EXECUTIVE SUMMARY
With the passage of the Affordable Care Act (ACA) in 2010, broad agreement has been reached on the need for fundamental reform of healthcare delivery and payment systems. Accountable care organizations (ACOs) have become one of the most discussed provisions of the ACA, and Medicare’s Shared Savings Program (SSP), the incentive program tied to ACOs, has the potential to change the delivery of healthcare. The SSP will attempt to improve the quality of care while reducing the growth in expenditures by encouraging the formation of ACOs.

The SSP is voluntary, and organizations that wish to participate will encounter advantages and disadvantages in its adoption. This article provides hospital administrators with basic information about the ACO requirements set forth by the Centers for Medicare & Medicaid Services and helps frame decision making about hospital participation in ACOs.

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Introduction

Accountable care organizations (ACOs) were proposed in the Affordable Care Act (ACA), signed into law in 2010, as a measure to slow rising healthcare costs and improve quality in the traditional Medicare program. ACOs have been defined and interpreted differently by various thought leaders in the field. Elliot Fisher, MD, director of the Dartmouth Center for Health Policy Research, defines an ACO as “a local network of providers that can manage the full continuum of care for all patients within their provider network” (Ronning 2010, 47). The ACA introduces the ACO concept through the creation of the Shared Savings Program (SSP) for Medicare reimbursement.

The ACA highlights the following criteria that ACOs must demonstrate to qualify for participation in Medicare’s SSP (Ronning 2010):

- Accountability for quality, cost, and care of a population of Medicare beneficiaries
- Participation for no less than three years
- Affiliation with a legal structure that can receive and distribute bundled shared savings payments
- Inclusion of primary care physicians; demonstration that enough primary care physicians are included whose combined Medicare population is at least 5,000
- Presence of a clinical and administrative management system
- Promotion of evidence-based medicine
- Reporting of quality and cost measures

- Coordination of care, including the use of technological systems
- Demonstration of patient-centeredness

Accountable care is not a new concept. The idea of assigning accountability to health organizations for their quality has been discussed for many years. For example, accountability was addressed in the attempted health reform of the 1990s, when the accountable party was the insurer or the health maintenance organization (HMO). By making facilities and providers directly responsible for accountability under the ACA, a higher quality of care is envisioned. The most notable difference between today’s measures of accountability and those in the managed care era is today’s incorporation of cost components. ACOs may be an effective way to begin reforming the US healthcare system because they avoid the question of where to begin, by addressing both provider payment and delivery system reform.

Many providers believe the incentives to participate in ACOs and Medicare’s SSP are too difficult to attain and too operationally burdensome to seek. In a survey of its members, the American Medical Association reported that 93 percent would not participate in an ACO (Wall Street Journal 2011). Changes were made to the proposed rule to accommodate providers’ concerns; however, serious reservations remain. This article explains basic aspects of ACOs and Medicare’s SSP and discusses challenges for organizations attempting to create and profit from an ACO. Factors that hospital administrators should
consider as they evaluate ACO participation are also addressed.

**Shared Savings Program**
The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing the SSP, which is an incentive program to promote the formation and use of ACOs. According to CMS, Medicare’s SSP is meant to promote accountability for a population of Medicare beneficiaries while improving the coordination of Medicare fee-for-service (FFS) items and services; encouraging investment in infrastructure and redesigned care processes for high-quality, efficient service delivery; and motivating providers to deliver higher-value care (CMS 2011). Through the SSP, Medicare will share a percentage of the achieved savings with those ACOs that successfully meet quality and savings requirements. Exhibit 1 shows the level of competency an ACO must reach in several key areas to be eligible for the SSP.

The SSP will focus on achieving the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures. For

**Exhibit 1**
Required Competencies for ACOs

<table>
<thead>
<tr>
<th>Leadership</th>
<th>At least 75% control of the ACO’s governing body must be held by ACO participants.</th>
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</thead>
<tbody>
<tr>
<td>IT infrastructure for popula-</td>
<td>ACOs only have to report on the quality measure “Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment”; CMS will double-weight this quality measure.</td>
</tr>
<tr>
<td>tion management and care</td>
<td>Infrastructure for monitoring, managing, and reporting quality</td>
</tr>
<tr>
<td>coordination</td>
<td>ACOs will report on 33 quality measures instead of 65; measures are standard across all ACOs. There will be no flexibility for different quality measures in different regions. For the first year of the ACO program, ACOs must have 100% reporting on all 33 measures before they are eligible to share in any savings.</td>
</tr>
<tr>
<td>Ability to manage financial risk</td>
<td>ACOs share their savings but also a great deal of risk depending upon which SSP model is used.</td>
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<tr>
<td>Ability to receive and distribute payments or savings</td>
<td>ACOs provide two models: one-sided risk-shared savings model (this option is available during an ACO’s initial three-year agreement period) and two-sided risk-shared savings and losses model.</td>
</tr>
<tr>
<td>Resources for patient education and success</td>
<td>ACOs must define, establish, implement, and periodically update processes to promote patient engagement.</td>
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Source: Developed by author based on information from AHA (2010).
organizations whose ability to achieve this aim would be improved by additional access to capital, CMS has created the Advance Payment Model within the SSP. ACOs participating in this model must not include any inpatient facilities and must have less than $50 million in total annual revenue, or they must only include inpatient facilities that are critical access hospitals and/or Medicare low-volume rural hospitals and have less than $80 million in total annual revenue. ACOs co-owned by a health plan are ineligible to participate in this model (CMS 2011). To further encourage organizations to form ACOs and participate in the SSP, Medicare has made several additional modifications to the SSP to lessen the burden and cost of implementation, including more flexibility in eligibility requirements, more flexibility in the governance and legal structure of a participating ACO, simpler and more streamlined quality standards, and increased sharing caps (CMS 2011).

Many aspects of the Physician Group Practice (PGP) Demonstration, which was administered by CMS under the mandate of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, were carried over in the SSP. The PGP Demonstration consisted of ten physician groups that participated in a five-year program, essentially serving as a pilot program for ACOs. Lessons learned from this model were used to shape the proposed rule for the SSP.

It is important to note that the Medicare SSP is a completely voluntary program. Organizations that do not consider themselves prepared to participate can “begin the transition towards a more coordinated delivery system, incorporating policies that promote success for the early participants and join the program at such time as they are ready” (CMS 2011). The SSP offers two models for ACO participation. The two-sided model (track two) has greater financial risk than the one-sided model (track one) does. However, it has the potential for greater rewards than does track one (Correia 2011). An ACO must choose one of the two tracks for the first three years. Exhibit 2 compares the models.

The ACA states that CMS must create a shared savings program to facilitate coordination and cooperation among providers and improve the quality of care for Medicare FFS beneficiaries while reducing unnecessary costs. While Medicare’s SSP attempts to fulfill this mandate, many observers are concerned that the implementation costs will not be worth the potential savings. Administrators must decide whether their organizations are prepared for this new form of reimbursement. Those whose organizations are not ready must decide whether to begin implementing these processes or to hold off as long as possible.

**Beneficiary Participation**

Beneficiaries’ acceptance of Medicare’s SSP and ACOs is one of the most important factors in determining the success of these initiatives. Some worry that beneficiaries will believe that ACOs are simply enhanced HMOs. Therefore, it is important that patients understand the difference (Berenson and Devers 2009). These perceptions will affect whether beneficiaries will select ACOs and whether they will support or oppose
them through political activity or other approaches. If ACOs are viewed as a means of making the healthcare system easier to navigate and improving the quality of care, the idea is more likely to be received positively. Ideally, the beneficiaries will see the ACOs as a way to receive more care for their health dollars and to put critical healthcare decisions in the hands of their doctors and the hospitals in their community. Beneficiaries’ acceptance in turn motivates private insurers to follow the ACO model. For hospital administrators, it is vital to clearly differentiate ACOs from HMOs in their marketing efforts. Furthermore, administrators must make clear to potential patients that participation in an ACO will first and foremost increase their quality of care.

### Exhibit 2
Financial Models Under SSP for ACOs

<table>
<thead>
<tr>
<th></th>
<th>Track One</th>
<th>Track Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for shared savings and shared losses</td>
<td>Potential for shared savings in all three years and potential for shared losses in year 3</td>
<td>Potential for shared savings and shared losses in all three years</td>
</tr>
<tr>
<td>Potential for shared losses</td>
<td>Year 1: only shared savings; year 2: only shared savings; year 3: up to 5% of shared losses</td>
<td>Year 1: 5%; year 2: 7.5%; year 3: 10%</td>
</tr>
<tr>
<td>Minimum savings rate (i.e., the minimum amount the ACO’s costs must be below its benchmark to receive any shared savings)</td>
<td>2% to 3.9% (3.9% for ACOs with greater than 5,000 beneficiaries)</td>
<td>2%</td>
</tr>
<tr>
<td>Net 2% rule</td>
<td>Savings calculated net 2% of the benchmark unless certain exceptions are met</td>
<td>No net 2% rule</td>
</tr>
<tr>
<td>Maximum shared savings and cap on savings</td>
<td>Up to 50% of amount of costs below benchmark plus 2.5% for serving Rural Health Center (RHC) and Federally Qualified Health Center (FQHC) populations Cap of 7.5% of benchmark</td>
<td>Up to 60% of amount below benchmark plus 5% for serving RHC and FQHC populations Cap of 10% of benchmark</td>
</tr>
<tr>
<td>Bonus for beneficiaries who use RHCs or FQHCs</td>
<td>2.5%</td>
<td>5%</td>
</tr>
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ACCOUNTABLE CARE ORGANIZATIONS

PARTICIPATION COSTS AND FINANCIAL IMPLICATIONS
While no ACO can predict exactly how much implementation of the SSP will cost, expenditures will likely be comparable to CMS’s PGP Demonstration. The average participating ACO in the PGP Demonstration spent $489,354 in initial costs and $1,265,897 to operate the project in the first year (Ronning 2010). Consistent with those figures, CMS has estimated that most ACOs will require a $1.8 million investment to get started. However, the American Hospital Association and other organizations have estimated the average investment to be much larger (Reynolds and Roble 2011).

In Medicare’s SSP, CMS would accrue all of the savings in Medicare FFS payments and share some of the savings with the ACO, and then the ACO would distribute its share of the savings to its organizations and providers. If the ACO successfully reduces the consumption of its participants’ services, it reduces its revenue levels and receives only a part of the savings realized. The ACO must also then cut its fixed and variable costs enough to offset the revenue reductions to maintain its bottom line.

CMS intends for ACOs to reward providers through financial incentives for success in delivering patient-centered medical care across multiple care settings. That success will be measured by the level of quality achieved in 33 clinical processes and outcome metrics. To achieve the required threshold of quality, primary care providers will have to reduce the acuity of their Medicare patients’ health problems by reducing those patients’ use of care and improving their health status (Reynolds and Roble 2011). To assist in this process, hospital administrators will need to ensure the adoption of practices and policies to encourage appropriateness and efficiency of care.

QUALITY METRICS
The goals of ACOs are to align care, reduce costs, and increase quality of care. Under the rule proposed by CMS, ACOs must report on the 33 quality metrics (reduced from 65 in the proposed rule) to participate. These measures are divided into four health domains:

- Patient/caregiver experience
- Care coordination/patient safety
- Preventive care
- At-risk population

The at-risk population domain includes measures that center on five conditions: diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease.

The data on the ACO’s performance will be collected using a variety of tools, which could include patient surveys, electronic health records, and claims. CMS intends for these quality measures to play a significant role in determining the ACO’s shared savings amount. CMS has stated that for the first year, the providers will merely need to submit data on all 33 measures to qualify for the maximum amount of shared savings. In subsequent years, CMS will implement a system that benefits organizations with greater overall quality scores (Mulvany 2011).

CMS has set a benchmark for each metric along with a minimum attainment level, and points will be received based on performance. ACOs that
perform below the minimum level will receive no points, those that perform above the minimum level but below the benchmark will receive points on a sliding scale, and those at or above the benchmark will receive the maximum number of points. CMS also proposes that each ACO make all information publicly available in a standard format. It believes this action will allow beneficiaries to make more informed choices and help ACOs in their efforts to improve quality and cost efficiency (Mulvany 2011).

IMPLEMENTATION CHALLENGES
An organization that wishes to form an ACO eligible to participate in Medicare's SSP will face numerous challenges. The most challenging aspect of creating an ACO is the startup cost. In spring 2011 an American Hospital Association study estimated that implementation will be much more expensive than CMS has indicated (Reynolds and Roble 2011). Administrators and providers worry that the daunting costs of implementation will not be worth the seemingly low reward. Furthermore, the SSP remains incomplete and its full implementation is questionable. Even if the SSP does launch well and prove effective, the concept of forming ACOs to serve commercially insured patients must still be addressed.

The pattern of care for employee or health plan enrollees might be entirely different from that of Medicare beneficiaries (Crosson 2011). One concern of purchasers and plans is that physicians collaborating with one another and with hospitals may increase their market power and substantially increase the savings they gain through negotiated contracts. This power shift would usher in higher provider prices, costing the purchasers much more than the current system does (Berenson and Devers 2009).

ADVANTAGES OF AN ACO
Under the ACA, any of the following arrangements may qualify as an ACO (CMS 2011):

- Professionals in group practice arrangements
- Networks of individual practices of professionals
- Partnerships or joint venture arrangements between professionals and hospitals
- Hospitals employing professionals
- Other groups of providers and suppliers the secretary of the US Department of Health and Human Services determines appropriate

The variety of options available for forming an ACO presents a significant advantage. Different arrangements may work better for different providers and may be less costly to form than maintaining current arrangements.

A second advantage is Medicare's SSP. Essentially, the SSP gives additional reimbursement to implement a model that health organizations should be moving toward on their own anyway. The ACO is guaranteed at least the standard Medicare reimbursement levels for beneficiaries who require services. ACOs will face less financial risk than healthcare organizations that depend on fixed capitation payments (Correia 2011).

Finally, the greatest advantage of ACOs, assuming they work as they
are intended to, is that they will help improve quality of care and reduce its cost. Hospitals have the potential to be at the forefront of creating ACOs. Hospital and health system administrators should consider how embracing ACOs now will better position their organizations in the marketplace for the future.

**Disadvantages of an ACO**

To appeal to consumers, CMS’s proposed rule incorporates a system referred to as retrospective attribution. This system will assign beneficiaries to ACOs on the basis of which physician has recently provided a plurality of the beneficiary’s primary care services. Even though this method will most likely be more accurate than basing attribution on the beneficiaries’ overall prior use, ACOs will not know for at least the first six months of each year precisely which beneficiaries they are accountable for. While this limitation may make management of risk more difficult for the ACOs, CMS has indicated it will provide extensive data on which beneficiaries will be assigned to an ACO on the basis of previous claims (Ginsburg 2011).

Because CMS will be basing financial benchmarks on historical per beneficiary costs, ACOs with providers that are already efficient will have to become even more efficient (Ginsburg 2011). This pressure, however, is slightly relieved by the fact that the yearly increase in the benchmark is a nationally uniform dollar amount per beneficiary.

The mandatory collection of quality metrics, which will have to be conducted at least partially by the ACO, could pose a significant cost to hospitals. Some of the data will be provided through claims; however, the rest will have to be obtained by the ACO through medical records or surveys.

Finally, CMS plans for quality measurement to evolve over the life of an ACO contract. Shifting quality metrics will place a higher perceived risk on the ACO; Ginsberg (2011) suggests that CMS commit to stability over the duration of a contract to help reduce the perceived risk.

**Factors for Hospital Administrators to Consider**

The shift to value-driven payment is likely unavoidable (Crosson 2011). Hospital administrators have many strategic and operational factors to consider as they evaluate opportunities related to ACOs and Medicare’s SSP. Exhibit 3 provides guidance to hospital administrators who wish to prepare their organizations for accountable care.

When considering how to better prepare for ACOs, one important factor is network development. It is essential that the right resources are placed in the right locations to serve the target market, including care provision in the appropriate setting (Damsky and Levin 2011). Fulfilling this imperative will require sufficient primary care physicians and nonphysician providers and appropriate ambulatory diagnostic and treatment facilities. As Exhibit 3 shows, focus should also be placed on physician alignment—beyond common financial incentives. For true alignment to occur physicians must share the ACO’s vision, use agreed-upon strategies to provide evidence-based care, and employ common management practices (Damsky and Levin 2011).
<table>
<thead>
<tr>
<th>Focal Area</th>
<th>Considerations</th>
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| Network Development          | • Healthcare administrators should create the optimal mix, scale, and distribution of assets across the care continuum.  
• They should determine the best location to offer every particular service based on patient needs and cost.  
• Administrators should proactively determine which practices are critical for enterprise-wide success.                                                                                                                                                                      |
| Governance                   | • When planning the governance of the ACO, administrators should ensure that Medicare beneficiaries and physicians are adequately represented.  
• Administrators should enact a clear conflict-of-interest policy to avoid antitrust law issues.  
• Administrators need to give careful consideration to which organizational structure representing all ACO organizational parties will work best for improving quality of care, decreasing costs, and allocating savings. |
| Physician Alignment          | • Hospitals and physicians need to collaborate and determine how they can work together to meet new requirements.  
• Organizations should evaluate their number and specialty of physicians and determine if they have the appropriate complement to serve the patient population.                                                                                                               |
| Process Improvement and Cost Efficiency | • Because the SSP will require hospitals to provide data about their costs and measures, hospitals will need to review their current cost control processes and determine how they can be improved.  
• Possible improvements include streamlining operations, reducing expenses, cutting hospital admissions, and avoiding duplicate costs.                                                                                                                             |
| Promoting Quality over Volume | • Administrators must align the organization’s incentives with efficient and high-quality delivery of care.  
• They should review avoidable admission trends and set goals for the reduction of these admissions through preventive care and patient education.                                                                                                                                                                                                 |
| IT Infrastructure and Systems | • IT is an essential part of ACO formation, because of the necessity to track data from across the organization and between organizations.  
At a minimum a hospital should have an IT system that can track admissions, tests referred, infection rates, patient falls, and other critical metrics to form an ACO.  
• The hospital should ensure that the entire network forming the ACO has compatible IT systems.                                                                                                                                                                                                                  |
ACCOUNTABLE CARE ORGANIZATIONS

EXHIBIT 3 continued

<table>
<thead>
<tr>
<th>Focal Area</th>
<th>Considerations</th>
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<tbody>
<tr>
<td>Positioning for Insurance Negotiation</td>
<td>• If hospitals are successful in keeping patients healthier and reducing hospital admissions, they may reduce revenues and increase insurance savings. They should use the bargaining power this situation creates to negotiate higher reimbursement rates with private insurers.</td>
</tr>
</tbody>
</table>

Source: Developed by author based on information from Grant Thornton (2011) and Damsky and Levin (2011).

Hospitals can become better positioned to form an ACO by focusing on cost management. They can do so by reducing readmissions or shifting care to lower-cost settings, thereby eliminating unnecessary utilization. The organization should also develop a culture focused on eliminating waste across the health system (Damsky and Levin 2011). These methods will help ensure that the number of patients served is maximized and current assets are used efficiently.

Managing patient care will also better prepare an organization for accountable care. Hospital administrators will have to work with providers at every level of care to ensure that care is managed across the continuum. For this approach to be effective, agreement must be reached within the network on best practices and incorporation of evidence-based protocols (Damsky and Levin 2011).

Organizations that have already been practicing the principles of coordinated care may be perfect candidates for the Pioneer ACO Model. The Pioneer ACO Model is designed for organizations with experience operating as an ACO or similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare (Center for Medicare and Medicaid Innovation 2011b). This model allows potentially greater savings and benefits than the regular proposed SSP. As with the track one and track two models, the Pioneer ACO Model will improve health outcomes for patients across the ACO while achieving cost savings for employers, patients, and Medicare (Center for Medicare & Medicaid Innovation 2011b). CMS also states that the model will accommodate specific organizational and market conditions in which Pioneer ACOs work.

For organizations that are small and unprepared to form ACOs, the Advance Payment Model within the SSP may be an option. This model gives participating ACOs advance payment that will later be recouped from the shared savings they earn. The Advance Payment Model is designed for small, rural, and physician-owned ACOs to assist in the initial cost of forming the ACO and participating in Medicare’s SSP (Center for Medicare & Medicaid Innovation 2011a). This model would greatly benefit organizations that have the potential to save using the ACO model but do not have the capital to cover the initial costs.

CONCLUSIONS AND IMPLICATIONS

Whether or not an ACO is worth the high initial investment by a hospital or health system depends on the situation. Large ACO groups are more likely
to benefit significantly and recover the initial costs more quickly than are small ACOs. Organizations that must make major changes in the way they provide care in order to participate may not find the program profitable initially. They will be challenged to remain viable in the future.

The pressures for accountable care are likely to increase in the future in both government-funded programs and commercial insurance. Hospitals and health systems that are not ready to enroll in Medicare’s SSP initially should at least begin to make changes in the way they provide care, putting polices in place that encourage coordinated and evidence-based care and forming relationships and partnerships with other providers to ensure a smooth transition to an ACO when one is developed. Using the decision framework described here, hospital administrators should evaluate their organizations’ capability to effectively participate in ACO initiatives.

REFERENCES