



# A Closer Look at ACOs

*A series of briefs designed to help advocates understand the basics of Accountable Care Organizations (ACOs) and their potential for improving patient care.*

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## Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know

### What's an ACO?

Since the Affordable Care Act was signed into law, there has been a lot of buzz about Accountable Care Organizations (ACOs). Supporters of ACOs see them as a way to reshape the way health care is delivered. They hope that ACOs will improve health care quality and reduce health care costs by getting providers to work together and focus on the quality of care, not the quantity.

The broad concept of an ACO is not complicated. An ACO is an entity that is made up of health care providers across the continuum of care (including acute care, long-term care, and behavioral and mental health care) that agrees to be held accountable for improving the health of its patients. If patients' health care costs end up being less than would otherwise be expected while health care quality is maintained or improved, the providers get to keep a share of that savings. Providers, therefore, have a financial incentive to work together to improve the health of their patients. A successful ACO should put the patient at the center of all its activities and ensure coordination of care.

An ACO is not an insurance plan. Rather, the ACO model provides for a new way to pay health care providers: Providers that are part of the ACO will continue to be paid by a third party payer, such as Medicare, Medicaid, or a private insurance plan.

While the concept may be straightforward, actually designing an ACO that will benefit health care consumers is difficult. There is no one-size-fits-all model for an ACO, and there are a great many unanswered questions about how they should operate. If they are implemented poorly, ACOs could simply end up limiting access to care, rather than improving quality.

This brief examines some of the key questions facing advocates and policy makers as ACOs take shape, and we suggest how consumer advocates can get involved in answering these questions in a way that benefits patients. Subsequent briefs have examined some of the complexities of ACOs in more detail. These pieces are available on our website at [www.familiesusa.org/resources/publications/](http://www.familiesusa.org/resources/publications/).

## The Promise of ACOs

Although ACOs are not the silver bullet that will fix all the problems within our health care system, they are potentially a powerful tool that could improve the quality of care and change the way providers are paid so that they are encouraged to deliver high-quality, low-cost care.

ACOs aim to fix the fragmentation in our health care system by addressing simultaneously both the way care is delivered (delivery system reform) and the way that it is paid for (payment reform). One of the goals of ACOs is to move the health care system away from a fee-for-service system, in which providers are paid for each service a patient receives, to one focused on delivering the best care at the best price. This is often described as high-value care.

In a fee-for-service system, the more services providers give, the more money they are paid. This creates a powerful incentive to provide more and more services, regardless of whether the services are improving the patient's health. In a value-driven system, providers will be paid based on the quality and cost of the care they provide. Changing the financial incentives that often drive the way providers deliver health care should help ensure that patients receive the right care at the right time in the right setting.

The most important of an ACO's many functions is to bring health care providers and community-based services together to work in a way that meets all the needs of its patient population. The ACO should help bridge the gap in communication that has often existed between providers (for example, between primary care providers and specialists), along the continuum of care (for example, between acute care and long-term care), and between health care providers and community-based services (for example, between doctors and Meals on Wheels programs).

The ACO will also be responsible for helping providers change the way they deliver care. ACOs should develop guidelines for their providers that establish how care should be delivered. ACOs may also give providers health information technology (HIT) that includes electronic health records and decision-support tools that will help providers and patients work together to explore different treatment options to determine which is best for the patient. An ACO will also serve important administrative functions, such as negotiating contracts with insurers, both private insurers and public programs like Medicare and Medicaid.

To deliver on the promise of lower costs through improved patient health, ACOs will have to develop truly *patient-centered* care. The Institute of Medicine has defined patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”<sup>1</sup> Part of providing patient-centered care means ensuring that patients have access to care when they need it. This means something as practical as being able to see health care providers the same day or on the weekend, rather than having to wait for an appointment and having a condition worsen. It also means providing the support that patients need, such as helping them transition between health care settings (for example, leaving a hospital for home or an assisted living facility). It should include coordination among all the patient’s health care providers and among care settings, particularly during transitions between settings. Care coordination should also include coordination among payers, including Medicare, Medicaid, Tricare, and other forms of coverage, as well as coordination of health and social services, such as transportation and nutrition.

## The Emerging ACO Landscape

The idea of creating an integrated health care entity is not new. Large health care systems like the Geisinger Health System in Pennsylvania or the Mayo Clinic in Minnesota have provided integrated care across the health care continuum for decades, often to wide acclaim.

What is relatively new is the idea of using payment reform to make a group of providers accountable for the quality of care they provide. Several demonstrations and experiments have tried this model in recent years. Medicare began a demonstration in 2005,<sup>2</sup> and the Dartmouth Institute and the Brookings Institution are testing ACO models with five different provider groups and private insurance companies in different parts of the country.<sup>3</sup>

As part of its efforts to promote better quality care and lower costs, the Affordable Care Act gave the development of ACOs a significant boost. The new law created several kinds of ACOs, including the Medicare Shared Savings Program ACO. This is a new type of payment within Medicare that providers can choose to participate in. Under this model, if the ACO lowers Medicare expenditures from year to year and meets quality measurements, the ACO will share in a percentage of the savings. The Centers for Medicare and Medicaid Services (CMS) issued final regulations for the Medicare Shared Savings Program ACO in October 2011.<sup>4</sup> The program will begin in 2012. The Affordable Care Act also authorizes Medicare to test other types of ACO models. For example, the Center for Medicare and Medicaid Innovation is testing 32 Pioneer ACOs in 18 states.<sup>5</sup>

On the Medicaid side, the new law authorizes a limited Medicaid ACO demonstration. The demonstration allows states to test Medicaid Pediatric ACOs over a five-year period. States are also pursuing Medicaid ACOs through other means, including state plan amendments and waivers. Colorado, for example, began enrolling beneficiaries in its Medicaid ACO model in 2011.<sup>6</sup>

In terms of private insurance, the Affordable Care Act does not explicitly promote the growth of ACOs that serve patients with this type of insurance. However, private insurers have historically adopted many of the payment reforms that have been pioneered by Medicare. If Medicare ACOs are successful, private insurers are likely to follow suit and develop ways to pay ACOs. This is why the development of Medicare ACOs is so important. In addition, private insurers are showing significant interest in encouraging the development of ACOs or of entities that in some ways resemble ACOs. This interest is understandable, as ACOs have the potential to reduce costs for all payers, including private insurers. However, in some cases, insurers may seek to blur the lines between a provider-based ACO and an insurance company. This concern highlights the need for advocates to push for vigilant patient protections as ACOs develop.

## The Role for Advocates

As providers reorganize themselves into ACOs, advocates have an important role to play to make sure that patients' interests and needs are met. This is true for ACOs that are established under Medicare's rules, as well as for those that emerge through Medicaid and the private sector.

Advocates should monitor the development of Medicare ACOs for several reasons. First, and most obviously, these ACOs will serve Medicare beneficiaries, who need access to high-quality care. Secondly, these ACOs will almost certainly include major health care institutions in some areas (large hospital systems, for example). This means that they will serve patients who are not in Medicare but who also need high-quality care. Finally, ACOs that are developed under Medicare rules will likely serve as models for ACOs that are developed to work with other payers, such as private insurers.

In addition, an increasing number of state Medicaid programs and large provider groups and institutions like hospitals are considering establishing new integrated entities. Some of these proposals are actually true ACOs, in which groups of providers across the care spectrum are held accountable by Medicaid or private insurers for quality and get to share in any savings. Other proposals may use the term ACO but are not truly ACOs. Some are forms of primary care case management, in which primary care doctors are given incentives to coordinate care. Others may be closer to new models for health insurance, in which a private insurer takes on a larger role in coordinating care. In still other cases, providers may be consolidating (for example, hospitals purchase physician groups) allegedly to create an ACO, but the necessary accountability mechanisms are yet to be established.

Because ACOs are at such an early stage of development, the most important role advocates can play in the process is to become involved in setting up the rules and in establishing the new entities. This can mean many things. For example:

- If a Medicaid program proposes an ACO, advocates should participate in the planning process to make sure beneficiaries' needs are met.
- If a large hospital system is acquiring a set of other providers and announces it will form an ACO, advocates should demand a voice in establishing consumer protections and rules for accountability.
- When federal and state regulations and policies are proposed in Medicare and Medicaid, advocates should consider submitting comments.
- Advocates should develop relationships with health care administrators, medical societies, insurance commissioners, and health departments, among others, to stay informed about changes to their local health care delivery system.

What follows is a list of key challenges that may be encountered in the ACO development process and how advocates might suggest these challenges be addressed.

## Challenges Facing ACOs

### Challenge 1:

#### Developing an ACO that Meets a Community's Needs

What a particular ACO will look like will depend largely on the health care delivery system in that area. ACOs could be any of the following:

- fully integrated health delivery systems,
- large multispecialty group practices that own or have strong affiliations with hospitals,
- physician-hospital organizations,
- physician-only organizations, or
- some combination of these.

For rural areas, because the providers may be spread over a large geographic area, a rural ACO is more likely to be virtual, while an urban one may be located in a physical location. In addition, different tools may need to be used to help rural providers with care coordination, such as telemedicine, which may not be a common tool that is used by urban ACOs.

Whatever form it takes, an ACO must be built on a foundation of primary care. Primary care providers are usually the ideal providers to coordinate patient care. Beyond this, an ACO should organize itself based on the needs of its patient population. For example, if the patient population is older, the ACO should include providers of long-term services and supports and community-based services such as Meals on Wheels. If the ACO treats a largely low-income population, the ACO will need to include safety net providers, such as federally qualified health centers (FQHCs), as well as transportation service providers.

In addition to a strong primary care foundation, ACOs should include a wide range of health care providers and community-based resources (beyond hospitals and doctors) through formal or informal relationships. ACOs must include an adequate and appropriate mix of health care providers and community-based services in order to manage patient care along the full care continuum.

Governance of ACOs is another concern. In most cases, an ACO will have some kind of governing body, such as a board of directors. The governing body should include patients and community-based service providers, as well as participating health care providers. The governing body should allow all ACO participants and the community to take part in the decision-making of the ACO, which will help ensure local accountability.

### Issues for Advocates

- ▶ Does the ACO have an adequate and appropriate range of providers and services, including a large primary care capacity?
- ▶ Can the ACO meet the community's health care needs, including cultural and linguistic concerns?
- ▶ Does the governance structure allow adequate participation by community members who are not health care providers?

## Challenge 2: Figuring Out Which Patients Are in the ACO

For the ACO model to work, there must be some way for the payer and the ACO to know which patients they are responsible for. Under most models, including the Medicare shared savings program model, beneficiaries will be automatically assigned to an ACO based on which doctors and providers they see. They will not have to enroll affirmatively in an ACO like they have to enroll in a health insurance plan. Rather, if Ms. Smith sees Dr. Jones for most of her care, and Dr. Jones is part of the ACO, then Ms. Smith is considered to be assigned to Dr. Jones's ACO for payment purposes.

However, there are other ways for beneficiaries to become part of an ACO. Some ACOs and payers may allow beneficiaries to explicitly enroll in an ACO. This could either be an active, voluntary choice by the beneficiary, or it could be some kind of automatic process made by the insurer. In some models, the payer could require the beneficiary to select an ACO, similar to selecting a primary care provider within a network. This last option, which is not part of any current Medicare proposal, would have the effect of limiting patients' access to providers and should be explored very carefully, and it should be implemented only after the adequacy of the ACO has been established.

Under any approach, two concerns are paramount: 1) Patients must know that they have been assigned to an ACO, and 2) patients need to know what their rights are regarding leaving the ACO. In most cases, providing patients with a way to opt out of the ACO is a good idea.

### Issues for Advocates

- ▶ How will patients know they are part of an ACO? The more direct and personalized the notification is, the better.
- ▶ Are there any limitations on access to providers? If so, what are they, and how can they be overcome?
- ▶ How can a patient leave the ACO?

## Challenge 3: Allowing Patients Freedom of Choice of Providers

Under the Medicare Shared Savings Program, patients will be able to see both ACO providers and non-ACO providers. The ACOs will not be like managed care insurance plans where patients can see only providers within their plan's network. However, the ACO will still be held financially accountable for all the care the patient population receives, both from ACO providers and from non-ACO providers.

For patients, this freedom of choice of provider is particularly important if a patient is undergoing a course of treatment with a particular provider. For providers, it should encourage health care providers both inside and outside the ACO to communicate and coordinate care, regardless of whether they share the same financial incentives, because it is in the best interest of the patient.

Some providers have voiced concerns that they should not be accountable for care that patients receive from providers outside the ACO. As a result, some ACO models (those paid by Medicaid and private insurers) may require patients to see providers only within the ACO. In these cases, consumer protections such as requiring adequate networks, ensuring continuity of care, and instituting an easy appeals process to obtain care outside the ACO are essential.

### Issues for Advocates

- ▶ Will patients have freedom of choice of provider? Will ACO providers be able to communicate adequately with non-ACO providers?
- ▶ If freedom of choice of provider is limited, ensuring an adequate range of providers within the ACO is even more vital. Advocates need also to build in consumer protections, including protections for ensuring continuity of care and an appeals process.

## Challenge 4: Holding ACOs Accountable for Quality

An ACO must be held accountable for the performance quality of its member providers. Without such measurement, beneficiaries, payers, and the public cannot be sure of the quality of care that beneficiaries receive and determine whether that care improves over time. Quality measurement also serves as a check on the temptation to produce short-term savings by limiting care, rather than by improving quality.

Under the Medicare shared savings program regulations, the quality of care that is delivered is linked to the amount of the incentive payment that an ACO can receive. This makes the ACO accountable for the care that its providers deliver. If the ACO providers lower costs and meet minimum quality requirements, the ACO receives an incentive payment. The higher the quality scores, the larger the incentive payment. On the other hand, if the ACO's health care providers do not meet the quality requirements, then the ACO will not receive any incentive payment.

Other ACO models may use different measures of accountability and different formulas for incentive payments. Advocates should make sure that whatever measures and formulas are used, they are rigorous enough to drive quality improvements. Whenever possible, the quality measurements should be standardized across different payers, both to limit the burden on health care providers and to help improve the quality measurement process.

### Issues for Advocates

- ▶ Is there rigorous quality measurement in place that evolves over time to ensure that quality is always improving?
- ▶ Is the quality measurement appropriate for the community and for the patients who will be served? For example, consider whether a measurement is suitable for a pediatric versus a geriatric practice; what the appropriate language and cultural standards should be; as well as whether there are particular conditions, like diabetes, that are especially prevalent.
- ▶ Will the formula for incentive payments ensure participation of an adequate range of providers?

## Challenge 5: Getting Providers and Patients to Work Better Together

To be successful, ACOs will need to drive a change in the culture both of health care providers and patients. Historically, doctors have not practiced in teams and have not communicated well across the care continuum. At the same time, many patients believe more care is better and the newest technology or medication is always the best, when in fact sometimes less intensive treatment can be more effective. ACOs aim to shift this culture to one where the emphasis is on care coordination and not simply doing more and more of the latest and costliest procedures.



To start the care coordination process, ACOs should explain to patients (through notices and other means) that the provider is part of an ACO and what that means for the patient. Providers should also include patients in the process of developing health care plans that reflect patient preferences and values. ACOs should also develop protocols to use shared decision making that explains the benefits and consequences of each treatment to patients (or their caregivers).

### Issues for Advocates

- ▶ As ACOs take shape, look for evidence (through surveys and other means) that providers are working in teams and communicating better with patients and among themselves.
- ▶ Use positions on governing boards to monitor patient involvement in treatment, such as the use of shared decision making.

## Challenge 6: Avoiding the Mistakes of Managed Care

Although they are not a form of health insurance, ACOs have some superficial similarities to health maintenance organizations (HMOs) and other managed care. When first conceived, managed care was intended to produce savings because insurers would benefit from reduced health care costs if their members' health was improved through initiatives like case management and better preventive benefits. In some cases, this worked. In many instances, however, insurers found it easier to reduce costs simply by closing provider networks, which limited patients' freedom of choice of provider, and by denying coverage of services. Little attention was paid to improving quality and paying for high-value care. As a result, in the 1990s, there was a significant backlash against managed care from both patients and providers.

Unlike managed care, ACOs are designed to be provider-based. They should use care coordination and quality measurement to improve health care quality and drive down health care costs. The focus should be on providing high-quality care, not limiting access to care.

Taking the responsibility of improving quality while lowering costs out of the hands of a third party, often a large company that has no ties to the community and that is not directly involved with providing health care, and putting it into the hands of a local organization that is made up of the providers who directly provide care to patients is among the most important differences between a managed care plan and an ACO. Nevertheless, there is a risk that poorly designed ACOs could pursue short-term savings by limiting access to care. That is why robust accountability measures are essential. It is also why payers (insurers) need to be kept separate from ACOs.

### Issues for Advocates

- ▶ Ensure patients and providers, not insurers, have authority over health care decisions.

## Conclusion

The development of ACOs is an important opportunity for health care advocates to participate in the reshaping of our health care system. If done well, ACOs hold the promise of reducing health care costs while improving quality for patients. But they will succeed only if the needs and concerns of patients are continually brought forward as these new entities develop. As ACOs emerge at the state and local level, advocates should inject themselves into the planning processes and ensure that consumers' interests are protected.

## Resources

ACO Learning Network, available online at <http://www.acolearningnetwork.org>.

Medicare Shared Savings Program Final Rule, available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>.

Medicare Shared Savings Program Proposed Rule, available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>.

National Committee for Quality Assurance (NCQA), available online at <http://www.ncqa.org/tabid/1312/default.aspx>.

National Quality Forum, available online at <http://www.qualityforum.org/Home.aspx>.

National Quality Measures Clearinghouse, available online at <http://qualitymeasures.ahrq.gov/about/index.aspx>.

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<sup>1</sup> Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington: National Academy Press, 2001).

<sup>2</sup> Centers for Medicare and Medicaid Services, *Medicare Physician Group Practice Demonstration* (Washington: Centers for Medicare and Medicaid Services, December 2001), available online at [http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP\\_Fact\\_Sheet.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf).

<sup>3</sup> More information about the Brookings-Dartmouth ACO model is available on the The Dartmouth Institute for Health Policy and Clinical Practice, Center for Population Health, Accountable Care Organizations web page, online at <http://tdi.dartmouth.edu/centers/population-health/policy-core/accountable-care-organizations/>.

<sup>4</sup> Centers for Medicare and Medicaid Services, Medicare Program; "Medicare Shared Savings Program: Accountable Care Organizations," 76 FR 67802, available online at <https://www.federalregister.gov/articles/2011/11/02/2011-27461/medicare-program-medicare-shared-savings-program-accountable-care-organizations>.

<sup>5</sup> Center for Medicare and Medicaid Innovation, Pioneer ACO Model, available online at <http://innovations.cms.gov/initiatives/aco/pioneer/>, accessed on February 10, 2012.

<sup>6</sup> Colorado Department of Health Care Policy and Financing, *Accountable Care Collaborative* (Denver: Colorado Department of Health Care Policy, 2011), available online at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246>.

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