Forming an Accountable Care Organization
Analysis and Recommendation
Community Hospital Group

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Introduction

Health care reform has produced a great deal of legislative and public interest and debate in the last 3 years. Most stakeholders agree change is critical, but the exact nature of the changes, the process used for transition, and the structure of the new healthcare system have remained the subject of vigorous debate. The passage of the Patient Protection and Affordable Care Act of 2010 (ACA) provides for a comprehensive system of changes to be introduced over the next four years. These changes are designed to improve the safety, quality, and efficiency of the medical care system while still reducing costs. On major change mandated in ACA is the Medicare Shared Savings Program which specifies a new reimbursement model which is value rather than volume based and incorporates quality measures as one criterion for reimbursement levels. To implement this, CMS announced a new program of Accountable Care Organizations (ACO) whose structure and operation are specified in a 429 page set of proposed regulations (the rule) published in the Federal Register on April 7, 2011. Healthcare organizations (HCOs) must now decide whether to combine capabilities to meet the criteria specified in the rule and form an ACO. The principles embodied in the ACO program (pay-for-performance, shared risk, careful reporting of core quality measures, and meaningful use of information technology) will have a dramatic effect on the practice of medicine and delivery of healthcare in the United States over the next 10 years. Therefore the decision about whether to form an ACO and join the program will be critical for every healthcare organization.

Community Hospital Overview

Community Hospital is a large 500 bed community hospital in an affluent suburb. The payer mix is a favorable one with 50% private insurance, 30% Medicare, and 20% Medicaid. This document will analyze and report the potential benefits and challenges that formation of an ACO will bring to Community Hospital and evaluate the resources requirements, process changes, and stakeholder impact associated with that undertaking. The ACO model requires a patient population large enough to effectively spread risk. For the CMS Shared Savings Program, the minimum threshold is 5000 patients. Based on our data for 2010, our patient base is more than adequate to satisfy to satisfy the Medicare requirement (hospital yearly patient admissions: 27000; Medicare 30% ~ 8100; emergency visits 51000, 30% Medicare ~15300; Multi-specialty & primary physicians outpatient visits was 550,000, 30% Medicare ~165,000).

Accountable Care Organizations - Definition

The Accountable Care Organization is a new model proposed by CMS in response to the ACA mandate. It creates networks of providers and organizations integrated to serve the needs of a defined patient population. The Center for Medicare & Medicaid Services website describes the program as follows.

Section 3022 of the Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to establish a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of Medicare fee-for-service beneficiaries
- Requiring coordinated care for all services provided under Medicare Fee-For-Service
- Encouraging investment in infrastructure and redesigned care processes

Eligible providers, hospitals and suppliers may participate in the Shared Savings Program by creating or joining an Accountable Care Organization, also called an ACO.

These types of networks, which are recognized as legal entities, can take a number of forms. Old models involved physicians who contracted with payers, however this structure was often viewed as restrictive and the capitated model potentially discouraged the provision of services to patients. The newer ACO model can involve hospitals, providers, possibly insurance plans, multi-specialty group practices affiliated with a hospital, Physician-Hospital Organizations, Independent Practice Associations, and finally virtual physician organizations. These various models differ significantly from the fee for service model which some feel encourages excess use of services and may not facilitate or improve the coordination of patient care. Current examples of networks with structures resembling the proposed ACOs include Kaiser Health System, Mayo Clinic and Cleveland Clinic. Each of these organizations owns hospitals and outpatient clinics and employs a wide variety of medical providers.

While CMS has initiated the ACO program under Medicare, their intention is to expand to Medicaid, and private payers are closely watching the development of this initiative. The ACOs will be accountable to Medicare for providing quality, cost effective care and would be rewarded with financial incentives for meeting performance targets. The original ACO proposal allowed for a phased in, pilot approach. The final legislation and the published rule differ from the original proposal and include the following elements: retrospective invisible enrollment, extensive quality measurement, coordination of care, shared savings, and an evolution toward stronger incentives such as shared risk (Merlis, 2010). Each of these elements contains extensive detailed requirements which will make the operational burden of implementation very challenging. An organization evaluating formation of an ACO must carefully consider all these factors.

Rationale

The Board of Directors has asked the management team to consider partnering with the Good Physician groups and other providers to form an ACO. The Board is tasked with keeping abreast of health care policy, and ensuring that Community Hospital explores new reimbursement paradigms with the potential to improve the efficiency and quality of patient care. The ACO model proposed by CMS represents a growing trend towards the use of integrated care systems to improve patient care quality while also improving efficiency and reducing costs. The proposed rule from CMS emphasizes the potentially increased revenue available to ACO member organizations who deliver cost savings to the Medicare program. Operating a successful ACO will require significant initial investment and intimate cooperation between a variety of provider groups to achieve the level of patient monitoring, care management and information technology necessary to meet the CMS cost and quality goals. We will now discuss potential benefits and challenges Community Hospital may encounter if we proceed with forming an ACO.

Benefits

ACOs can provide an avenue for improvements in patient care and quality outcomes, reduction of operational inefficiencies and opportunities for shared cost savings. As we explore these possible benefits, keep in mind that the current ACO concept published by CMS has not been completely vetted, has many unintended consequences, and may be extremely difficult for a real world healthcare organization to implement.

Improving the quality of care provided to patients requires the ability to measure metrics, provide feedback and coordinate care through collaboration between provider stakeholders. Programs such as Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) and the Meaningful Use initiative are the first steps in transitioning HCO reimbursements to a pay-for-performance model and away from fee-for-service. The ACO system will "begin transforming quality reporting from the current retrospective system to a real-time mode, so that clinicians can identify trends and signs of declining quality (among individual patients, panels and populations) in time to effectively intercede" (Enders, Battani & Zywiak, 2010). Reporting about ongoing care delivery requires the implementation of a clinical information exchange anchored by a robust electronic health record (EHR). The EHR acts as a hub for patient data and forms the connecting link between hospitals, physician practice organizations, pharmacies and ancillary services. In addition to the benefits of real-time quality reporting, interfacing the EHR with other HCOs participating in the ACO will provide enhanced coordination of care and advanced decision support capabilities, adding to our goal of improving patient care.

Another primary function of the ACO is to encourage providers and HCOs to view patient care as continuum both over time and over large groups of patients. Ideally, our ACO

would take responsibility for using outpatient case management and mid-level providers to control the cost of care for patients with chronic illnesses while still improving the quality of care for our population of patients as a whole (Miller, 2009). In the inpatient setting, hospital-acquired infections and preventable readmissions are two never-events that can be tracked and reduced by quality improvements mandated by ACO membership. Within our organization adverse events such as catheter-associated UTIs cause hardship to our patients and incur added costs in uncompensated readmissions. Forming an ACO will expand our capabilities to track quality measures, identify opportunities for improvement, and educate our staff physicians about the ways quality improvement and best practices can simultaneously improve care and lower costs. If the focus on quality and performance metrics produces meaningful cost savings, Community Hospital can share in those gains. Studies have shown that improved hand-offs between inpatient and outpatient providers and expanded at-home education and visits by supporting medical personnel reduce readmission rates and smooth the transfer of care back to the patient's primary care provider (Miller, 2009). Again, proactive measures avoid unnecessary care, and the ACO does well by doing good.

In the past different compensation models for provider organizations have ranged from pure fee-for-service to capitation with varying degrees of hybrid methodology between the two extremes. The current proposed CMS rule for ACOs specifies that Medicare would continue to pay medical providers by the current fee-for-service method, however,

> "CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or to be held accountable for losses. CMS is also proposing to establish a minimum sharing rate that would account for normal variations in health care spending, so that the ACO would be entitled to shared savings only when savings exceeded the minimum sharing rate" (U.S. Department of Health & Human Services, 2011).

For example, if Good Physicians and Community Hospital teamed up to form an ACO, Medicare would compute a cost benchmark for varying treatments associated with our population of 'attributed' beneficiaries depending on our geographic area, Medicare's costs in that area over the preceding three years, and the patients' severity of illness (Cohen, 2010). The physicians and hospital would bill for our services, both parties receiving current fee-for-service reimbursement rates. At the end of the year, CMS would tally our total charges and if they fell below 98% of the benchmark, our ACO would share in the difference. The potential for increased revenue can only be realized if operational costs are kept well in hand. The projection is that consistent use of the care reforms reviewed above combined with new health information technology capabilities will produce the expected cost savings.

Another possible compensation model that has been discussed involves episode-of-care or ‘bundled’ payments where a single payment is made for all the care by all providers relating to a particular episode of illness or chronic condition in a patient. Again this payment model incentivizes the ACO to coordinate care between the PCP, specialist and hospital through integrated care systems which can provide better outcomes and lower costs (Miller, 2009). This model is not implemented in the current CMS rule, which adopts the ACO integrated care system to improve outcomes by reducing unnecessary services and avoiding preventable complications, but it may be considered for future introduction.

Strategic Advantage of an ACO

There may be a strategic advantage for Community Hospital in forming an ACO. The current rule from CMS states that, “Medicare would continue to pay individual health care providers and suppliers for specific items and services as it currently does under the Original Medicare payment systems” (healthcare.gov, 2011). Additionally, ACO performance relative to a standard benchmark would be used to assess whether the ACO is eligible for shared savings, or liable for losses. As in most strategic decisions, a higher potential return carries a higher risk for loss. If Community Health has evidence for believing that it is capable of meeting and exceeding the benchmarks promulgated by CMS as compared to its competitors in the marketplace, it may be financially advantageous to form an ACO. However, it is important to note that Community Hospital’s partners in the ACO must cooperate in achieving the appropriate benchmarks so that the aggregate performance of the ACO is adequate. The lessons learned from the ACO should also leave Community Hospital well positioned to participate in future pay for performance programs initiated by other payers. Finally, successfully meeting ACO quality and performance metrics will demonstrate to the community that Community Hospital is truly committed to providing the highest quality, most cost effective healthcare available anywhere.

Reporting to the Board

Since the only implementations of an actual ACO have been demonstration projects, there is very little objective information about how ACO management reports to its Board of Directors. The ACO is itself an independent legal entity with its own Board of Directors distinct from the Boards of its component organizations. The ACO Board provides oversight and guidance in the same way as any governing board, and the CMS rule requires that at least one member be a Medicare beneficiary who is not on the provider or management staff of the ACO. The coordination between the ACO Board and the Boards of its components is not legally well defined at this time, although the arrangements to account for and distribute shared saving must be specified in the initial ACO formation application to CMS. The ACO management will provide standard quality, safety, and performance data to its Board as well as additional reports required in the CMS rule, and presumably these will be available to the hospital and physician group governing bodies. These Boards may also share some members with the ACO Board,

although the antitrust implications of this and of the ACO concept in General are still being worked out.

Proposed Measures for Evaluation and Scoring

Measurement is essential for assessing performance against goals. Well-considered and timely measures are also useful tools for monitoring progress, highlighting improvement opportunities, and monitoring the overall 'health' of an on-going program. Since the proposed ACO venture is a new program with which we have little experience, it is especially important that we monitor it properly and comprehensively to satisfy the quality measure reporting requirement for the Medicare Shared Savings Program, to support internal quality improvement efforts, and to test system suitability for use in other incentive payment programs. Yet measures have to be based on data that can be feasibly collected, without imposing undue burdens on the financial, human and IT resources of the organization. The team considered the purpose of ACO, utility and relevance to the organization and the local community, evaluation requirements from payer incentive programs, and practicality of data collection when recommending the proposed measures.

The purpose of an ACO is to improve the quality and reduce the cost of health care for the community by delivering better coordinated care. The success of the ACO may also positively impact market competitiveness when improved health care quality over a continuum of time and patient population can be demonstrated. Therefore it is advantageous to have metrics that can be advertised to the community at large (including potential patients) as well as reported to payers.

For the Medicare Shared Savings Program, CMS has proposed to measure quality of care using nationally recognized measures in five key domains: patient experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health. (CMS issued ACO Providers Factsheet, CMS website).

Considering all these, the team proposes the following measures to be reported to the ACO oversight committee (or responsible governing body):

1. Population base and related statistics

- The hospital and the ACO will need to track patient assignments and patients' payer association. The ACO should also produce statistics on the population demographics and disease statistics. This will be greatly complicated by the retrospective invisible methodology CMS plan to use for patient assignment, but once we have the first year's data, some projections can be made.

- Statistics on the population base can also serve as the ACO's market share indicator. Coupled with positive population disease management outcome statistics, it can also serve as a marketing point for the ACO. (DeVore & Champion, 2011)

2. Quality measures

Standardized quality measures for hospitals, in the dimensions of process, outcome, and patient experiences have been well established as required for accreditation (Joint Commission) and by the CMS. Standard inpatient safety measures are also well established and will be monitored. Chassin et al. (2010) evaluated a subset of Joint Commission 2010 core measures used as hospital accountability measures, and showed that the required reporting of these measures did indeed improve hospitals' compliance with evidence based best practices which subsequently also improved clinical outcomes.

Ambulatory care quality measures have up to now been less uniformly collected. Yet in order to gauge the success of the ACO and satisfy CMS reporting requirements, quality measure data from the ambulatory care setting is also required. It will be required that participating physician groups measure and report on an agreed upon set of CMS Physician Quality Reporting measures, including the areas of preventive care, diabetes, heart failure, coronary artery disease, and hypertension, as well as patient experience measures.

In addition, the ACO as a whole will need to establish transition-of-care and care coordination quality measures. We again recommend starting with process and outcome measures in the areas of diabetes care, heart failure, and coronary artery disease. (e. g. Rice et al., 2011 for diabetes care). CMS is also requiring monitoring of utilization measures. Oncology utilization measures including bone scan or CT scan in high-risk patients, appropriate use (or avoidance) of bone scan or CT scan in low-risk patients, appropriate radiation therapy and adjuvant therapy are examples of the CMS utilization dimension. These process measures will encompass components for all providers in the care continuum. All participating entities in the ACO, including out-patient and in-patient providers, will be jointly responsible for outcome measures on the population basis.

Each ACO participating entity must meet pre-determined minimum goals on composite measures in order to be eligible for either share savings or for automatic continued participation in the ACO. If certain entity does not meet pre-determined and agreed-upon thresholds, a special review will need to be conducted to determine the course of action.

3. Costs saving measures

The CMS will automatically compare per patient cost of our ACO population to the reference benchmark described above. This takes past spending on the same population over the prior three

years and adjusts for inflation, spending growth for similar patients from same community not assigned to the ACO, and spending growth for all Medicare beneficiaries. Whether we receive any shared savings and how we compare with other ACOs will help us determine the cost effectiveness of our operations.

The CMS proposed rule contains in total 65 quality measures that an ACO must meet in the first year of the program to qualify for potential incentive payment rewarding the ACO for cost sharing. However, given the short time frame, many in the industry felt that this is unrealistic goal. An industry analysis found 29 of the measures to be reasonable, and recommended 3 to be deferred due to unclear or non-existing specifications. It suggested 9 measures to be removed, and found the remaining 24 measures to be burdensome. It also presented concerns to the CMS that the performance scoring approach may encourage competition instead of collaboration, and actually discourage participation in the shared savings program (Epic, June, 2011). Also, while the CMS proposed using Medicare claims data for the measures to ease the burden on health care organizations, the ACO would likely want to monitor its own performances frequently for timely feedback. Therefore the burden would still be considerable if the whole array of 65 measures were tracked, as is still required by the current rule as written.

Anticipated Impact to Stakeholders

In addition to financial impacts which will be discussed in the next section, the proposed ACO has the following anticipated impacts on stakeholders internal and external to the hospital:

1. Improved coordination of cares: reduced duplication of services, improved resolution of treatment conflicts, which will result in,
   - Cost saving for payers and the community
   - Over all improved health care quality and experience for patients.

   This anticipated impact is consistent with organization's mission of providing high quality care and impacting community health, while utilizing organization and community resources efficiently. If realized it will enhance the hospital's perceived value to the community
2. Forming the ACO will require more efficient and frequent clinical information exchange. Hospital staff physicians and nurses must share patient medical data and relevant notes with outpatient physicians, and vice versa. Admitting physicians, specialists, and primary care physicians will work together more closely.
3. Registration and admitting staff will need to obtain complete and accurate care providers information and proper consent in order to achieve meaningful information sharing while maintaining HIPAA compliance.
4. Culture change for physicians, from professional autonomy and individual responsibility to shared responsibility and extensive collaboration.

5. Information sharing beyond hospital boundary: Pull/upon request is easier with most existing systems. Push method is less demanding of providers (not having to remember requesting information) and may have bigger enabling impact on improving continuity of care. Implementing the Push method involves bigger modification to the current system, larger start-up investment, and more complex privacy and security arrangements.
6. Revenue decrease in certain areas/specialties due to reduced service volume. Shared savings bonus may not be sufficient to adequately offset the loss of revenue. (Health Affairs, 2010)
7. Case management or medical home scenarios: Coordination responsibility needs to be assigned, and workload in certain clinical support/care areas will have to be re-balanced. Additional staff may be required, and we will need to establish protocols for notifying and resolving treatment conflicts or incongruence, in episodic and maintenance phases.
8. To enable proper utilization: Compilation of evidence-based clinical guidelines and review with all ACO healthcare providers who will agree to monitoring of their compliance with guidelines and clinical pathways. This will require additional IT effort and personnel to enable embedded clinical decision support and monitoring of clinician compliance.
9. Other additional IT costs: Data warehousing for quality and financial metrics. Start-up cost to improve hardware infrastructure and upgrade connectivity and integration of information systems. Budget for service contracts and maintenance of system hardware and software and management of data for participating providers with less IT capability.
10. Require establishment of data collection and auditing process for new measures and financial impact assessments. Require periodic review and update of measures.
11. Additional accounting staff to manage distribution of shared savings (or accrued losses) among participating parties, legal staff to manage complex relationships between the ACO and Medicare and between parties within the ACO, and executive staff to manage the ACO.

Financial Impact

The ACO concept is laudable and offers the potential for major improvements in patient care, overall patient health and well-being, and cost-effectiveness of the medical care system as a whole. Unfortunately, the complex 429 page draft rule released by the Department of Health and Human Services in April (Federal Register, April 7, 2011) specifies a defective financial model that makes it impossible for any organization, no matter how well qualified and hard-working, either to recover its investment in the formation of the ACO or operate sound fiscal and budgetary systems that are sustainable over the long term.

The operational framework for the ACO reimbursement program was developed based on the just completed Medicare Physician Group Practice (PGP) Demonstration Project conducted by CMS from 2005 to 2010 (Haywood & Kosel, 2011). This project was offered to a highly selected set of academic medical centers and large physician group practices chosen based on their extensive experience, information technology infrastructure, and financial strength. The participating physicians and organizations were reimbursed based on their traditional Medicare fee-for-service charges, but were also eligible to share in Medicare savings if they demonstrated compliance with a panel of 32 quality measures and if the overall cost of care for their "attributed" patients was lower than the costs incurred by a comparable group of patients matched for geographic location and severity of illness. The groups received 80% of Medicare's savings as a bonus and were not at risk for any of the cost overruns if care was more expensive than that of the control group. By year four of the project all 10 PGP's met at least 29 of the 32 quality goals, but the financial results as shown in the table (Iglehart, 2011). were mixed.

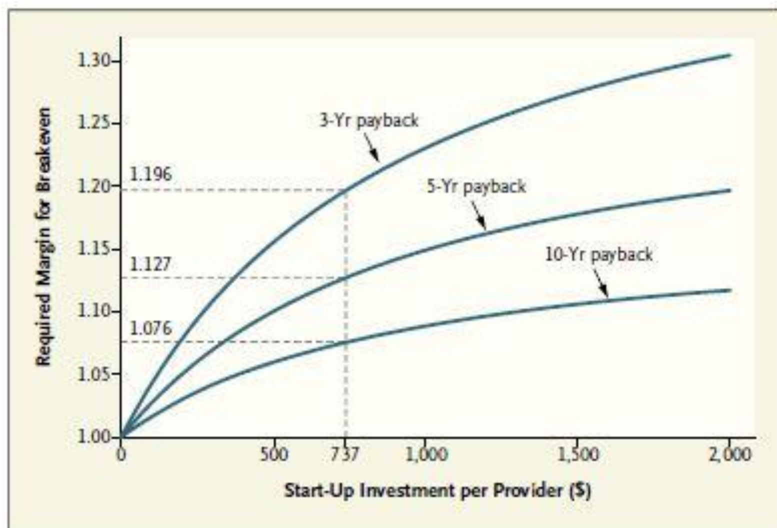
Summary Results of the Physician Group Practice Demonstration, Performance Years 1–4.*

Physician Group Practice	Percentage of Quality Goals Attained				Shared Savings Payments ($)			
	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Billings Clinic, Billings, MT	90.91	97.78	98.11	92.45	0	0	0	0
Dartmouth–Hitchcock Clinic, Lebanon, NH	95.45	97.78	92.45	94.34	0	6,689,879	3,570,173	328,798
Everett Clinic, Everett, WA	86.36	95.56	94.34	94.34	0	129,268	0	0
Forsyth Medical Group, Winston-Salem, NC	100.00	100.00	96.23	96.23	0	0	0	0
Geisinger Clinic, Danville, PA	72.73	100.00	100.00	100.00	0	0	1,950,649	1,788,196
Marshfield Clinic, Marshfield, WI	81.82	100.00	98.11	100.00	4,565,327	5,781,573	13,816,922	16,154,242
Middlesex Health System, Middletown, CT	86.36	95.56	92.45	94.34	0	0	0	0
Park Nicollet Clinic, St. Louis Park, MN	95.45	97.78	100.00	100.00	0	0	0	0
St. John's Clinic, Springfield, MO	100.00	100.00	96.23	98.11	0	0	3,143,044	8,185,757
University of Michigan Faculty Group Practice, Ann Arbor	95.45	100.00	94.34	96.23	2,758,370	1,239,294	2,798,006	5,222,852

* Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

In year one only two of 10 organizations received shared savings payments, increasing to five of 10 in year three and four. In year four there were $38.7 million of savings generating $31.7 million in bonuses to the providers. The vast majority of the performance bonuses went to just three institutions (Marshfield Clinic, St. John's Clinic, and University of Michigan), and four of the provider groups received no bonus at all for the entire project duration, a disappointing result for group selected to have the resources and skills to succeed in the demonstration.

In order to succeed, ACO's must collect and report data on quality of care, create new care models and incentives, and develop legal and financial systems to distribute shared savings among their stakeholders. Developing these capabilities will require significant initial costs for new legal and managerial entities, information technology, and other infrastructure (Luft, 2010). The PGP participating organizations invested an average of $1.7 million in startup costs the first year alone, a mean investment of $737 per individual provider. To recover this investment over a five-year time horizon would require a 13% margin to break even. Eight out of ten participants in the PGP did not recover their initial investment. With the initial three-year contract period envisioned by CMS for the first generation of ACO's, the required operating margin would be an extremely unlikely 20% as shown in the figure (Haywood, & Kosel, 2011).



Required Operating Margin Needed for an ACO to Recover the Start-Up Investment.

The proposed rules for ACOs are significantly more stringent than the conditions imposed during the PGP demonstration. There is an extensive list of 65 quality measures that must be met to qualify for shared savings. If savings are achieved, less than 50% goes to the provider organization (as opposed to 80% in the PGP). While ACO's selecting the safest of the CMS reimbursement models are protected from losses during the first two years of the program, all participants must accept shared risk and possible reimbursement cuts as of the year three and beyond, if cost and quality targets are not met. If the very experienced and well-financed groups in the PGP did not succeed under less rigorous conditions, it is hard to imagine how other, often smaller, organizations can possibly comply with these more difficult requirements and still maintain financial stability.

To make the task even harder, the ACO's panel of attributed patients (for cost calculations) is retrospectively assigned at the end of every year based on an arbitrary algorithm related to which primary care provider they saw for the majority of their visits. The CMS rationale for this method is that patients would react adversely to having their provider choice

limited to a single ACO (just as they did earlier with HMOs), but this leaves the ACO responsible for "out of network" care over which it has no control and which may even occur in a distant geographic area with much higher overall medical costs (e.g. the patient from New Hampshire who winters in Florida). This greatly increases the economic risk of the ACO model. The cost savings predicted for ACO's are to be provided in large part by better coordination of care, better preventive care, case management, and strong incentives to support clinical guidelines and evidence-based best practices. When the patient assignment is retrospective and invisible, and the ACO teams do not know which patients they are actually managing, it becomes extremely difficult to apply these principles and highly likely that the cost-cutting goals will not be met. To add insult to injury, the rules are operationally burdensome, granting the Department of Health and Human Services the right to conduct site visits and audits and "to inspect all books, contracts, records, documents, and other evidence" to ensure compliance with the ACO contract (Federal Register, April 7, 2011).

Under these conditions, 93% of the members of the American Medical Group Association and all 10 of the high-performing groups in the PGP have said they have serious reservations and will be unable to participate without major revision to the rules. Given that it will take at least 5 to 7 years to recover initial startup costs and that careful pro forma projections predict operating losses for the foreseeable future, the financial risk of ACO participation seems prohibitive.

Implications of Not Moving forward with ACO Status- David

The unsustainable growth in the total cost of medical care represents an irresistible driving force which will bring extensive changes in the health care system. Reform is coming. The federal government will enforce some type of transition from volume-based to value-based reimbursement. If incentive systems such as ACO's do not produce the required savings, the new Independent Payment Advisory Board created in the Affordable Care Act of 2009 may feel compelled to introduce systems of penalties to force providers into some type of organization that coordinates care, eliminates wasteful duplication, and accomplishes the same functions. This process could be even more painful than the current ACO proposal. In the worst case, this path could even lead to the enactment of a single-payer national healthcare system with strict price controls and rationing of care as is seen in the Canada and Europe.

Another risk of delay in ACO formation is that physician groups, with strong support from CMS, might come to dominate the evolution to an ACO model. As physician controlled ACO's proliferate, they would likely favor coordinated outpatient care, move as many procedures as possible from hospital to outpatient clinic settings, and maximize efforts to reduce hospital admissions. The decline in hospital census would be accompanied by a fall in revenues, reducing the operating margins necessary to support infrastructure improvements and potentially

even lowering hospital bond ratings making it harder to borrow the large sums needed for major expansion. In the worst case, a declining financial position could lead to lower employment, decreased influence in their communities, and overall decline in the role hospitals play in society (Kocher & Sahni, 2010).

One way to reduce the risk of such outcomes is to participate in other bundled care or pay-for-performance initiatives which offer a more realistic path toward value-based reimbursement. Such systems and contracts are being developed and offered by many private insurers. In contrast to the ACO rule published by CMS, such private organizations would manage a defined population of patients who are strongly incentivized to keep their care within the organization, would share savings or losses relative to a pre-established global budget, and would be eligible for supplemental payments for meeting defined quality metrics (in order to subsidize the upfront cost of the information technology and integration mechanisms necessary to produce shared savings).

Conclusions

Arguments in Favor of Forming an ACO

The ACO model promises many important theoretical benefits to patients, providers, healthcare organizations, the community, and the healthcare system as a whole. The underlying principle is that the current system suffers from fragmentation of care and that the care integration achieved by the ACO structure will improve both the quality and the cost efficiency of medical care. The expected gains are achieved by implementation of enterprise-level health information technology which allows rapid and comprehensive information sharing among patients, physicians, hospitals, and medical providers in multiple discipline. This should eliminate wasteful duplication of care, eliminate resources wasted on ineffective care, and provide decision-support resources that keep clinicians focused on the use of evidence-based guidelines and best practices.

That same information technology will allow the collection of detailed data on quality of care which can be compared to internal and external standards to identify opportunities for improvement and facilitate organizational efforts to deliver higher-quality care. The collection and analysis of quality metrics and practice results can be applied to populations of patients as well as individuals, yielding data to support the development of new generation best practices that can improve outcomes both for individual patients and large populations.

The ACO model creates incentives for healthcare organizations to build the information technology infrastructure, organizational management structure, and organizational culture to deliver higher-quality medical care at lower cost. This will reduce the unsustainably high cost of medical care, of great benefit to society, and will position healthcare organizations for further

growth and improvement as healthcare reimbursement transitions from volume-based to value-based criteria.

Arguments Against Forming an ACO

The ACO model can potentially provide tremendous benefits to individual patients, to healthcare providers, and to the healthcare system as a whole. Unfortunately in its rush to satisfy multiple constituencies all across the political spectrum, CMS has created a completely untenable design for its ACO system. The objections to participating in an ACO at this time fall into five major categories (Reynolds, 2011):

1. Startup costs will likely be prohibitive and will be recovered only under extremely long time horizons, if at all.
2. Participating ACOs will lack the key tools identified in the literature as being indispensable in driving down unnecessary costs. CMS determines the beneficiaries assigned to the ACO only at the end of the program year based on which physician provides a plurality of their primary care. When beneficiaries are identified only retrospectively and invisibly, the organization has no chance to perform the intensive monitoring and intervention necessary to improve the quality and reduce the cost of care.
3. Participants in the program assume significant downside risk for costs over which they have no control. CMS has trumpeted the provisions that allow Medicare beneficiaries to seek care from any provider and in any clinical setting they wish. Providers actually face termination from the program if there is any attempt to discourage patients from receiving care outside the ACO. The ACO will have no timely access to data on out-of-network utilization or to the medical results produced by that care. They may not even know that such care is being furnished. This can lead to unnecessary duplication of tests and services within the ACO and also provides a financial incentive for providers outside the ACO to maximize utilization, exactly the problems the ACO program was supposed to eliminate.
4. Even if the ACO succeeds in generating significant savings, there are extensive preconditions and limitations on any payment received. CMS can summarily cancel any and all such payments due to the ACO if the number of beneficiaries falls below 5000 anytime during the program year, if the ACO fails to report any of the 65 required quality indicators, if the ACO fails to meet performance metrics on one or more of the quality indicators, or if the ACO fails to adhere to any of the burdensome operational requirements (submission of marketing materials for prior review, notification of changes in network structure or personnel, etc.) described in the rule.
5. Shared savings bonuses are not payable until program year actual costs fall below 98% of the calculated benchmark, and the percentage of such savings to be paid is linked to a still undefined overall performance threshold on the 65 quality metrics. Maximum shared savings are capped at 10% of the program year benchmark cost.

Final Recommendation

It is simply not possible for a real-world healthcare organization to operate under these conditions. The risk of financial losses that would handicap or even bankrupt the HCO is too high. Unless the final ACO rule to be published this fall implements major changes from the preliminary version published in April, the Community Hospital System should decline to participate in the program at this time. On the other hand, the potential benefits to patients and society are strongly consistent with Community Hospital's mission, and all prudent organizations will want to maximize readiness to move to a value-based reimbursement model as the US health care system continues to evolve. We should therefore continue negotiation and coordination with physician groups and other providers to assure we have the capability to move forward rapidly if the current rule is revised to properly address real world contingencies or if a new, more workable program is proposed.

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