Scientific Underpinning

of

Preventive Medicine Associates Inc.

Evolving Towards an Accountable Care Organization

What Is an Accountable Care Organization?

Imagine a health system that pays doctors and hospitals to keep you well, not just treat you when you're sick. A system where doctors would have a financial incentive to limit unnecessary tests and prod patients to exercise more and eat better; A system where hospitals would benefit from – now this is really radical – keeping you out of the hospital. This is the goal behind accountable care organizations, or ACOs, the latest health care delivery model that's poised to get a test ride in the national health overhaul legislation

In the existing fee-for-service payment system used by Medicare and most private insurers, doctors get paid more by giving more services and hospitals make more by increasing admissions. With ACOs, doctors and Hospitals would get paid based on their ability to hold down overall costs and beet quality-of-care indicators. In effect, their pay would be based on improving care, not driving more of it.

If the ACOs fail to meet certain quality and cost savings targets, the providers in the ACO would face lower payments from Medicare. On the flip side, the ACOs would also be awarded for keeping patients happy and meeting national quality standard such as making sure diabetics get regular foot exams and women get their annual mammograms. In effect, ACOs are an attempt to build integrated health systems like the Mayo Clinic where none exist. But Mayo took several decades to become a global destination for health care.

The accountable care organization (ACO) is one of the latest designs for managing Medicare that is gaining traction among policymakers desperate to control costs and boost quality in the system. Proponents of the concepts want to see it tested along with such alternatives as patient-centered medical homes, pay-for-performance and payment bundling.

A typical Medicare ACO would include a hospital, primary care physicians, specialist and potentially other medical professionals. Services would still be billed under fee-for-service, but the organization's members would coordinate care for their shared Medicare patients with the goal of meeting and improving on quality benchmarks. Because ACO members are held jointly accountable for this care, they would share in any cost savings that stem from the quality gains.

Medicare spends three times more per beneficiary in some regions than is does in others, with no clear evidence that the additional dollars result in higher quality of care or better outcomes. The system also tends to promote high-volume and high-intensity health services, regardless of the quality of care provided and whether that care is coordinated.

The accountable care organization attempts to address these issues by linking payments to the quality and utilization of health services. Although it is a relatively new concept, it incorporates and builds on ideas from several other reform models that have been discussed for years. An accountable care organization manages Medicare services by both physicians are hospitals. Although the idea has some basic themes, the details still need to be worked out. For example, some ACO models include hospitals; some don't.

An ACO needs to be big enough so that any cost saving can be tied to quality improvements and not year-to-year fluctuations in care, he said. That means it should have a population of at least 5,000 Medicare beneficiaries or 15,000 beneficiaries with private insurance. Patients would retain the right to choose their physicians, so the ACO relies on patients' natural physician-selection patterns.

Research has shown that more than 80% of patients assigned to a physician affiliated with a heoretical ACO would still be with members of that same organization a year later.

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