

How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations

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The Patient Protection and Affordable Care Act of 2010 directs the Centers for Medicare and Medicaid Services (CMS) to create a national voluntary program for accountable care organizations (ACOs) by January 2012. ACOs are provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the groups' clinicians.

Accountable Care Models

Accountable care organizations will be largely based on physician practices that, in turn, may be organized as patient-centered medical homes. Many ACOs will also include hospitals, home health agencies, nursing homes, and perhaps other delivery organizations. There are at least five different types of practice arrangements that could serve as ACOs. These are the integrated or organized delivery system, multispecialty group practices, physician-hospital organizations, independent practice associations, and "virtual" physician organizations, all described below.

1. **Integrated Delivery Systems**

Integrated delivery systems involve a common ownership of hospitals, physician practices, and—in some cases—an insurance plan. Some examples are Kaiser Permanente, Group Health Cooperative of Puget Sound, and Geisinger Health System. These systems typically have aligned financial incentives, electronic health records, team-based care, and resources to support cost-effective care.

2. **Multispecialty Group Practices**

Multispecialty group practices usually own or have a strong affiliation with a hospital. Examples of this type of arrangement include Mayo Clinic and Cleveland Clinic. They usually do not own a health plan but, rather, have contracts with multiple health plans in their areas. Most have a long history of physician leadership and highly developed mechanisms for providing coordinated clinical care.

3. **Physician-Hospital Organizations**

These organizations are a subset of the hospital's medical staff. One example is Advocate Health in Chicago. Most were formed in the 1990s in response to managed care pressures to negotiate with health plans. Some function like multispecialty group practices, focusing on reorganizing the delivery of care to achieve more cost-effective coordination. Although they may be less well suited than integrated delivery systems or multispecialty practices to qualify as ACOs, many could structure themselves to meet the criteria for that type of organization.

4. **Independent Practice Associations**

Independent practice associations consist of individual physician practices that came together largely for purposes of contracting with health plans. Over time, however, many of these have evolved into more-organized networks of practices that are actively engaged in practice redesign, quality improvement initiatives, and implementation of electronic health records. One example is Hill Physicians Group, in Northern California. Such organizations could qualify as ACOs, and that might encourage other independent practice associations to evolve similarly, given sufficiently strong financial incentives and technical assistance.

5. **Virtual Physician Organizations**

Finally, a number of small, independent physician practices, many located in rural areas, can organize to become "virtual" physician organizations, such as Community Care of North Carolina. This process can be led by individual physicians in rural areas or by a local medical foundation, state Medicaid agency, or similar organization that can provide the leadership, infrastructure, and resources to help small practices develop disease registries; implement electronic health records; share information; and provide better-coordinated, cost-effective care. These virtual networks could qualify as ACOs and serve as models for other groups of small practices.

Physicians can choose one or more of the above models, depending on what best fits their needs and local circumstances. But because there are so many options, the payment systems that the CMS creates for ACOs should evolve with the models chosen. Specifically, the more-integrated forms of accountable care, such as integrated delivery systems and multispecialty group practices, are capable of assuming the greatest risk. This would make them natural candidates for capitation or bundled payments, in which providers assume a relatively greater share of risk. In contrast, less structurally integrated forms of ACOs, such as virtual physician organizations and more loosely organized independent practice associations, are best suited—at least initially—to low degrees of risk. For them, a form of limited, partial capitation for selected illnesses may be most appropriate.

To facilitate delivery system transformation and focus attention on desired health outcomes, payment systems need to change. Payment based on outcomes achieved, rather than on volume of services provided, will be the motivation for providers to focus their attention on improving the underlying systems of care.

Considerable technical assistance will be needed to implement the learning system for the development of ACOs. This will be particularly true for loosely organized independent practice associations and virtual physician networks, which currently lack the size and resources to become ACOs.