



Accountable Care Organizations: *A new model for sustainable innovation*



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Foreword



As the 2010 Patient Protection and Affordable Care Act (PPACA) begins to be implemented, the likelihood of changes in payment models that reward provider performance and enhance coordination of care is high. Consumer satisfaction with the U.S. health care system is suboptimal: Only 20 percent of adults grade it “A” or “B” versus 38 percent who give it a “D” or “F.”¹ Redundant paperwork, unnecessary tests, avoidable complications and readmissions, high costs and poor service plague the system.

Accountable care organizations (ACOs) are proposed by some as the solution to these problems. The alignment of physicians, hospitals and other providers into risk-bearing organizations is not a new idea: Just a decade ago, physician-hospital organizations offered similar promise. However, the alignment of primary care physicians with specialists, hospitals, health plans and other industry stakeholders proved unusually challenging.

This paper offers a current assessment of ACOs – their structures, capabilities and challenges – and explores the likelihood that this new model will become a sustainable innovation in health care delivery.

Respectfully,

A handwritten signature in blue ink, reading "Paul H. Keckley".

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¹ 2009 Survey of Health Care Consumers, Deloitte Center for Health Solutions, http://www.deloitte.com/dtt/cda/doc/content/us_chs_2009SurveyHealthConsumers_March2009.pdf. Accessed January 31, 2010

Abstract



To understand how accountable care organizations (ACOs) might drive payment reform in the public and private health care sectors, this paper reviews the basic origins, definition and drivers of ACOs, and describes key features of proposed ACO initiatives, including the federal government's proposed pilot program. In addition, using an assessment of ACO literature and Deloitte analysis, the paper profiles four structural approaches that are eligible for ACO status and puts forth seven key capabilities that are important considerations for ACO performance. Finally, this paper offers Deloitte's perspective on the path forward and describes potential innovations that could increase ACO adoption.

Executive summary

Accountable care organizations (ACOs) are a method of integrating local physicians with other members of the health care system and rewarding them for controlling costs and improving quality. While ACOs are not radically different from other efforts to improve the cost-effectiveness of health care delivery, such as health maintenance organizations (HMOs), physician-hospital organizations (PHOs) and independent practice associations (IPAs), their innovation lies in the flexibility of their structure, payments and risk assumption. Similar to physicians in integrated health care delivery systems, such as the Mayo Clinic, Geisinger and Intermountain Healthcare, ACO physicians are accountable for the outcomes and expenditures of their assigned population and are tasked with collaboratively improving care to reach cost and quality targets set by the payor. ACOs can be either voluntary or involuntary, and distribute bonuses when targets are met as well as levy penalties when targets are missed.

A functional ACO should include, at a minimum, primary care physicians, specialists and, typically, a hospital; it also should be able to administer payments, set benchmarks, measure performance and distribute shared savings.

A variety of federal, regional, state and academic hospital initiatives are investigating how to implement ACOs. Currently, ACO specifications are flexible enough to accommodate a range of provider organizations, including fully integrated health care systems, multi-specialty group practices, physician hospital organizations and independent physician associations.

The 2010 Patient Protection and Affordable Care Act (PPACA) includes a Medicare pilot ACO program which aims to explore optimal ACO structures and processes. The program is voluntary and bonuses are distributed based on cost benchmarks set by the Secretary of Health and Human Services (HHS). The pilot program also leaves it to the Secretary's discretion to determine an organization's eligibility. Other programs in Massachusetts and Vermont, at Baylor, and through the Dartmouth/Brookings ACO collaborative, are attempting to understand which entities work best and in which region.

Based on an assessment of ACO literature coupled with Deloitte's analysis, this paper concludes that successful ACOs are more likely to have specific competencies in governance and leadership, operational and clinical effectiveness, IT and infrastructure, risk management and workforce organization.

Finally, to enable ACOs to lower costs and improve care, health plans and providers should consider reasonable targets to reduce spending and improve outcomes. At the same time, physicians and consumers will look for a rationale to participate. Because the best ways to do this will likely depend on regional and cultural factors inherent in individual health care delivery systems, there is considerable value in ACO structural and operational flexibility.

Drivers of payment reform

Among the drivers of health care payment reform which support the need for ACO adoption are:

- **Increased attention to regional variation in costs and quality:** The need for better but less expensive health care delivery is a major issue driving U.S. health care reform. Regardless of the final impact of reform, pressure to reduce inappropriate variation and costs is expected to escalate. Studies indicate patients may pay more for care that does not correlate to optimal outcomes.^{2,3} Furthermore, regional differences in health care supply, delivery and practice lead to variations in spending that do not correspond to health care quality.^{4,5,6} Taken together, these regional variations are significantly increasing the overall cost of health care and threatening the sustainability of the U.S. health care system.^{7,8,9,10,11}
- **Increased efforts to align payment incentives with performance rather than volume:** It is hypothesized that the traditional Fee for Service (FFS) model incentivizes physicians and facilities to perform services but not to coordinate care and improve patients' overall health.¹² In 2008, the Commonwealth Fund polled over 200 opinion leaders in the health care industry and found that 70 percent of respondents believed that the current FFS system leads to inefficiencies in care.¹³ When asked, the majority of opinion leaders cited fundamental payment reform and incentives for care quality as key measures to improve the overall performance of the U.S. health care system.¹⁴ Because the United States' volume-based incentive structure is one of the drivers of projected cost increases, which are expected to be over six percent per year through the end of the decade, alternatives that reward lowest-cost/highest-outcome results are considered necessary to slow the health cost spiral forecast.

² Fowler FJ, et al. "Relationship Between Regional Per Capita Medicare Expenditures and Patient Perceptions of Quality of Care," 2008, *JAMA*, Vol. 299, no. 20, pp. 2406–2412

³ Chandra A and Baicker K. "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," 2004, *Health Affairs*, Vol. 23, pp. w184–w197

⁴ Fisher ES, et al. "The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care," 2003, *Health Affairs*, pp. 273–87

⁵ Fisher ES, et al. "The implications of regional variations in Medicare spending. Part 2: The content, quality, and accessibility of care," 2003, *Health Affairs*, pp. 288–98

⁶ Wennberg JE, Fisher ES and Sharp SM. "The Care of Patients with Severe Chronic Illness: An Online Report on the Medicare Program by the Dartmouth Atlas Project," 2006, *The Dartmouth Atlas of Health Care*, http://www.dartmouthatlas.org/atlas/2006_Chronic_Care_Atlas.pdf. Accessed January 21, 2010

⁷ Skinner J. *The Implications of Variations in Medicare Spending for Health Care Reform*. Invited Testimony Committee on Energy and Commerce United States House of Representatives 2009. United States House of Representatives

⁸ Orszag PR and Ellis P. "The Challenge of Rising Health Care Costs – A View from the Congressional Budget Office," 2007, *New England Journal of Medicine*, Vol. 357, pp. 1793–1795

⁹ Bynum J, Fisher ES and Skinner J. *The Policy Implications of Variations in Medicare Spending Growth*, 2009, The Dartmouth Institute for Health Policy and Clinical Practice. http://www.dartmouthatlas.org/atlas/Policy_Implications_Brief_022709.pdf. Accessed February 4, 2010

¹⁰ Fisher ES, Bynum J, and Skinner J. "Slowing the Growth of Health Care Costs – Lessons from Regional Variation," 2009, *The New England Journal of Medicine*, Vol. 360, no. 9, p. 849–852

¹¹ Orszag, PR and Ellis P. "Addressing Rising Health Care Costs – A View from the Congressional Budget Office," 2007, *New England Journal of Medicine*, Vol. 357, pp. 1885–1887

¹² Hackbarth GM. MedPAC Medicare Payment Advisory Commission, *Reforming America's Health Care Delivery System*, 2009, Senate Finance Committee Roundtable on Reforming America's Health Care Delivery System. <http://www.medpac.gov/documents/Hackbarth%20Statement%20SFC%20Roundtable%204%2021%20FINAL%20with%20header%20and%20footer.pdf>. Accessed February 4, 2010

¹³ Stremikis K, Guterman S and Davi K. *Health Care Opinion Leaders' Views on Payment System Reform*, 2008, The Commonwealth Fund. <http://www.commonwealthfund.org/Content/Publications/Data-Briefs/2008/Nov/Health-Care-Opinion-Leaders-Views-on-Payment-System-Reform.aspx>. Accessed January 31, 2010

¹⁴ Ibid

Overview: Accountable care organizations

The PPACA includes a number of payment reform pilots which will be evaluated for impact on the unsustainable growth of health care spending; among these are medical homes, pay for performance (P4P), a CMS Payment Innovation Center and the creation of accountable care organizations (ACOs). Because ACOs are theorized to increase health care quality while decreasing costs, the concept is generating significant interest from both government and private payors.

Additionally, because the ACO structure proposes to give providers more autonomy and financial incentive to practice better and more efficient medicine, there may be an adequate provider business case to ensure eventual, widespread participation.

Definition

An 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.

The conceptual framework

The ACO idea originated from a number of health policy thought leaders interested in practical solutions to implement integration and coordination of care.^{15,16} Work from the Dartmouth Institute for Health Policy and Clinical Practice suggested that, although formal integration of health care providers can be labor-intensive and unpopular, local “virtual” networks of providers were already working together to care for their patient population.^{17,18} These virtual networks, sometimes referred to as “the extended hospital medical staff organization” (HMSO), could be held accountable for health care quality and costs. Because HMSOs already exist, there is no need to force collaboration. Furthermore, to reflect regional differences in health care supply and practices, it has been proposed to incentivize the HMSOs to moderate spending relative to their past performance rather than a national benchmark.

The concept of integrating and coordinating health care delivery is not new. For example, membership in HMOs increased in the 1990s as health plans, hospitals and physicians sought to capitalize on greater cooperation to deliver more cost-effective health care.^{19,20} Unlike these previous iterations, however, ACOs would rely on providers to review their own work and set standards rather than payors. Additionally, by taking advantage of existing communities, rather than consolidating physician groups with hospitals as was done in the ‘90s, the resulting ACO would be a more harmonious construct.^{21,22,23}

¹⁵ Shortell SM and Casalino LP. *Accountable Care Systems for Comprehensive Health Care Reform*. March 1, 2007, Robert Wood Johnson Foundation Research and Publications. <http://www.rwjf.org/pr/product.jsp?id=32861>. Accessed January 24, 2010

¹⁶ Fisher ES, et al. “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” December 5, 2007, *Health Affairs*, Vol. 26, pp. w44-w57

¹⁷ Ibid

¹⁸ Fisher ES, et al. “Fostering Accountable Health Care: Moving Forward in Medicare,” January 2009, *Health Affairs*, Vol. 28, pp. w219-w231

¹⁹ Emanuel L, et al. “Bringing Market Medicine to Professional Account,” March 12, 1997, *JAMA*, Volume 277(12), pp. 1004-1005

²⁰ Employer Health Benefits Annual Survey, 2009, The Kaiser Family Foundation & Health Research and Educational Trust, <http://ehbs.kff.org/pdf/2009/7936.pdf>. Accessed January 14, 2010

²¹ Fisher ES, et al. “Fostering Accountable Health Care: Moving Forward in Medicare,” January 2009, *Health Affairs*, Vol. 28, pp. w219-w231

²² Hackbarth GM. MedPAC Medicare Payment Advisory Commission, *Reforming America's Health Care Delivery System*, 2009, Senate Finance Committee Roundtable on Reforming America's Health Care Delivery System. <http://www.medpac.gov/documents/Hackbarth%20Statement%20SFC%20Roundtable%204%2021%20FINAL%20with%20header%20and%20footer.pdf>. Accessed February 4, 2010

²³ McKethan A and McClellan M. “Moving From Volume-Driven Medicine Toward Accountable Care,” August 20, 2009, *Health Affairs Blog*. Accessed January 14, 2010

Nor is the concept of paying for performance (P4P) novel. However, in the case of ACOs, rather than being held to a national benchmark derived from aggregate data, the ACO would be rewarded for achieving gains against its own baseline. This would help control national spending while taking into account the wide variation in regional populations, practices and resulting spending.

MedPAC weighs in

ACOs transitioned from a concept to a proposed federal payment program when the Medicare Payment Advisory Commission (MedPAC) recommended that Congress consider ACOs, among other payment reforms, as a way to slow the trajectory of Medicare spending.²⁴ In its report to Congress, MedPAC suggested that an ACO should:²⁵

1. Be composed of a minimum of 5,000 patients so that improvement could reliably be measured.
2. Be held to a fixed dollar spending target in advance.
3. Have a formal organization and structure that allows ACOs to make joint decisions on capacity.
4. Have both private and public payors to ensure that physician incentives are uniform across the payor mix.
5. Either:
 - a. Be voluntary, wherein high performance is rewarded with bonuses for quality and cost control – in which case MedPAC acknowledges that FFS rates need to be constrained to reduce overall spending; or
 - b. Be mandatory, wherein overall spending is reduced with bonuses for quality or cost targets, or a mandatory organization where both bonuses and penalties are applied.



²⁴ MedPAC Medicare Payment Advisory Commission, Report to the Congress: Improving Incentives in the Medicare Program: Chapter 2, June 2009, http://www.medpac.gov/documents/Jun09_EntireReport.pdf. Accessed February 10, 2010

²⁵ Ibid

Key components of ACOs in the recently enacted federal pilot

The 2010 Patient Protection and Affordable Health Care Act includes a pilot ACO program which takes effect on January 2012. While both the House and Senate proposed ACO pilots, the enacted law includes only Medicare beneficiaries in the initial pilot and specifies widespread implementation if successful.^{26,27,28}

The exact specifications of an ACO are left to the discretion of the Secretary of HHS.^{29,30,31} The idea is to use the demonstration project to determine what structures and processes work best and for which region of the country, as in "let the market decide."³²

Eligible organizations: Proposals point to four organizational models that are eligible to be an ACO; however, ultimately, any organization deemed appropriate by the Secretary is likely to be eligible.

Payments and bonuses: The Senate version of the bill indicated that ACOs are eligible for bonuses if they meet both a quality and cost benchmark;^{33,34} however, this may transition to bundled payments if shown to be successful.³⁵ The draft legislation states that per-capita Medicare spending should be below a benchmark set and adjusted yearly at the discretion of the Secretary.³⁶ According to the proposed law, the benchmark will combine the projected national growth rate and the local patient characteristics. It is likely that ACO payments will follow the construct in the Senate bill, aligning ACOs with episode-based payments for Medicare and, perhaps, other plans.

Key features of an ACO: The organizations that can become an ACO and their bonus targets are flexible; however, the proposals stipulate that an eligible organization desiring to be an ACO should demonstrate the following seven capabilities:

1. Define processes to promote care quality, report on costs and coordinate care.
2. Develop a management and leadership structure for decision making.
3. Develop a formal legal structure that allows the organization to receive/distribute bonuses to participating providers.
4. Include the PCPs of at least 5,000 Medicare beneficiaries
5. Provide CMS with a list of participating PCPs and specialists.
6. Have contracts in place with a core group of specialist physicians.
7. Participate for a minimum of three years.

²⁶ H.R. 3590, 111th Cong. 2009, "Patient Protection and Affordable Care Act," Washington, DC: US Senate, 2009

²⁷ H. R. 3962, 111th Cong. 2009, "Affordable Health Care for America Act," Washington, DC: US House of Representatives, 2009

²⁸ Kaiser Family Foundation, *Side-by-Side Comparison of Major Health Care Reform Proposals*, 2009, The Kaiser Family Foundation

²⁹ H.R. 3590, 111th Cong. 2009, "Patient Protection and Affordable Care Act," Washington, DC: US Senate, 2009

³⁰ H. R. 3962, 111th Cong. 2009, "Affordable Health Care for America Act," Washington, DC: US House of Representatives, 2009

³¹ *Side-by-Side Comparison of Major Health Care Reform Proposals*, 2009. The Kaiser Family Foundation

³² ACO Fundamentals, November 2, 2009, Brookings-Dartmouth ACO Learning Network, <https://xteam.brookings.edu/bdacoln/Pages/Webinars.aspx>. Accessed December 20, 2009

³³ H.R. 3590, 111th Cong. 2009, "Patient Protection and Affordable Care Act," Washington, DC: US Senate, 2009

³⁴ *Side-by-Side Comparison of Major Health Care Reform Proposals*, 2009. The Kaiser Family Foundation

³⁵ Ibid

³⁶ Ibid

Emerging ACO pilots reflect increased interest

ACOs originated from the desire to have smaller groups replicate larger organizations, such as the Mayo Clinic, Geisinger and Intermountain Healthcare, whose success is proposed to rest on the collaborative culture of their physicians, continual process improvements and aligned incentives. Currently, a number of pilot programs across the country and in different institutions are testing this hypothesis, including the following:

Dartmouth Institute for Health Policy and Clinical Practice and the Brookings Institute: As part of the Dartmouth/Brookings Institute ACO collaborative, three sites – the Carillion Clinic (VA), Norton Healthcare System (KY) and the Tucson Medical Center (AZ) – have signed on for an ACO pilot program with private payors and, eventually, Medicaid.^{37,38} Additionally, the ACO collaborative is providing a toolkit and learning community for a wide range of health care systems that are interested in implementing their own ACOs.^{39,40}

Massachusetts: Massachusetts' Special Commission on the Health Care Payment System proposed that the state move from FFS payment to a "Patient-Centered Global Payment System" in which capitated payments would be made to ACOs.⁴¹ In July 2009, the Commission made recommendations to the legislature and governor on how to implement ACOs and other payment reforms.⁴² Unlike the proposed federal pilot, Massachusetts is considering a system that would allow providers to assume risk and take into consideration patient preferences.

Vermont: As part of its "Blueprint for Health" reform initiative, Vermont passed legislation to pilot an ACO that would be integrated with the "Blueprint for Health" Enhanced Medical Home.⁴³ The state currently has three potential ACOs enrolled in the joint Dartmouth/Brookings Institute national ACO learning project and at least one is poised to implement in 2010.⁴⁴

Colorado: As part of the state's Medicaid reform effort, Colorado created the Accountable Care Collaborative. This project is focused on delivering efficient and coordinated care that improves the overall health of clients. The state will implement this program in late 2010 starting with 60,000 clients. If the program demonstrates success, it will be expanded in later years.⁴⁵

Academic hospitals: Both Baylor hospital system and the Robert Wood Johnson Foundation (RWJF) are piloting test ACOs. The pilot program at the Robert Wood Johnson Medical School in New Jersey will include 100-150 physicians, various specialties and will be linked to half a dozen hospitals. RWJF's bonus and payment structure is still to be determined.⁴⁶ Baylor is planning to incorporate 4,500 physicians and 13 of its hospitals into an ACO and implement a bundled payment system to control costs. As part of Baylor's plan to increase participation, it is directly marketing the ACO idea to employers and offering them lower costs in exchange for, possibly, limited health insurance plan choices.^{47,48}

³⁷ Cys J. *Accountable care organizations: A new idea for managing Medicare*. August 31, 2009, American Medical Association, <http://www.ama-assn.org/amednews/2009/08/31/gvsa0831.htm>. Accessed January 25, 2009

³⁸ Lewis J. *Accountable Care Organizations: Forging Stakeholder Partnerships for Health Care Performance and Efficiency*, January 20, 2010. Dartmouth Institute for Health Policy and Clinical Practice, Northeast Home Health Leadership Summit, <http://www.hca-nys.org/documents/LewisAccountableCareOrganizations.pdf>. Accessed January 25, 2010

³⁹ Ibid

⁴⁰ Lewis J. *What Could be Next for Health Care? The Debate in Washington, 2009*, The Dartmouth Institute for Health Policy

⁴¹ Kirwan LA and Iselin S. *Recommendations of the Special Commission on the Health Care Payment System, 2009*, Division of Health Care Finance and Policy-Commonwealth of Massachusetts, http://www.mass.gov/Eohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf. Accessed January 25, 2010

⁴² Kowalczyk L. "Hospitals attack state pay proposal," October 4, 2009, *Boston Globe*. http://www.boston.com/news/local/massachusetts/articles/2009/10/04/health_executives_wary_of_proposed_payment_system_appeal_to_patrick/. Accessed January 21, 2010

⁴³ Vermont-2009 State Quality Improvement Institute: Accountable Care Organizations (ACOs) Meeting Presentations & Resources, AcademyHealth, <http://www.academyhealth.org/files/SQII/StateWrite-ups.pdf>. Accessed January 21, 2010

⁴⁴ Ibid

⁴⁵ Colorado-The Department of Health Care Policy and Financing, 2010, Accountable Care Collaborative, <http://www.colorado.gov/cs/Satellite/HCPFHCP/1233759745246>

⁴⁶ Arvantes J. *New Jersey Prepares to Launch Accountable Care Organization*, December 8, 2009, American Academy of Family Physicians, http://www.aafp.org/online/en/home/internal/error_page.html?status=404. Accessed January 21, 2010

⁴⁷ Roberson J and Landers J. "Baylor will try new Rx: Hospital group prescribes shared payments, focus on results to get disparate providers to act in unison," 2010, Factiva

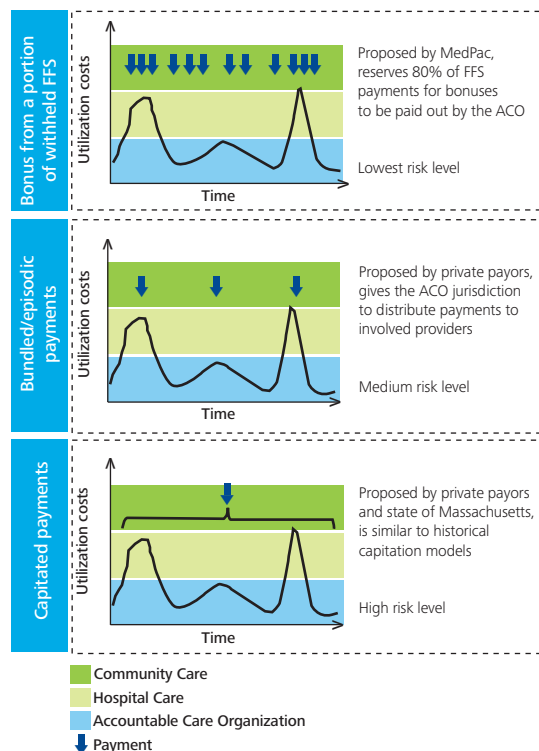
⁴⁸ Terry K. "Healthcare Markets Show How to Bend The Cost Curve," January 2, 2010, BNET.com, <http://industry.bnet.com/healthcare/10001569/healthcare-markets-show-how-to-bend-the-cost-curve/>. Accessed January 25, 2010

Flexibility may differentiate ACOs from prior integration efforts

As mentioned earlier, the concepts behind ACOs – physician accountability, performance-based incentives and integrated health care – are not new. ACOs' innovation lies in the degree of autonomy given to physicians and the flexibility with which networks of providers can set up ACOs.

Currently, the providers who establish the ACO are responsible for setting key performance metrics, the care pathways and processes, the collaboration formats and media, and for aligning incentives. Additionally, and perhaps most importantly, providers can choose to accept from among a variety of payment structures that, in turn, offer flexibility in the amount of risk the ACO chooses to assume (Figure 1). This innovation is proposed to avoid some of the lessons learned during previous integration and accountability initiatives where, in some cases, physicians assumed too much risk and were unable to continue to practice.⁴⁹

Figure 1: ACO payment options



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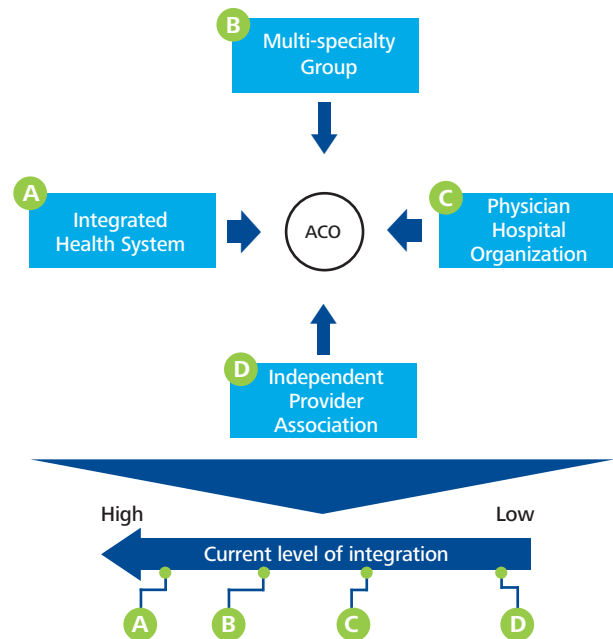
⁴⁹ Emanuel L, et al. "Bringing Market Medicine to Professional Account," March 12, 1997, *JAMA*, Volume 277(12), pp. 1004-1005

Four types of provider organization structures can be ACOs

Any group of providers that can administer payments and demonstrate the seven capabilities described above has the potential to become an ACO. Based on these criteria, the American Academy of Family Physicians, the American Medical Association, the Urban Institute, the Brookings Institute, and the Robert Wood Johnson Foundation describe a diverse set of provider organizations that can become an ACO. These include academic medical centers, HMSOs, and proposed collaborations between health plans and providers (HPPNs).^{50,51,52} While HMSOs and HPPNs may represent a future type of physician organization (although some HMOs could be considered HPPNs), there are currently four physician organization models with the potential to individually or collaboratively form an ACO. These are (1) Integrated Health Systems; (2) Multi-specialty Groups; (3) Independent Practice Associations (also referred to as interdependent physician organizations); and (4) Physician Hospital Organizations.

Because some physician organizations are more integrated than others (e.g., an Integrated Health System compared to a typical Independent Practice Association) they may have earlier success at becoming an ACO. Figure 2 presents each type of physician organization on a relative scale of their current degree of integration, which may indicate the ease with which they could transition to an ACO.

Figure 2: Provider organizations that can become ACOs



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⁵⁰ Devers K and Berenson R. *Robert Wood Johnson Quality/Equality Program Areas*, 2009, Robert Wood Johnson website, <http://www.rwjf.org/qualityequality/product.jsp?id=50609>. Accessed January 14, 2010

⁵¹ AAFP *Accountable Care Organization Principles for Accountable Care Organization*, December 16, 2009, AAFP, <http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20091216aco-principles.html>. Accessed January 21, 2010

⁵² Shortell SM and Casalino LP. *Accountable Care Systems for Comprehensive Health Care Reform*, March 1, 2007, Robert Wood Johnson Foundation Research and Publications, <http://www.rwjf.org/pr/product.jsp?id=32861>. Accessed January 24, 2010

ACO core competencies: Deloitte's perspective

The ACO was originally intended to include a broad range of provider organizations to achieve the type of performance that characterizes fully integrated health care systems such as the Mayo Clinic, Geisinger Health System and Intermountain Healthcare.^{53,54,55} However, as the pilot programs roll out it may become evident that some provider organizations, specifically those that are more integrated, are better suited to be an ACO than others.

Although it is expected that a provider organization's current degree of integration will predict an ACO's success, integration can mean different things to different stakeholders. Based on ACO literature and Deloitte's analysis of provider integration capabilities, eligible organizations should consider assessing their operational effectiveness in order to evaluate their potential success as an ACO.^{56,57,58,59} Namely, provider organizations should have the following core competencies and critical success factors (Figure 3):

Figure 3: Seven core ACO competencies and associated critical success factors

Core competency	Critical success factors
Leadership	<ul style="list-style-type: none"> • Ability to develop strong teams and shared culture • Ability to mediate stakeholder priorities • Ability to clearly, regularly and consistently communicate vision, strategy and direction to internal and external stakeholders • Ability to change direction when necessary • Ability to innovate
Governance	<ul style="list-style-type: none"> • Ability to design and execute strategy and management performance goals • Ability to leverage cultural strengths and neutralize cultural challenges • Ability to access and deploy capital efficiently to implement strategy • Ability to recruit and retain competent leadership • Ability to use fact-based planning to engage trustees • Ability to leverage profit with purpose
Operational management	<ul style="list-style-type: none"> • Ability to incorporate clinical performance measurements (safety, efficacy, effectiveness, costs, outcomes, satisfaction, productivity, efficiency) to optimize accountability and gainsharing • Ability to contract effectively with health plans and employers to leverage capabilities and performance • Ability to align supply chain vendors in collective gainsharing and achieve optimal purchasing efficiency. • Ability to manage regulatory compliance
Clinical management	<ul style="list-style-type: none"> • Ability to manage clinical pathway adherence by care teams • Ability to redesign and align population-based health management processes with evidence-based guidelines • Ability to coordinate care across patient conditions, services, and settings over time • Ability to manage patient behavior and implement patient outreach, adherence and self care

(continued)

⁵³ Cortese D and Smoldt R. "Taking Steps Toward Integration," December 5, 2006, *Health Affairs*, Vol. 26, pp. w68–w71

⁵⁴ Fisher ES, et al. "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," December 5, 2007, *Health Affairs*, Vol. 26, pp. w44–w57

⁵⁵ McKethan A and McClellan M. "Moving From Volume-Driven Medicine Toward Accountable Care," August 20, 2009, *Health Affairs Blog*. Accessed January 14, 2010

⁵⁶ Shortell SM and Casalino LP. *Accountable Care Systems for Comprehensive Health Care Reform*, March 1, 2007, Robert Wood Johnson Foundation Research and Publications. <http://www.rwjf.org/pr/product.jsp?id=32861>. Accessed January 24, 2010

⁵⁷ MedPAC Medicare Payment Advisory Commission, *Report to the Congress: Improving Incentives in the Medicare Program: Chapter 2*, June 2009, http://www.medpac.gov/documents/Jun09_EntireReport.pdf. Accessed 2/4/2010

⁵⁸ Fisher ES, et al. "Fostering Accountable Health Care: Moving Forward in Medicare," January 2009, *Health Affairs*, Vol. 28, pp. w219–w231

⁵⁹ Devers K and Berenson R. *Robert Wood Johnson Quality/Equality Program Areas*, 2009, Robert Wood Johnson website, <http://www.rwjf.org/qualityequality/product.jsp?id=50609>. Accessed January 14, 2010

Figure 3: Seven core ACO competencies and associated critical success factors (*continued*)

Core competency	Critical success factors
Infrastructure and IT	<ul style="list-style-type: none"> • Ability to build and make effective use of information technologies for health care delivery and administration at provider, patient and system level • Ability to integrate systems and aggregate data across multiple sites of care • Ability to synthesize data into dashboards for management decision-making • Ability to leverage IT infrastructure to reduce paperwork and workflow inefficiency
Risk assessment	<ul style="list-style-type: none"> • Ability to identify and mitigate the impact of at-risk populations of patients • Ability to identify and interdict operational problems that pose risk
Work force	<ul style="list-style-type: none"> • Ability to effectively design and allocate a health care workforce • Ability to optimize workforce productivity in team-based incentive structure • Ability to control fixed and variable costs for workforce through innovation in HR design • Ability to manage outsourced relationships and strategic partnerships to cost-effectively enhance core competencies

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Assessment of provider organizations

Given these competencies, some provider organizations are better equipped than others to form an ACO (Figure 4). For example, an integrated health system like Geisinger may already be acting as an ACO and easily transition to a fully operating ACO. On the other hand, a collection of independent practice associations that choose to form an ACO may not have the IT infrastructure necessary to

track patients and outcomes; may not have access to necessary capital; and may not have strong leadership to make choices about rates and utilization and, therefore, may struggle initially. Regardless, the flexibility of the ACO structure and incentives may spur innovative collaboration among physicians, hospitals and health plans so that their outcomes resemble that of the Geisinger, Mayo and Intermountain Healthcare models.

Figure 4: Assessment of provider organizations' ACO suitability

Estimated U.S. physician membership (providers may be part of more than one entity)	A	B	C	D
Core competency	Integrated Health System	Multi-specialty Group	Physician Hospital Organization	Independent Provider Association
Leadership				
Governance				
Operational management				
Clinical management				
Infrastructure and IT				
Risk assessment				
Work force				

High  Low

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Key challenges to ACO implementation: Deloitte's perspective

The ACO concept is gaining considerable momentum because of the PPACA pilot and health plan and consumer demands for improved value from providers. As a result, the ACO model may be a sustainable feature of the U.S. health care industry in coming years.

Based on the Medicare demonstration project and numerous ACO pilot projects under way, stakeholders should be able to determine the key design and implementation details that will help to facilitate widespread adoption. In the meantime, four major challenges to ACO implementation exist:

Physician buy-in: Physician organizations such as the American Academy of Family Physicians, the American College of Cardiologists and the American Medical Association have stated their support for payment reform, specifically for ACOs. However, there is likely to be considerable physician opposition if an adequate physician business case cannot be made.^{60,61} Specifically, physician groups may resist capitation and penalties that put physicians at risk, which in turn decreases the ability of the ACO to reduce overall health care costs.^{62,63,64} Additionally, physicians' culture of independence and autonomy will have to be addressed if the ACO effort for accountability is to succeed where Physician Hospital Organizations struggled. Per lessons learned from PHOs, governance issues will likely surface immediately. The relationships between primary care providers and specialists have the potential to be an issue, and the criteria for physician inclusion or exclusion in the ACO, apart from credentialing and hospital admitting status, will require considerable thought.

Conceptually, ACOs are intended to accommodate a wide variety of physician practice settings – solo to large group and so on. It is meant to be flexible enough to encompass even small physician practices; however, these practices may lack the necessary resources to make the initial IT and infrastructure investments.^{65,66} Integrated systems like Geisinger Clinic, Mayo Clinic and Intermountain Healthcare are consistently cited as model examples of collaboration and integration, yet it is unlikely that a small, independent physician association will have access to similar administrative and governance expertise to continually manage risk, utilization and costs in a way that satisfies both providers and consumers.⁶⁷

Consumer response: Several legislative proposals suggest that patients might be assigned to an ACO based on their primary care physician; however, the patient is free to see providers outside of their ACO and even switch ACOs. Some have suggested Medicare and Medicaid might be the optimal application of the ACO, creating a possible scenario wherein privately insured consumers transition to a medical home when they enroll in either of these programs and that medical homes serve as an entry point to the ACO. Unless there are HMO-like restrictions on provider selection, ACOs, payors and employers may need to capitalize on consumers' desire for more coordinated health care to get buy-in to the ACO model.⁶⁸ Mandatory assignment to a medical home might meet stiff resistance from consumers, and could unsettle relationships among physicians.

⁶⁰ AAFP *Accountable Care Organization Principles for Accountable Care Organizations*. December 16, 2009, AAFP, <http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20091216aco-principles.html>. Accessed January 21, 2010

⁶¹ Dove JT, Weaver WD and Lewin J. "Health Care Delivery System Reform: Accountable Care Organizations," September 8, 2009, *Journal of the American College of Cardiology*, Vol. 54, pp. 985–8

⁶² Varney S. "Congress Proposes New Physician Payment System," January 4, 2010, *All Things Considered*, NPR, <http://www.npr.org/templates/story/story.php?storyId=122217323>. Accessed January 14, 2010

⁶³ Goldsmith J. "Health Affairs Blog," August 17, 2009, *Health Affairs*, <http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/>. Accessed January 14, 2010

⁶⁴ Devers K and Berenson R. *Robert Wood Johnson Quality/Equality Program Areas*, 2009 Robert Wood Johnson website, <http://www.rwjf.org/qualityequality/product.jsp?id=50609>. Accessed January 14, 2010

⁶⁵ Poon EG, et al. *Assessing the level of healthcare information technology adoption in the United States: a snapshot*, 2006, BMC Medical Informatics and Decision Making, Vol. 6

⁶⁶ Balfour DC, et al. "Health Information Technology – Results From a Roundtable Discussion," 2009, *Journal of Managed Care Pharmacy*, Vol. 15

⁶⁷ Crosson FJ. "Medicare: The Place To Start Delivery System," 2009, *Health Affairs*, Vol. 28

⁶⁸ 2009 *Survey of Health Care Consumers*, Deloitte Center for Health Solutions, http://www.deloitte.com/dtt/cda/doc/content/us_chs_2009SurveyHealthConsumers_March2009.pdf. Accessed January 31, 2010

Payments and incentives: There is no single, agreed-upon ACO payment structure. One benchmark, the Senate pilot, proposes a voluntary FFS bonus payment but also adopting capitation if the Senate-proposed global payment pilot proves effective. Separately, commercial health plans are using performance-based threshold goals (milestones) to align payments with provider performance. These health plans are expected to initiate provider report cards and implement optimal network design (open networks versus closed, tiered networks, et al) to align provider performance with incentives. Potential issues include:

- If the payments move toward global payments and partial capitation, how much risk can and/or will providers assume?
- If a FFS payment structure continues, how will providers react to either levied penalties or reduction in the set FFS?

Infrastructure to manage risk: Access to information systems, medical management protocols and procedures for monitoring patient adherence, contracting with health plans and employers, collection and distribution of dollars, and compliance with regulatory requirements at the state and federal levels requires capabilities not usually resident in a provider organization. Clearly, the costs and effort associated with these activities are substantial; therefore, having knowledgeable managers with relevant experience will be important to effectively implementing ACOs. In some cases, outsourcing is optional but in other cases, where physician organizations do not have the expertise to manage risk, outsourcing may be necessary. Historically, provider organizations have struggled to manage financial risk from employers and health plans, preferring bonus arrangements that do not have a substantial downside risk. The maturation of the ACO model will necessarily require increased willingness to accept substantial risk and effectively manage costs, outcomes and compliance – all of which should be seamless to patients, efficient for payors and strongly supported by provider participants.

ACOs: Who benefits

ACOs’ attempts to limit costs and increase effectiveness will require the collaboration of providers, payors and consumers. All three stakeholder populations form an interdependent ecosystem that will determine if the ACO concept succeeds; however physicians and payors will be the primary drivers of initial success. Provider and payor stakeholder benefits and trade-offs are detailed in Figure 5:

Figure 5: ACO stakeholder benefits and trade-offs

Stakeholder	Benefits	Trade-offs
Payors	<ul style="list-style-type: none"> Slows costs Increases favorable outcomes 	<ul style="list-style-type: none"> May need to help providers manage and assume risk May need to help providers leverage outcomes data May need to collaborate to make sure incentives are aligned across multiple payors
Providers	<ul style="list-style-type: none"> More autonomy to practice effectively Same reimbursement for fewer procedures and tests 	<ul style="list-style-type: none"> Have to leverage capital for IT and infrastructure Have to negotiate collaboration between providers Have to change autonomous physician culture and collaborate to distribute incentives Have to negotiate collaboration with hospitals May have to assume risk

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As advocates seek widespread adoption of the ACO model, three directional signals and their associated questions should be tracked to gauge the degree of institutionalization:

- Value proposition proof:** Will ACOs deliver substantially improved value to the health care system through better care, improved outcomes and lower costs? Stakeholders would do well to watch closely the results of the ACO pilots being implemented by the state of Vermont and by Dartmouth/Brookings, Baylor and Robert Wood Johnson.
- Team-based clinical effectiveness:** Do ACOs effectively create and manage clinical processes that balance individual performance with team-based goals? Can provider organizations transition from individualistic cultures, where physicians are sole decision-makers, to a team-based climate, where allied professionals and consumers play active roles? Can innovations in care

delivery, adherence to evidence-based practices, and integration of allopathic medicine with alternative health care treatments be achieved in team-based cultures? Can payment models be designed to accelerate ACO performance and attract top talent?

- Consumer acceptance:** Will end users (consumers) demand care from ACOs once they recognize its value proposition or will they be content with current care options and/or otherwise non-committal?

Lag indicators for each of these situations will provide useful tracking information but, inevitably, lead indicators – new payment models to ACOs by payors and consumers, new operating structures and clinical processes that improve ACO performance, new methods of leveraging technology to deliver “more, better and cheaper” – will mark ACO evolution.

Looking ahead

ACOs do not represent a significant paradigm shift in U.S. health care; rather, they are a compilation of integration tactics that have been tried at different times and in different systems. Their success, therefore, will depend on how well providers, payors and patients navigate the challenges that limited the effectiveness of previous integration and accountability efforts.

From these earlier efforts and ongoing ACO pilots, the health care industry can glean some important insights:

- **Structuring the relationships among physicians, hospitals and health plans is challenging.** Aligning incentives and structuring measurable goals in cost reduction and quality improvement require careful deliberation.
- **Results are not achieved quickly.** It takes time and capital to acquire the information systems, patient and provider support services and results validation capabilities that ACOs require. These capabilities often do not reside within a provider organization, but collaborating with other parties can be problematic given historic tensions between primary care physicians and specialists, hospitals and health plans and so on.
- **The process of refining and improving ACO performance is ongoing.** New clinical conditions add new dimensions of medical management. New participants – health plans, physicians, hospitals, allied health professionals – require modification of operating models. The ACO is a dynamic organization; it must be led by managers who are equipped to adapt and execute.

Given these challenges, a provider organization that is considering an ACO should ask:

- Do we enjoy relationships among physicians and with hospitals that are suitable to effective operation as an ACO?
- Do we have the capital to acquire needed technology and operational expertise to implement the ACO? Given other capital requirements – clinical programs, workforce development, technology, ICD-10 compliance by 2013, participation in the HITECH stimulus funds program, and routine upkeep and maintenance – from where will ACO capital be obtained? Which priority comes first?
- Do we need a partner? Is managing risk in a complicated structure a core competency of our organization? Should our strategy for ACO deployment be built on a long-term relationship with an outside entity or a commitment to “make” rather than “buy”?

Depending on the success of the Medicare and other regional pilots, ACOs likely will be a central focus of delivery system reforms. The ACO model will no doubt encounter regulatory and structural challenges; however, one or more of the four models may become the standard – it is just too soon to know with certainty. What is known is that current health care costs are not sustainable. Organizing for improved coordination of care and shifting accountability to providers for costs and outcomes is a logical step in U.S. health care reform.

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