believes that compared to other countries:

1. the cost of health care in the United States on a per capita basis is too high
2. the health of the United States population is too low
3. health care in the United States is not sufficiently accessible, particularly for the uninsured
4. health care in the United States is not sufficiently coordinated
5. the quality of health care services in the United States is too low
6. the federal government, as the largest purchaser of health care services in the United States, has the right to demand high quality, reasonably priced, accessible, coordinated health care services
7. the federal government should no longer purchase health care services on a fee-for-service (or a la carte) basis because it gives health care providers an incentive to order more tests and perform more procedures in order to make more money
8. there needs to be a "sea change" in how health care is delivered and paid for in the United States

ACO's are a first step in this sea change

According to the national health care reform legislation, an ACO is a group of providers who are willing to work together to manage and coordinate the care of the Medicare fee-for-services beneficiaries assigned to them and who are willing to be accountable for the quality, cost, and overall care of these beneficiaries. Under the legislation, Medicare will continue to pay the providers in the group for the services that they provide to these Medicare beneficiaries on a fee-for-service basis. However, if the group--through the management and coordination of the these Medicare beneficiaries' care--is able to provide high quality, accessible care to these Medicare beneficiaries at a significant savings to Medicare, then the providers in the group get to share in this savings. The ultimate goal is not to pay providers on the basis of the number of tests they order and procedures they perform, but rather on the basis of their provision of high quality, accessible, coordinated, low cost care.

Under the legislation, groups that can qualify as ACO's include:

1. hospitals employing professionals
2. partnerships or joint ventures between hospitals and professionals
3. group practices
4. networks of individual providers
5. such other groups as Medicare deems appropriate

The group must agree to take care of at least 5,000 Medicare fee-for-service beneficiaries and must have a sufficient number of primary care physicians for the number of beneficiaries assigned to it.

Medicare recently issued a 429-page set of proposed rules to implement the ACO provisions of the legislation. These proposed rules were met with widespread criticism from the health care industry because the requirements for an ACO were extremely burdensome, the cost of developing an ACO was extremely high, and the benefits of developing an ACO were too uncertain. Medicare estimated that the average cost of developing an ACO would be approximately \$1,800,000. In contrast, the American Hospital Association estimated that it would cost a 200-bed, single hospital system approximately \$11,600,000 and a 1,200-bed, five hospital system approximately \$26,100,000 to develop an ACO.

In response to this criticism, Medicare has proposed three initiatives to get ACO's up and running as soon as possible. The first initiative is the Pioneer ACO Model. Under the Pioneer Model, health care delivery systems that already have the providers and systems in place to manage and coordinate care would be permitted to become ACO's and to move from a shared savings model to higher risk/reward models quickly. The second initiative is the Advanced Payment Initiative. Under this initiative, Medicare would pay an ACO a portion of its anticipated savings up front in order help the ACO cover its start-up costs. The third initiative is a series of educational sessions for those interested in becoming an ACO.

The future for ACO's in West Virginia is uncertain. Because of the extraordinarily high cost of developing an ACO, there are very few entities in West Virginia that could afford to develop an ACO.