Accountable Care Organizations: Back to the Future?

Editor’s note: Accountable Care Organizations (ACOs) are networks of providers that assume risk for the quality and total cost of the care they deliver. Public policymakers and private insurers hope that ACOs will achieve the elusive “triple aim” of improving quality of care, improving population health, and reducing costs. The model is still evolving, but the premise is that ACOs will accomplish these aims by coordinating care, managing chronic disease, and aligning financial incentives for hospitals and physicians. If this sounds familiar, it may be because the integrated care networks of the 1990s tried some of the same things, and mostly failed in their attempts. This Issue Brief summarizes the similarities and differences between the new ACOs and the integrated delivery networks of the 1990s, and presents the authors’ analysis of the likely success of these new organizations in affecting the costs and quality of health care.

The move toward ACOs comes from the need to contain costs in the Medicare program. The Affordable Care Act authorized Medicare to contract with ACOs, which will assume risk for the quality and costs of care they deliver. As envisioned by its proponents, ACOs will save money because they will reorganize care to be more effective and efficient. Each ACO must care for at least 5,000 Medicare recipients for at least three years, and agree to meet certain quality standards and cost targets. If an ACO saves money, it shares in the savings; if it puts itself at risk for losing money, it can gain a larger share of the savings.

- Two assumptions underlie the promise of ACOs: that better care coordination will improve quality at any given cost, and that ACOs will slow the rate of growth in Medicare spending. The Centers for Medicare and Medicaid Services (CMS) estimates that ACOs will save the federal government $940 million over four years, if 270 organizations participate in the program.
- To date, CMS has awarded contracts to 153 ACOs. The majority of them are led by hospital systems, although some are spearheaded by physician groups. The number of contracts is expected to double after another round of awards in January 2013.
- In theory, ACOs will improve quality and lower costs using several methods, including disease management programs, improved care coordination, alignment of incentives for physicians and hospitals via shared savings, use of nonphysician providers, and the formation of patient-centered medical homes.
ACOs resemble integrated delivery networks of the 1990s in some ways

This latest attempt at reorganizing care strongly resembles the integrated delivery networks (IDNs) of the 1990s, which linked physicians, hospitals, and alternative care sites. Hospitals created joint ventures with their medical staffs and formed physician-hospital organizations and management services organizations to negotiate contracts with insurers.

- Both models emphasize coordination of care and disease management. Both focus on primary care providers as the key to improving quality, managing risk, and controlling costs.
- Structurally, both models encourage horizontal consolidation of hospitals and vertical (or virtual) integration of hospitals, physicians, and providers of postacute care.
- Payment systems in both models seek to escape the volume incentives of fee-for-service by relying on risk contracting, capitation, and employed physicians.

ACOs differ from integrated networks in other ways

However, ACOs are not just another name for the integrated networks of the 1990s. There is less consensus now on what should be the ACO’s organizational core—a hospital system, physician group practice, or some wholly new type of organization—and over what the new entity should do, or stop doing, to reduce spending.

- In contrast to the earlier networks, the impetus for ACOs comes from the demand side (CMS) rather the supply side (providers). CMS is patron and protector of the current restructuring effort, seeking to bring down costs to help alleviate the federal deficit.
- In the 1990s, there was some agreement that capitated contracts between insurers and IDNs would cut costs by reducing hospital admissions and inpatient days, and by restricting out-of-network utilization. In contrast, Medicare ACOs cannot directly control patients’ choice of physician or health care utilization.
- More than 20 years later, ACOs may benefit from more advanced information technology and more sophisticated payment systems than the IDNs. ACOs are developing alternative payment systems beyond capitated arrangements, such as bundled payments and shared savings through pay-for-performance for providers.

What the network experience tells us about ACOs

For the most part, IDNs did not deliver on their promises. They lacked the information technology needed to manage risk contracts; they overpaid for physician practices; they acquired hospitals without achieving economies of scale; and they failed to coordinate care for most beneficiaries. What might the ACOs learn from this experience to avoid the same fate?

- Although they were labeled integrated and networks, most of the earlier organizations did not have unified governance and did not take a systems approach to organizational planning. ACOs will need to pay more attention to integrating everything from personnel matters to physician culture.
- Coordination among multiple providers is harder than it sounds. And it poses daunting challenges, as Medicare fee-for-service beneficiaries see an average of two primary care providers and five specialists across four sites of care annually.
The parallels between the ACOs and the IDNs seem quite strong, raising concerns that the newer entities will have the same fate as the earlier networks. In the 1990s, the ability of IDNs to achieve economies of scale and a seamless continuum of care was oversold. Today, policymakers need to realistically assess and periodically revisit the promises and premises of ACOs.

- Just like the 1990s networks, ACOs need to target specific population segments that would benefit most from coordinated care, such as people with multiple chronic conditions. Coordination will not likely reduce total expenditures for the broader low-risk Medicare population.
POLICY IMPLICATIONS

Continued

• Strategic change needs to be carefully implemented. Providers may need to pay more attention to change management and devote considerable time and money to infrastructure features and capabilities. Although CMS wants organizations to assume greater risk within three years, research on organizational change suggests a more realistic window is five to seven years.

• Medicare’s need to slow growth of its payments may move it toward providing a budget-based capitation payment. It may be that Medicare will give a set amount to ACOs, and ACOs will do the best they can with that amount. If that happens, it will be a true test of how much waste there is in the system.

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