Health Care

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Accountable Care Organizations: The Unicorn in the Health Care Garden

By John Marshall, Esq.

The accountable care organization, or "ACO," is one of the key elements of the federal health care reform law, the Patient Protection and Affordable Care Act ("PPACA") enacted on March 23, 2010. The PPACA describes ACOs in only seven pages, but they are intended to provide a totally new model for delivering health services to Medicare beneficiaries. ACOs offer physicians and hospitals incentives to work together to provide quality care to Medicare beneficiaries, while keeping costs down. However, the concept is still short on details. Mark Smith, M.D., President and CEO of the California Healthcare Foundation, may have described them best:

"The accountable care organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one."

The PPACA initially establishes a national voluntary program where ACOs are formed and apply for certification from the US Department of Health and Human Services to participate in a Medicare Shared Savings Program. This program is scheduled to be in place to sponsor initial projects by January 1, 2012, with a three-year phase in plan. The ACOs are supposed to be organizations led by providers (physician groups and hospitals) that have collective accountability for the entire continuum of care for a specific group of at least 5,000 patients. The law provides for payment reforms to reward quality improvements, and a slowdown of increases in spending, as well as establishment of standards to measure success in achieving patient health and patient confidence. While no one method for providing economic incentives has been mandated, the ACOs aim to incentivize and reward physicians and hospitals to work together for better performance, patient satisfaction, and cost savings. It remains to be seen whether physicians and hospitals can work together any better to contain costs than they have in the past, rather than compete for scarce dollars.

The concept of physicians working together or with hospitals to provide better and more efficient patient care is new to many states. California, however, already has substantial experience with many aspects of the ACO model. In 2009, California already had 285 physician organizations, including integrated medical groups and independent physician associations (IPAs) of sole practitioners banding together to contract with insurers.

The Kaiser Foundation/Permanente Medical Group model for coordination of care has been in place for over 60 years. Physician groups and hospitals that contract with HMOs already have experience (good and bad) in coordinating care and costs through the HMOs' pricing and payment mechanisms. However, patient participation in these models is generally mandatory, whereas participation by Medicare beneficiaries under the ACO model will be voluntary.

Some physician groups and hospitals have previously joined together in various models (hospital purchases of physician practices, establishment of foundations to provide care, risk pools, and other models), with mixed success. Hospital acquisitions of physician groups which

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were the craze in the 1990s have gone by the wayside in the new millennium. The mandates for and implementations of Electronic Medical Records (EMRs), including federal stimulus money to many organizations, now make information already gathered in previous physician encounters, hospital visits, and diagnostic tests readily available to other caregivers, and thus already help to reduce unnecessary duplicate tests and improve monitoring of health conditions. However, this information needs to be available to everyone in the continuum of care, not just within the hospital or within the medical group – and this was one of the goals in the mandate for ACOs in PPACA.

There are also unresolved regulatory hurdles. Combinations of health care providers may have antitrust implications, and economic incentives between hospitals and physician groups may violate various federal (Stark, fraud and abuse, anti-kickback) and state (Speier, anti-kickback) regulatory prohibitions. And unlike most other States, California prohibits the "corporate practice of medicine," which disallows most hospitals (other than teaching hospitals) from directly employing physicians. These are but some of the problems that will need to be overcome to realize the lofty goals of ACOs: to reduce costs, increase the quality of health care, and increase the public's perception of the quality of care being provided.

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