

Lawton R. Burns, PhD, MBA

*LDI Senior Fellow,
James Joo-Jin Kim Professor of
Health Care Management
University of Pennsylvania*

Mark V. Pauly, PhD

*LDI Senior Fellow,
Bendheim Professor of
Health Care Management
University of Pennsylvania*

Accountable Care Organizations: Back to the Future?

Editor's note: Accountable Care Organizations (ACOs) are networks of providers that assume risk for the quality and total cost of the care they deliver. Public policymakers and private insurers hope that ACOs will achieve the elusive "triple aim" of improving quality of care, improving population health, and reducing costs. The model is still evolving, but the premise is that ACOs will accomplish these aims by coordinating care, managing chronic disease, and aligning financial incentives for hospitals and physicians. If this sounds familiar, it may be because the integrated care networks of the 1990s tried some of the same things, and mostly failed in their attempts. This Issue Brief summarizes the similarities and differences between the new ACOs and the integrated delivery networks of the 1990s, and presents the authors' analysis of the likely success of these new organizations in affecting the costs and quality of health care.

Affordable Care Act spurs development of ACOs

The move toward ACOs comes from the need to contain costs in the Medicare program. The Affordable Care Act authorized Medicare to contract with ACOs, which will assume risk for the quality and costs of care they deliver. As envisioned by its proponents, ACOs will save money because they will reorganize care to be more effective and efficient. Each ACO must care for at least 5,000 Medicare recipients for at least three years, and agree to meet certain quality standards and cost targets. If an ACO saves money, it shares in the savings; if it puts itself at risk for losing money, it can gain a larger share of the savings.

- Two assumptions underlie the promise of ACOs: that better care coordination will improve quality at any given cost, and that ACOs will slow the rate of growth in Medicare spending. The Centers for Medicare and Medicaid Services (CMS) estimates that ACOs will save the federal government \$940 million over four years, if 270 organizations participate in the program.
- To date, CMS has awarded contracts to 153 ACOs. The majority of them are led by hospital systems, although some are spearheaded by physician groups. The number of contracts is expected to double after another round of awards in January 2013.
- In theory, ACOs will improve quality and lower costs using several methods, including disease management programs, improved care coordination, alignment of incentives for physicians and hospitals via shared savings, use of nonphysician providers, and the formation of patient-centered medical homes.

ACOs resemble integrated delivery networks of the 1990s in some ways

This latest attempt at reorganizing care strongly resembles the integrated delivery networks (IDNs) of the 1990s, which linked physicians, hospitals, and alternative care sites. Hospitals created joint ventures with their medical staffs and formed physician-hospital organizations and management services organizations to negotiate contracts with insurers.

- Both models emphasize coordination of care and disease management. Both focus on primary care providers as the key to improving quality, managing risk, and controlling costs.
- Structurally, both models encourage horizontal consolidation of hospitals and vertical (or virtual) integration of hospitals, physicians, and providers of postacute care.
- Payment systems in both models seek to escape the volume incentives of fee-for-service by relying on risk contracting, capitation, and employed physicians.

ACOs differ from integrated networks in other ways

However, ACOs are not just another name for the integrated networks of the 1990s. There is less consensus now on what should be the ACO's organizational core—a hospital system, physician group practice, or some wholly new type of organization—and over what the new entity should do, or stop doing, to reduce spending.

- In contrast to the earlier networks, the impetus for ACOs comes from the demand side (CMS) rather the supply side (providers). CMS is patron and protector of the current restructuring effort, seeking to bring down costs to help alleviate the federal deficit.
- In the 1990s, there was some agreement that capitated contracts between insurers and IDNs would cut costs by reducing hospital admissions and inpatient days, and by restricting out-of-network utilization. In contrast, Medicare ACOs cannot directly control patients' choice of physician or health care utilization.
- More than 20 years later, ACOs may benefit from more advanced information technology and more sophisticated payment systems than the IDNs. ACOs are developing alternative payment systems beyond capitated arrangements, such as bundled payments and shared savings through pay-for-performance for providers.

What the network experience tells us about ACOs

For the most part, IDNs did not deliver on their promises. They lacked the information technology needed to manage risk contracts; they overpaid for physician practices; they acquired hospitals without achieving economies of scale; and they failed to coordinate care for most beneficiaries. What might the ACOs learn from this experience to avoid the same fate?

- Although they were labeled integrated and networks, most of the earlier organizations did not have unified governance and did not take a systems approach to organizational planning. ACOs will need to pay more attention to integrating everything from personnel matters to physician culture.
 - Coordination among multiple providers is harder than it sounds. And it poses daunting challenges, as Medicare fee-for-service beneficiaries see an average of two primary care providers and five specialists across four sites of care annually.
-

-
- Evaluations of disease management programs for patients with chronic illness have shown that some programs may improve patients' functional status but do not save money. The Congressional Budget Office found insufficient evidence that disease management programs can even pay for themselves.
 - ACOs are designed to work in tandem with a patient-centered medical home, in which a team led by a primary care physician provides comprehensive services. Demonstration projects suggest that any improvements in quality and costs rest on long-term practice transformation, an internal capacity for organizational learning, physicians' willingness to collaborate and function as part of a team, and a multiyear commitment to change. Implementing all of these changes will take considerable time and money.
 - Perhaps no single element of ACOs has received as much attention and funding as information technology. However, research on decision support systems, computerized physician order entry and electronic health records reveal mixed effects on costs and quality. Overall, it suggests that information technology is necessary but insufficient to improve outcomes.

The Achilles' heels of ACOs: primary care workforce, physician practice organization, and out-of-network utilization

ACOs face inherent challenges in meeting their goals. Their success may be limited by existing shortages in the primary care workforce, the dearth of large multispecialty physician groups, and the absence of direct controls on out-of-network utilization by Medicare beneficiaries.

- ACOs rest on a foundation of primary care physicians who can coordinate all medical care for high-risk patients in addition to supplying their own services. However, there is a shortage and uneven geographic distribution of primary care physicians nationwide. It is unclear how large a role nonphysician providers will play in meeting the increased demands of the patient-centered medical home, and whether these providers can lower cost.
- Larger physician groups deliver care that is higher quality and more efficient. These groups may be in the best position to house the patient-centered medical home, but the number of groups has remained stagnant for decades. The spread of large multispecialty groups has been limited to certain states and regions, such as California. Quick change is unlikely.
- Primary care providers must curb utilization for Medicare patients, because the ACO is at financial risk. But unlike the earlier networks, the primary care provider is not an explicit gatekeeper and cannot directly control patient use of out-of-network providers and specialists. Instead, they must rely on persuading patients to avoid self-referrals to specialists.

POLICY IMPLICATIONS

The parallels between the ACOs and the IDNs seem quite strong, raising concerns that the newer entities will have the same fate as the earlier networks. In the 1990s, the ability of IDNs to achieve economies of scale and a seamless continuum of care was oversold. Today, policymakers need to realistically assess and periodically revisit the promises and premises of ACOs.

- Just like the 1990s networks, ACOs need to target specific population segments that would benefit most from coordinated care, such as people with multiple chronic conditions. Coordination will not likely reduce total expenditures for the broader low-risk Medicare population.

POLICY IMPLICATIONS

Continued

- Strategic change needs to be carefully implemented. Providers may need to pay more attention to change management and devote considerable time and money to infrastructure features and capabilities. Although CMS wants organizations to assume greater risk within three years, research on organizational change suggests a more realistic window is five to seven years.
- Medicare's need to slow growth of its payments may move it toward providing a budget-based capitation payment. It may be that Medicare will give a set amount to ACOs, and ACOs will do the best they can with that amount. If that happens, it will be a true test of how much waste there is in the system.

This Issue Brief is based on the following article: L.R. Burns and M.V. Pauly. Accountable care organizations may have difficulty avoiding the failures of integrated care networks of the 1990s. Health Affairs, November 2012, vol. 31, pp. 2407-2416.

Published by the Leonard Davis Institute of Health Economics, University of Pennsylvania, 3641 Locust Walk, Philadelphia, PA 19104.

Janet Weiner, MPH, Associate Director for Health Policy, Editor

Dan Polsky, PhD, Executive Director

Visit us on the web at <http://ldi.upenn.edu>

Issue Briefs synthesize the results of research by LDI's Senior Fellows, a consortium of Penn scholars studying medical, economic, and social and ethical issues that influence how health care is organized, financed, managed, and delivered in the United States and internationally. The LDI is a cooperative venture among Penn schools including Medicine, Nursing, Dental Medicine, Communication, Law, and Wharton, and the Children's Hospital of Philadelphia. For additional information on this or other Issue Briefs, contact Janet Weiner (e-mail: weinerja@mail.med.upenn.edu; 215-573-9374).

© 2012 Leonard Davis Institute

Published by the
Leonard Davis Institute
of Health Economics
University of Pennsylvania

Issue Brief



3641 Locust Walk
Philadelphia, PA 19104-6218
215.898.5611
fax 215.898.0229
ADDRESS CORRECTION REQUESTED

Nonprofit Organization
U.S. Postage
PAID
Permit No. 2563
Philadelphia, PA 19104