# A Radiologist's Primer on Accountable Care Organizations

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The Patient Protection and Affordable Care Act that was signed into law in March 2010 included specific language codifying a new health care entity, the accountable care organization. The accountable care organization model is put forward as a way to increase value in health care, that is, improving outcomes as efficiently as possible. It is not known whether this concept can be applied successfully beyond the carefully selected examples where it already functions. Three general principles figure prominently in known successful models: the provision of efficient primary care, shared savings, and IT infrastructure. The authors discuss these concepts, ongoing uncertainties, and how radiologists may fit into an accountable care organization.

**Key Words:** Accountable care organization, health care reform, information technology

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## INTRODUCTION

There has been much attention and concern directed to accountable care organizations (ACOs). Guidelines for developing ACO projects were written into section 3022 ("Medicare Shared Saving Program") of HR 3590, the Patient Protection and Affordable Care Act (ACA). Policymakers hope that ACOs will become one of several ways to achieve good outcomes as efficiently as possible in the provision of health care in the United States. Radiologists have expressed concerns that the ACO model will expedite the demise of unrestricted volume-based fee-for-service reimbursement in existence since the early 1990s, eliminate the opportunity for radiology practices to maintain independence, and place radiologists at an economic disadvantage [1]. Now, to anticipate payment changes, radiologists must understand the structure of ACOs and learn how they may participate in, and benefit from, this care model.

## ACCOUNTABLE CARE ORGANIZATIONS: WHAT AND WHY?

As health care expenditures in the United States continue to grow, there is increasing evidence that much of what is presumed to represent excessive cost is devoted to discretionary "supply-sensitive" services, including more frequent hospital stays, specialist referrals, and greater use of diagnostic testing [2,3]. Areas in the United States that have lower per beneficiary Medicare expenditures tend to provide higher quality care [4]. Although the data and their interpretation remain controversial, both precepts have been at the core of the current health reform [5]. With these two empirical observations in mind, health care policy experts have been searching for reforms that can simultaneously slow the growth of spending and improve measurable outcomes [3,6,7]. The guidelines for eligible ACOs in the ACA were derived from successful examples, including large physician organizations, such as Monarch Health Care in Orange County, California; fully integrated systems such as the Geisinger Clinic, centered in Danville, Pennsylvania; and regional and statewide organizations, such as the Pittsburgh Regional Health Initiative, Kaiser Permanente, and Community Care of North Carolina [8]. Also, policymakers drew from experiences of success in the CMS Physician Group Practice Demonstration [9].

These experiences and examples have guided the general concept of what an ACO can be, what it might look like, and how it could function. However, on the basis of the writings of key policymakers, especially Mark McClellan at the Brookings Institute and Elliott Fisher at Dartmouth [8], and the text of the ACA itself, the bill intentionally leaves great latitude as to

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acceptable organizational structure while identifying several core requirements of any eligible program [10]:

1. An ACO must be ready to begin by January 1, 2012.
2. It must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
3. It must agree to participate for no less than 3 years.
4. It must have a formal legal structure that would allow it to receive and distribute payments for shared savings.
5. It must include enough primary care professionals sufficient for at least 5,000 Medicare fee-for-service beneficiaries to be assigned to it.
6. It must have processes in place to promote evidence-based medicine, report on quality and cost, and coordinate care.

In addition, there are various not yet detailed requirements about "patient-centeredness," the Physician Quality Reporting Initiative, and the use of electronic health records [11]. Finally, payments will continue to be made to providers in an ACO under the original Medicare fee-for-service program, except that an ACO may also receive payment for shared savings as long as it meets quality performance standards established by the secretary of the US Department of Health and Human Services. As denoted in the name, any savings that accrue will be shared between the ACO and CMS.

Although the text of § 3022 of the ACA describes only fee-for-service payments, policymakers seek over time to move payment methodologies toward capitation models [12]. For example, it has been suggested that other payment reforms, such as bundled payments for episodes of care, may be most effective if they are tied to the overall accountability of care that would exist in ACO models [13]. Furthermore, the policymakers responsible for supporting the ACO model would like ACOs, at their core, to reduce the growth of health care spending [8]. Correspondingly, some more established ACOs will, at their outset, bear full insurance risk and be paid through full or partial capitation [14]. Policymakers describing ACOs have even referred to them as "shadow capitation" [15].

## PRACTICAL CONSIDERATIONS

### Primary Care

The provision of effective primary care is the core premise of any ACO. Primary care practices are able to focus on prevention, early diagnosis, and chronic disease management. Primary care does not imply only primary care doctors, as the optimal allocation of resources will favor collaboration with nurse practitioners and physicians' assistants, registered nurses, as well as electronic support, especially in the efficient management of chronic diseases and prevention [12,16,17] (R. Berenson, personal communication, April 15, 2010).

### Shared Savings

The concept of shared savings represents a central component of the ACO incentive structure. Accountable care organizations will be eligible to receive shared savings payments if their estimated average per capita Medicare expenditures are at least the specified percentage below the established benchmark. If this condition is met, ACOs will be eligible for shared savings payments in the form of a set percentage of the difference between their spending and such benchmarks [10]. The ACA authorizes the secretary of the Department of Health and Human Services to determine these percentages and benchmarks. Of relevance to radiologists, the savings will be realized through reductions in specialty and hospital expenditures, including appropriate utilization and referrals; reduction in emergency room visits, admissions (especially readmissions), in-hospital infections, and adverse events; and shortened lengths of stay.

### Technology

Electronic health records, with all their implications for coordination of care, represent the backbone of an efficient care model [18,19]. Information systems should exist as data warehouses and not be proprietary. But the optimal use of health IT in our opinion also includes

- the promotion of direct patient communication outside of office visits;
- availability of up-to-the minute performance data for doctors;
- simplifying the goal of doing the right thing at every contact with the patient;
- saving money, including presenting value propositions to the care provider at the point of care; and
- supporting disease registries.

### Risk

Current ACO models fall along a risk spectrum ranging from organizations bearing no risk, but able to receive bonuses, to those paid through partial or full capitation. Most ACOs will not take on this full insurance risk but should be able to manage performance risk. As organizations grow, they will be able to take on more risk. There should not be incentives to avoid sicker patients, which were problematic under capitation models in the 1990s, when many doctor groups took on full insurance risk. Additionally, ACOs will not succeed if they are viewed merely as methods of delivering less care. On the other hand, they must be able and allowed to remain profitable if they succeed in keeping people healthier.