The accountable care organization has been a model for health care reform, yet its modest success has been limited to a handful of health care systems across the country. However, the accountable care organization model has recently taken on far greater significance since being introduced as one of Medicare’s pilot programs in the Senate’s health reform bill. The phrase is attributed to Dr. Elliot Fisher of Dartmouth Medical School. Dr. Fisher has led the Dartmouth Atlas Project — a project that has, for the last 30 years, painstakingly documented the variation in care across the United States. (Click here for an interactive map of some of the Dartmouth Atlas results). The Dartmouth Atlas has focused on both the quality of health care as well as its cost. More importantly, they have reported on the relationship between the two, and their findings are nothing short of an indictment of our current paradigm.

Specifically, their findings illustrate that there exists wide variations in the cost of care across the country, and profoundly, that the regions that spend more per patient do not necessarily obtain better outcomes. So what to do? Dr. Fisher believes he has found at least part of the answer: the Accountable Care Organization, known as an “ACO”.

**What is an ACO, and How Does it Differ from Other Payment Reforms?**

In his paper “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” Dr. Fisher acknowledges that the term ACO “grew out of an exchange between he and Dr. Glenn Hack Barth at a MedPAC meeting in November of 2006”. (Fisher, 2006 n. 7). Dr. Fisher’s purpose in writing the aforementioned paper was to help identify the proper “locus for shared accountability” for a patient’s health care. HMO’s and other health insurers are obvious candidates, but as Dr. Fisher notes, HMOs only comprise a small percentage of the current market, and health plans in general have focused on negotiating favorable prices within relatively open networks of providers. (Fisher, 2006, p. 45). The “medical home” (also referred to as a Patient Centered Medical Home or PCMH) is another candidate, but is taken out of the running by Dr. Fisher because of the untested nature of medical homes, and their requirement of new payment mechanisms. (Id.).

Dr. Fisher notes that a better option already exists: “virtual” organizations consisting of the various physicians that are associated with local acute care hospitals. As Dr. Fisher notes, these physicians are either directly affiliated with such hospitals through their inpatient work, or through the care patterns of the patients they serve. Dr. Fisher refers to these multi-speciality group practices that are bunched around local hospitals as an “extended hospital medical staff.” He argues that improving quality and lowering cost should be realized by fostering greater accountability on the part of this “extended medical staff.”

In a recent Urban Institute paper on ACOs by Kelly Devers and Robert Berenson (pdf summary here, full pdf here), the authors point to three essential characteristics of ACOs:
1. The ability to provide, and manage with patients, the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post acute care;

2. The capability of prospectively planning budgets and resource needs; and

3. Sufficient size to support comprehensive, valid, and reliable performance measurement. (Berenson, p. 2.).

In exchange for investing in this reformed health care provider structure, the ACO members will share in the savings that results from their cooperation and coordination. Thus, ACOs can—theoretically—act as a reform tool by incentivizing more efficient and effective care. This would help to combat the current perverse incentives of overutilization and overbuilding of health care facilities and technology.

In 2007, Dartmouth’s Institute for Health Policy and Clinical Practice headed by Dr. Fisher and Dr. James Weinstein, teamed up with the Brookings Institution’s Mark McClellan to create The Brookings-Dartmouth ACO Learning Network. The ACO Learning Network will serve as a support tool for providers looking to transition to the ACO framework. In the “Overview” section of their site (available as a pdf here), the Brookings-Dartmouth team provide a useful chart comparing the ACO model to other payment reform models such as “bundled payments,” “medical homes” and capitation. Click the image below to enlarge.

**Click the image below to enlarge.**

ACO Compared to Other Payment Reforms - Fisher et al. 2009 - Click to Enlarge

**Various Extant Structures Utilized**

Since Dr. Fisher’s introduction of the ACO concept, the idea has continued to be refined. In their 2007 paper “Accountable Care Systems For Comprehensive Health,” Dr. Stephen Shortell and Dr. Lawrence Casalino envision a broad range of ACOs in addition to the “extended medical staff” originally described by Dr. Fisher. Drs. Shortell and Casalino identify extant organizational structures that could be leveraged to create ACOs, including the Multi-speciality Group Practice (MSGP), the Hospital Medical Staff Organization (HMSO), the Physician-Hospital Organization (PHO), the Interdependent Physician Organization (IPO), and the Health Plan Provider Organization or Network (HPPO/HPPN). (Shortell et al., 2007, p. 10). Below is a table from their paper that organizes the different ACO models while
group believes there would have to be at least 5,000 beneficiaries in the ACO for it to be viable. The ACO would provide CMS with a list of their providers willing to participate in the ACO. As discussed above, the beneficiaries would be determined by, among other things, the patterns of patient referrals in the region. However, beneficiaries would not be “locked in” to a given provider. (Fisher et al., 2009, p. 4). The ACO would receive savings if their risk-adjusted, per beneficiary spending levels were below their benchmark. Id.

**An Ultra-Simplified Example**

A hypothetical independent practice association (IPA) teams up with a community hospital to create an ACO. Medicare determines a benchmark, that is, what it will cost to treat the average beneficiary in that geographic area per year–let’s say $10,000. The physicians submit their traditional claims to Medicare under the RBRVS system while the hospital submits its typical DRG-base claim. Thus, the traditional fee-for-service system remains in place. At the end of the year, Medicare determines if the ACO has provided care for less than $10,000. If they have, the ACO is entitled to share in the cost savings, and the savings are divided among the providers and hospital. Though simple in theory, ACOs become more difficult when attempting to construct payment models that will distribute the savings of the ACO to the individual providers. Shortell provides another helpful chart that lays out some of the options; **Click on the image to enlarge**.
from Dr. Jeff Goldsmith PhD, president of Public Health Services at the University of Virginia. In his Health Affairs article entitled “The Accountable Care Organization: Not Ready for Prime Time,” Dr. Goldsmith recalls previous attempts to at implementing payment reform models based on shared risk:

The problem with this movie is that we've actually seen it before, and it was a colossal and expensive failure. During the 1990s, many hospitals and physicians believed that the Clinton health reforms would force them into capitated contracts with health plans. . . . Risk-bearing physician/hospital organizations and hospital-sponsored preferred provider organizations (PPOs) sprang up all over the country. . . . Some of these hospital/physician efforts actually succeeded and survive today. . . . However, these were outliers in an expensive failure. Employers and patients preferred open panels managed by health insurers to closed panels managed by providers. Billions of dollars were lost. . . . Many of the practice acquisitions were reversed, as hospital systems sought to rein in their expenses and adjust to an open-panel world dominated by point-of-service style health plans.

However, the 1990s left behind an expensive legacy: highly concentrated local provider markets….There were numerous reasons for the 1990s collapse of at-risk hospital/physician partnerships, besides the failure to find willing buyers of their services. These efforts lacked infrastructure, experienced management, as well as reliable and timely cost information to support cost management. They assumed global risk but paid for care on a fee basis, just as Fisher and colleagues propose. But these hospital-sponsored organizations could neither redistribute income nor exclude their high-cost providers (who inconveniently generate most hospital profits).

Some things have clearly changed in the ensuing decade. . . . A rapidly increasing percentage of physicians, particularly primary care physicians, are now hospital employees. A larger percentage of the physician community receives hospital subsidies for call coverage. Many of these subsidies are, in fact, extorted from the hospital by specialists in scarce supply, destined to become scarcer. An entire generation of 80-hour-a-week baby-boomer physicians are retiring and being replaced by younger physicians who want to work 30 hours a week. You are not going to see a lot of these younger physicians in utilization review committee meetings after hours; they are going to be at their kids’ soccer practices.

What hasn't changed is the fragmentation of care, the huge disparities in income and political power inside physician communities, and also the level of suspicion that physicians have of their now much more powerful local hospitals. There is also, sadly, a thundering absence of collegiality – in my view, the central
The precondition of assuming risk and managing care. This absence is palpable in suburbs and even more pronounced in many "lifestyle dominated" resort communities in the sunbelt… They are “collections” of physicians, not communities.

The hospitals in these areas appear formidable: they have beautiful campuses, prestigious boards, and deep financial reserves. … But these hospitals have been picked clean of vital outpatient services by their medical “communities.”

Entire disciplines have disappeared from hospitals: ophthalmology, cosmetic surgery, gastroenterology, urology. Even community-based internists and family practitioners have stopped coming to the hospital; their patients are cared for by hospitalists who work full time inside the hospital.

The result of our previous attempts at ACO-like integrated care, Dr. Goldsmith points out, is that…

...while the hospital has become more involved in subsidizing physician practice, physician communities have drawn away from the hospital and function increasingly independently on a day-to-day basis. Wennberg’s own data show that something like 40% of physicians no longer have any Medicare hospital-related fee income. So squashing hospitals and physicians back together into economic interdependence in a joint hospital/physician economic pool makes no real-world sense.

Dr. Goldsmith goes on to note that there have been some successful ACOs, but that they haven’t been “virtual” in the sense that Dr. Fisher points out, rather, they are real organizations with P+Ls, medical directors, and management infrastructure. Prominent examples in my home region include Carilion Health System in Roanoke and the Bon Secours Health System in Richmond. Voluntary ACO arrangements, with Medicare and with private insurers, may find enthusiastic partnerships with many of these hospital-sponsored physician groups. …

The Senate Bill

In defense of the Brookings-Dartmouth model, the group has gone on record in favor of voluntary ACOs. To Dr. Goldsmith’s relief, the Senate’s health reform plan incorporates ACOs on a voluntary pilot program basis. You can read their rebuttal to Dr. Goldsmith here. Section 3022 of the Senate bill — which amends Title XVIII of the Social Security Act (42 U.S.C. 1395) — introduces ACOs under the name “Medicare Shared Savings Program. (View a pdf of the extracted ACO part of Senate bill here).

The Senate’s plan is remarkably similar to the Brookings-Dartmouth model. Under the Senate’s plan, ACOs will be eligible to receive a percentage of the cost savings that they have realized under the traditional fee-for-service Medicare system. The requirements are set forth in section (B)(2). Furthermore, the ACO shall enter into a 3 year agreement with HHS whereby the ACO must agree to contain at least 5,000 Medicare beneficiaries, while being prevented from engaging in risk selection. The ACO must define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth or other remote patient monitoring tools. The ACO must also demonstrate to HHS that it meets the yet-to-be defined criteria for “patient-centeredness”.

Whether ACOs will succeed is impossible to determine with certainty. The panopticon that would be ACO management looking over the shoulders of physicians may be enough to turn off many physicians. Nevertheless, as even Dr. Goldsmith acknowledges, some ACOs have thrived.
Moreover, the voluntary ACOs in the Senate’s bill represent a measured approach towards reforming our system without a wholesale transformation. As Dr. Atul Gawande describes in a lesser-cited pre-"Cost Conundrum" article, the most sound approach is often “path-dependent,” that is, it builds on what already exists. As Dr. Gawande notes:

...accepting the path-dependent nature of our health-care system—recognizing that we had better build on what we’ve got—doesn’t mean that we have to curtail our ambitions. The overarching goal of health-care reform is to establish a system that has three basic attributes. It should leave no one uncovered—medical debt must disappear as a cause of personal bankruptcy in America. It should no longer be an economic catastrophe for employers. And it should hold doctors, nurses, hospitals, drug and device companies, and insurers collectively responsible for making care better, safer, and less costly. ...

Whether the shared savings will entice physicians on a large scale is uncertain. What is certain is that our current fragmented system incentivizes providers to offer neither cost-effective nor coordinated care. Though it is unlikely that physicians and hospitals will flock to ACOs from the start, the vision of ACOs conceived of by the Dartmouth-Group and described in the Senate bill may nevertheless prove itself a useful tool in a larger arsenal of approaches meant to salvage our unsustainable health care system. In other words, the Senate’s approach could provide a path-dependent solution toward the collective responsibility and better outcomes that Dr. Gawande mentions. And as described in the Senate bill, physicians and hospitals will not be offered a new path, but rather a resurfaced path that would retain fee-for-service, while providing a safer and smoother ride for the patient.