Accountable Care Organizations:

What Are They and Why Do I Need to Know?

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There is considerable buzz around the nation and within the healthcare community about healthcare reform, the specifics of what it is intended to accomplish, how it will work, and how to pay for it. One of the main conceptual ideas for mitigating the cost of Medicare to the federal government is to change the method of paying hospitals and physicians. One such concept is the Accountable Care Organization (ACO). This article will describe ACOs and other payment reform initiatives, outline the proposed key requirements and timing, discuss the implications to hospitals and physician group leaders, and identify what actions should be taken now to prepare for these significant changes.

Definition of an ACO

ACOs have been defined as organizations that:

A. Can provide primary care and basic medical/surgical inpatient care for a population of patients
B. Are willing to take responsibility for the overall costs and quality of care for the population
C. Have the size and scope to fulfill this responsibility[1]

Depending on which version of the reform bills passes, many different organizational models could qualify to be an ACO. These include integrated delivery systems (IDS), physician–hospital organizations (PHO),

independent practice associations (IPA), large multi-specialty group practices, and partnerships between organizations. ACOs will probably include one or more hospitals and could include nursing homes, outpatient centers, home healthcare, rehabilitation, and other providers of medical care to seniors and others enrolled in Medicare.

ACO Premise

Healthcare is a large, complex industry. There are significant variations in the consistency and quality of care across our nation as well as the cost to provide it. According to 2006 Medicare data, the range in Medicare spending per enrollee was $5,311 in Honolulu, Hawaii to $16,351 in Miami, Florida—more than a threefold difference.[2] These variations hold true not only globally on a per capita basis, but also for care of individual conditions such as cardiac or orthopedic procedures. Additionally, costs per capita are unsustainable. Current projections estimate that the Medicare fund will be depleted by 2019 if there is no change in current spending levels.[3] This, combined with the lack of consistent quality, the need to correct the physician fee schedule (i.e., the so-called sustainable growth rate ["SGR"] adjustment) annually, and the current potentially perverse incentives of fee-for-service (FFS) payment structures, which encourage the use of more services without necessarily achieving higher quality, lead to the need to revamp methods of payment.

While enrollment by state varies considerably, the Medicare Advantage program covers 28 percent of Medicare enrollees and relies on private insurance companies selling products to increase enrollment.[4] These private insurance companies attract members through enhanced benefit packages and often use delegated models to medical groups through capitation payments to control utilization and cost. However, Medicare Advantage programs on a per enrollee basis cost 114 percent more than fee-for-service Medicare in 2009.[5] Therefore, the Medicare Advantage program is not seen as a single solution for holding down the rate of increase in the cost of care. Other solutions, which are based on a platform of traditional payment (FFS), but create added incentives for controlling costs and maintaining quality, have been proposed by a variety of public and private bodies.

1 Medicare Payment Advisory Committee, *Report to the Congress: Improving Incentives in the Medicare Program,* June 2009, p. 39.

2 2006 Medicare Reimbursement by Hospital Referral Region, *Dartmouth Atlas Project,* accessed at www.dartmouthatlas.org, September 4, 2009.

3 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, March 2008. From Kaiser Family Foundation, *Medicare: A Primer 2009 (#7615-02),* January 2009, at www.kff.org.

4 Kaiser Family Foundation, *Medicare: A Primer 2009 (#7615-02),* January 2009, at www.kff.org.

5 *Ibid.*

Regardless of the outcome of healthcare reform, the impetus to develop new patient care models that counter volume growth and improve quality will assure focus on ACOs as an integral piece of payment model reform.

The term ACO was coined to describe organizations that have redesigned the healthcare delivery system to take collective responsibility for improving patient care by centering on the care delivery to the patient—instead of around maximizing revenue.[6] Examples of organizations that have done this include: Mayo Clinic; providers in Grand Junction, Colorado; Kaiser Permanente; Geisinger Health System; Intermountain Healthcare; Healthcare Partners Medical Group; and others. They have restructured their compensation models to encourage teamwork, collaboration, and clinical integration around each patient's needs. ACOs agree to take responsibility for quality outcomes and the overall annual Medicare spending for their patients.

Medicare recently piloted an incentive structure that is seen as a precursor to the ACO model. The Physician Group Practice (PGP) Demonstration Project includes ten large physician groups, covering 5,000 physicians and 224,000 beneficiaries through which providers can receive a share of the cost savings generated. Actual FFS payments are compared to predetermined expenditure targets; if payments are lower than targets, the savings are shared between Medicare and the physician organization. Based on the results for the third year of the study, quality scores have improved on five chronic conditions, and $32 million was saved. Five physician groups earned $25 million as their share of the savings.[7] These results have encouraged legislators and regulators to implement similar structures to encourage greater provider accountability for cost and quality going forward.

Table 1. Proposed Requirements to Form an Accountable Care Organization from September 22, 2009 Senate Finance Committee and House Tri-Committee (H.R. 3200)

Who can form an ACO	Groups of providers and suppliers who have an established mechanism for joint decision making (e.g., capital purchases and distribution of bonus payments). These can be: • Practitioners in group practice arrangements • Networks of practices • Partnerships or joint venture arrangements between hospitals and practitioners • Hospitals employing practitioners • Other groups of providers of services and suppliers that CMS deems appropriate • Practitioners who are physicians, nurse practitioners, physician assistants, clinical nurse specialists, and others
Qualifications as an ACO	Meet at least the following criteria: • Agree to be accountable for overall care of their Medicare beneficiaries. • Agree to participate for a minimum of three years. • Have a formal legal structure that would allow the organization to distribute bonuses to providers. • Include primary care physicians for at least 5,000 Medicare FFS beneficiaries. • Give CMS information regarding primary care physicians and specialists participating in the ACO as required by CMS. • Have arrangements in place with a core group of specialists. • Have a leadership and management structure, including with regard to clinical and administrative systems. • Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care. • Demonstrate "patient-centeredness" as determined by CMS.
Calculation of bonuses	• ACOs with three-year average Medicare expenditures below benchmark are eligible for shared savings. • Shared savings could be adjusted by CMS to account for differing sizes of ACOs.
How to earn incentive payment	ACO must meet certain quality thresholds, suggested to be: • Clinical processes and outcomes • Patient and caregiver perspectives on care • Utilization and costs
Data reporting requirements	• Have the ability to submit data at the group and provider level for the measures. • CMS will be authorized to incorporate reporting requirements and incentive payments, penalties related to the physician quality reporting initiative (PQRI), electronic prescribing, electronic health records, and other similar initiatives.
Beneficiary assignment	• Be based on use of Medicare items and services in preceding periods.
Baseline thresholds and rewards	• Spending baseline: Determined on ACO level using most recent three years of total per beneficiary spending for those beneficiaries assigned to ACO. • Target: Baseline plus flat dollar amount = risk adjusted average expenditure growth per beneficiary nationally. • Baseline resets at the end of the three-year period.
Timing	• Program begins January 1, 2012.

6 E.S. Fisher, D.O. Staiger, J.P.W. Bynum, and D.J. Gottlieb, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs*, Vol. 26, No. 1 (2007): w44–w57 (published online December 5, 2006; 10.1377/hlthaff.26.1.w44).

7 CMS, "Medicare Demonstration Show Paying For Quality Healthcare Pays Off," August 17, 2009.

Exhibit 1. **Accountable Care Organization Proposed Structure**

- ACO responsible for:
  - Clinical care management (clinical integration)
  - Capture data for continuum of care
  - Measure, monitor costs and quality

Key Requirements and Timing

The September 22, 2009 Senate Finance Committee and the July 14, 2009 House Tri-Committee healthcare reform proposals present programs and pilots to test and refine the efficacy of ACOs as a model to control costs and improve quality.[8] Therefore, regardless of the outcome of healthcare reform, the impetus to develop new patient care models that counter volume growth and improve quality will assure focus on ACOs as an integral piece of payment model reform. In its June "Report to Congress: Improving Incentives in the Medicare Program," the Medicare Payment Advisory Commission (MedPAC) suggested ACOs as a key component of their recommendation to lower Medicare costs and support quality improvement initiatives.

MedPAC and the September 22, 2009 Senate Finance Committee Chairman's Mark recommend that ACOs have a minimum requirement for size (i.e., primary care physicians caring for at least 5,000 Medicare FFS beneficiaries). This is intended to reduce the likelihood that any cost savings or quality improvement is due to random variation. In actuality, the systems and processes required to proactively manage quality and costs require a fairly sizeable revenue and patient base to support the infrastructure costs.

The Senate Finance Committee has made it clear that if the voluntary route is pursued, Medicare FFS payments will be constrained, which may induce other organizations to form ACOs to become eligible for bonuses.

As of September 25, 2009, in the proposed legislation, groups of providers who voluntarily meet certain statutory criteria will be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. This means there is no selection process or waiting period; those providers who qualify can participate. The program is scheduled to begin on January 1, 2012. The payment structure will offer only rewards in the form of shared savings to induce participation. Providers who do not volunteer are unaffected and will continue to receive FFS payments. The Senate Finance Committee has made it clear that if the voluntary route is pursued, Medicare FFS payments will be constrained, which may induce other organizations to form ACOs to become eligible for bonuses.[9]

Frequently Asked Questions

Given the swirl of proposed changes as part of healthcare reform, there has also been considerable confusion that can lead to misperceptions. Here are a few questions gathered from hospitals and physicians across the country.

Does this mean that we take capitated payments?

No. Based on current proposals, Medicare will still pay providers on a fee-for-service basis. Those who participate as an ACO will be eligible to receive bonus payments if they meet quality and resource use targets (i.e., cost reduction less than anticipated trend). Of course, providers who participate in capitated Medicare Advantage plans can continue with whatever arrangements they currently have.

How many ACOs can/should a hospital have?

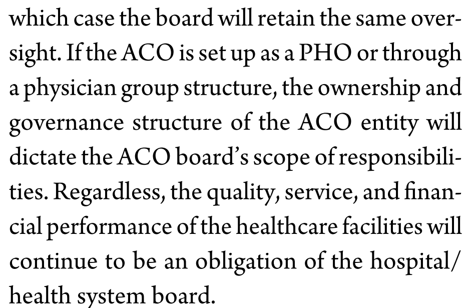
Most hospitals will only have one, but may participate as a provider in the network for others. For example, an academic medical center may be part of the network of many other community hospital-sponsored ACOs.

How will ACOs affect hospital/health system board responsibilities and accountability?

If your organization is an integrated delivery system, it may already qualify as an ACO, in

8 The healthcare reform proposals discussed here include the following: Senate Committee on Finance, *America's Healthy Future Act of 2009,* September 22, 2009 and House Tri-Committee, *America's Affordable Health Choices Act of 2009* (H.R. 3200), July 14, 2009.

9 Senate Committee on Finance, *America's Healthy Future Act of 2009,* September 22, 2009, p. 88.



which case the board will retain the same oversight. If the ACO is set up as a PHO or through a physician group structure, the ownership and governance structure of the ACO entity will dictate the ACO board's scope of responsibilities. Regardless, the quality, service, and financial performance of the healthcare facilities will continue to be an obligation of the hospital/health system board.

Does this mean ACOs will replace Medicare Advantage?

No. Medicare Advantage will still be part of Medicare's arsenal to control the rate of increase in healthcare costs. ACOs are another proposed solution to assist in that effort.

How is this different from Medicare Advantage?

Medicare Advantage relies on private insurance companies to build a network of providers, sell its product to Medicare beneficiaries, and manage utilization, cost, and quality. Hospital and physician providers receive reimbursement that has been negotiated and contracted with the private insurance company. An ACO has a direct relationship with Medicare to serve Medicare fee-for-service (FFS) beneficiaries. Providers will continue to receive their Medicare FFS payments and will be eligible for a bonus if quality and resource use targets are met.

Do we have to form a new entity?

It depends on how you are currently organized. If your organization already has a network of providers in place that are clinically and/or financially integrated to provide high-quality care to a defined population, you may only need to make modifications to your existing structure or financial relationships. If, however, you have many independent physicians and healthcare providers in your market who do not have a structure in which they make joint decisions, can allocate payments, and coordinate and share financial, utilization, and quality data, then yes, you will most likely need to form a new entity.

How is this different from gainsharing?

Gainsharing encourages hospitals and physicians to work together within specific service lines (e.g., orthopedic) to gain efficiencies and reduce costs. ACOs are broader, can be more comprehensive, and focus on a population of Medicare beneficiaries versus a specific service line.

What if we don't want to participate?

At this point, participation will be voluntary. However, in order to help pay bonuses to ACOs that perform well, Medicare FFS payments will be constrained. So if you want an opportunity to increase (or even just retain) your revenue from Medicare patients, organizations should consider participation as an ACO.

Will this affect our payments from commercial health plans and payers? What about Medicaid?

ACOs are proposed as a model for Medicare. However, should they prove successful as a

model for containing costs, we anticipate other payers, including commercial payers, would begin looking to introduce similar payment models. Medicare has often been a bellwether for payment reform across payer types.

How do I know it is right for my organization? What are the implications of ACOs we should consider?

Ultimately, it depends on each organization and the organization's level of existing integration to determine whether an organization is ready to participate as a Medicare ACO. However, understanding the implications and risks of Medicare's new push for accountability for both hospitals and physicians is worthy of every organization's attention—if only to begin to strategically plan for the future.

Implications and Risks for Hospitals

Given the motivation to control Medicare costs and the initial promise of the pre-ACO pilot, hospitals need to act now to prepare for the significant changes associated with healthcare payment system reform. Under an ACO, a hospital is one piece of the patient experience and an expensive part of the cost. Whether ACOs as defined are implemented, the fact is that Medicare payments will be reduced, and any increase will require demonstrated improvements in quality (e.g., no readmissions) as well as commitment to **reducing the overall rate of increase** in the cost of care. By ignoring these trends, hospitals place themselves in an extremely vulnerable position—both from a financial and market perspective. For many hospitals, ACOs represent a dramatic change from the *status quo*. There are many implications and risks for hospitals to consider, shown in Table 2.

Table 2. Hospital Implications and Risks

Implications	Risks
There will be **less money** on a fee-for-service basis, so providers must fundamentally change the way a patient's health is managed to mitigate negative financial consequences.	Care models change before the payments are aligned, leading to negative financial results.
ACOs can be led by a **partnership** between hospitals and physicians **or medical groups on their own**. If you want to be a part of the change, start now.	Physician groups will take the initiative, leaving hospitals as commodities. Hospitals with the lowest costs will be preferred.
There needs to be a **fundamental mindset change** from filling beds and growing volume to providing high-quality care in the most appropriate, lowest cost setting or managing the patient's health to avoid a procedure, ED visit, or hospitalization altogether (i.e., optimal care for a population).	Medicare payment changes and commercial payers lag, creating financial risk for the efficient, forward-thinking providers.
There will be a battle for market share and patient loyalty, which should improve quality outcomes and decrease costs.	Hospital loses market share and costs go up.
Hospitals will need to **remove silos** (medical specialties and hospital departments) and streamline care around the patient. Hospitals can be leaders in developing coordinated systems of care; but this will require new relationships with physicians as partners and collaborators.	Bureaucracy and "silo" mentality create a barrier to success.
Hospitals will need to be one component of a **coordinated team**—led by physicians—that identifies the best, most appropriate care for the patient.	Hospitals' desire to be in control instead of truly partnering could limit successful outcomes.
Hospital reimbursement will be affected if the **post-acute care** is not optimized and coordinated. This will require care management capabilities and post-acute services to be strengthened and expanded across the continuum. This will require **coordinated teams of physicians and care managers** to assure clean "hand-offs" and consistent communication among providers.	Lack of coordination of patient care post-discharge or lack of available resources (e.g., SNF, home health) leads to readmission and negative financial consequences for the hospital.
New **infrastructure investments** (e.g., clinical systems across the hospital–physician–ancillary provider continuum, data warehouse, disease registries, and real-time reporting for physicians) are required to restructure the delivery system for long-term success.	Capital is not available or exceeds the estimated incentive payments in the short term, requiring a longer-term return on investment.
Hospitals may need to create or restructure their current **model** (e.g., employment, PHO, foundation model, co-management, physician contracts) **to partner and align with physicians.**	Restructuring existing relationships and payment mechanisms could create conflict and a need for timely resolution.
Physician leadership capabilities are key in clinical care redesign and quality improvement.	There is a lack of physicians willing and able to lead change of this magnitude.
Quality improvement/innovation is required, especially for the complex patients who are high risk for higher utilization of higher-cost services.	There is not adequate time, resources, or focus allocated to identify and test new initiatives and ideas.
Leadership across the organization is critical to lead the change, set and enforce parameters, provide resources, and ensure focus.	There is not adequate leadership, time, resources, or focus to lead change of this magnitude.
The ACO may **not require** all of the current hospital **capacity** or **clinicians** due to reduced utilization.	Excess capacity of hospitals will increase cost, leading some to close. Physicians not successful at meeting quality and resource targets could be excluded from the ACO.

Implications and Risks for Physicians

Under an ACO, physicians have a significant leadership role in the redesign of the care delivery process. For many physicians, ACOs represent a dramatic change from the *status quo*. There will be a need to streamline the way care is delivered, reduce variation through the application of evidence-based protocols, improve coordination, and develop innovative models to improve a patient's health. There are many implications and risks for physicians to consider, shown in Table 3.

While there may be potential risks as well as financial rewards, participation as part of an ACO could lead to enhanced satisfaction with the clinical delivery model and greater professional satisfaction for physicians.

Critical Factors for Successfully Implementing an ACO

Given what we know today, here are the key takeaways for leaders of hospital and physician organizations across the country:

- **Strong, collaborative** physician and management **leadership** across the organization will be required to set and enforce parameters and foster system-wide success. Skill in balancing the perspectives of various entities (e.g., primary care/specialists, physician/hospital, inpatient/outpatient) will be key.
- **Organized physician entity(ies)** that are self-governed and drive individual physician performance to meet **group AND system-wide goals** must be created or maintained.
- A **structure** must be in place for joint decision making (e.g., capital, payment distribution) that facilitates physician–hospital alignment.
- **Systems** (e.g., data warehouse, EMR, CPOE, disease registries, online/real-time reporting tools and alerts) and **efficient processes** (e.g., uniform metrics, clinical and financial information) must be in place to support data exchange and

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Table 3. Physician Implications and Risks

Implications	Risks
There will be **less money** on a fee-for-service basis, so providers must fundamentally change the way a patient's health is managed to mitigate negative financial consequences.	Care models change before the payments are aligned, leading to negative financial results.
ACOs can be led by a **partnership** between hospitals and physicians **or medical groups on their own**.	Physicians are not organized into medical groups or structures that coordinate care. They stay fiercely independent and do not work together to collectively improve a patient's health and evolve clinical practice.
New **infrastructure investments** (e.g., data warehouse, EMR, PACS, disease registry, online/real-time reporting tools) are required to restructure the delivery system for long-term success.	Capital is not available or exceeds the estimated incentive payments in the short term, requiring a longer-term return on investment.
There needs to be a **fundamental mindset change** from growing volume, doing more procedures, and seeing more patients to providing high-quality care in the most appropriate, lowest cost setting or managing the patient's health to avoid a procedure, ED visit, or hospitalization altogether (i.e., optimal care for the population).	Physicians do not see the big picture and their new role in the continuum. Fixation on maintaining the status quo and/or fear of change means physician organizations that do not respond get left behind. Payment deteriorates and practice income and stability suffers.
Physicians will need to take a **leadership** role in coordinating patients through the continuum of care by working with their colleagues in new ways.	Physicians stay focused and busy in their practice and are intent on holding on to the status quo. They lose sight of or do not develop the resources and infrastructure to communicate and connect with their physician colleagues in a way that optimizes patient care. Practice income and stability will ultimately suffer.
Physicians will need to agree upon and utilize **evidence-based medical protocols** that reduce cost and provide appropriate outcomes.	Lack of tools to guide best practices will mean continued variation in care and lack of ability to contain cost increases or improve quality. Ultimately, reimbursement rates and practice stability will suffer.
Physicians will need to have the **reporting tools** to compare themselves to peers to continually improve their performance and the efficacy of diagnosis and treatment.	Data are not available, complete, timely, or accurate. Physicians are resistant to being measured and to change.
Battle for market share and patient loyalty becomes a greater focus, which could improve quality outcomes and decrease cost.	Physician loses market share, and costs go up.
Hospitals and physicians may need/want to create or restructure a **model** (e.g., employment, PHO, Foundation model, co-management) **to partner and align.**	Restructuring existing relationships and payment mechanisms will create conflict and need for timely resolution.
Physician leadership capabilities are key in clinical care redesign and quality improvement.	Lack of physicians willing and able to lead change of this magnitude; hospital management takes the lead, minimizing the role and collaborative nature of physician leadership. Ultimately, success in delivering clinical results will suffer.
Quality improvement/innovation is required, especially for the complex patients who are high risk for high utilization of high-cost services.	There is not adequate time, resources, or focus allocated to identify and test new initiatives and ideas.
Leadership across the organization is critical to lead the change, set and enforce parameters, provide resources, and ensure focus.	There is not adequate leadership, time, resources, or focus to lead change of this magnitude.
There is an increased need for **physicians and a clinical workforce who can** coordinate across the ACO's continuum of care	There is a lack of training for/expertise of the skills required to efficiently coordinate care for ACOs.
The ACO may not require all of the current clinicians it currently has due to reduced utilization.	Those physicians who do not adapt and perform will lose patients and revenue.

Other Significant Reform Changes

In addition to ACOs, there are other significant payment reform initiatives, some of which can be managed with or without organizing as an ACO. A description of each is described below.

Bundled Payments

As a patient moves between a general acute care hospital stay and a range of post-acute care providers, Medicare currently pays each provider individually for the services they provide. It has been proposed that Medicare test new incentives and payment models that encourage providers to better coordinate across a patient's episodes of care.

There are a few demonstration projects currently testing this concept: the Acute Care Episodes (ACE) demonstration project, which bundles physician and hospital payments for 15 days in 28 cardiac and nine orthopedic procedures; and the Robert Wood Johnson-funded Prometheus payment model, which pays case rates for selected cases of cancer, orthopedics, cardiac, and preventive care.

The Senate Finance Committee has proposed bundling across a continuum of acute inpatient and post-acute care services for 30 days.

Think of it as an extension of DRG payments—but the payments must include the cost of physician care and potentially post-acute care as well.

Medical Home

The concept of a "patient-centered medical home" defines a new type of primary care physician–patient relationship in which the doctor is responsible for coordinating and managing the care a patient receives in multiple settings. Patients, in turn, accept greater responsibility for managing their condition with the support of their healthcare team. Frequent communication and connectivity between patient and physician are a necessity. Tools such as electronic medical records and other resources that grant patients greater access to their physicians by means other than seeing them in their office (e.g., e-visits, secure e-mail, online patient health records, remote monitoring, telemedicine) are vital.

The medical home is designed to improve care coordination and enable patients and physicians to maintain an ongoing relationship. Patients are encouraged to become partners in their own care. In the proposed demonstration project, physicians will receive a fee per patient to cover the additional costs of monitoring and coordinating care in addition to the fee-for-service payment.

Reducing Avoidable Hospital Readmissions

Avoidable readmissions are one factor driving unnecessary increases in healthcare costs. In their proposed inpatient prospective payment system rule for FY 2009, CMS indicated that a 13 percent reduction of "potentially avoidable" readmissions would result in a savings of $12 billion. CMS has proposed direct adjustments to DRG payments for preventable admissions, performance-based adjustments, and public reporting of readmission rates. Medicare data on readmission rates for eight conditions could become available publically. The draft legislation has proposed that starting in FY 2013, hospitals with a preventable readmission within 15 days would see their Medicare reimbursement reduced.

Gainsharing

The draft legislation would extend the gainsharing pilot currently underway. Gainsharing is the concept that providers will work together to streamline care and reduce costs if they can share in the savings they realize. However, the ACO concept effectively creates a mechanism to do this across an entire population versus just a single specialty, which gainsharing has traditionally focused on.

co-management, and measure quality and cost across a continuum (i.e., hospital, physicians, pharmacy, outpatient services).

- **Improved efficiency** and **efficacy** through care management, use of clinical pathways, dedicated hospital-based teams (e.g., hospitalists, SNFists, intensivists), and systems that assure effective hand-offs **across the continuum**.

- The organization must assess its ability to **approach** the **market** and **payers** as an integrated system (i.e., hospitals, physicians, and other providers of care). The integration may be virtual (i.e., based on clinical and/or financial integration) and not necessarily all owned or controlled by a single entity.

- The organization's culture must include a **relentless focus on redesigning clinical care delivery** across the continuum to find new ways of improving efficiency, service, and quality.

- **Compensation structures** must assure **alignment** of financial incentives for physicians, management, and front-line personnel that rewards desired outcomes (i.e., productivity AND overall results including both cost and quality).

- **Leadership** must demonstrate **flexibility** and **financial acuity** to manage the transition. There will be multiple payment methodologies, changing incentives, and new care delivery models throughout this transition period. Therefore, staying nimble and tracking results will be key to success.

The payoff for achieving success in these areas as an accountable care organization will be improved patient care, lower costs, and better profitability compared to those organizations that do not organize. Because the promise of ACOs assures that it will be an integral piece of payment model reform, hospitals and physicians should start today to understand and plan their path towards becoming one.

What Should Organizations Do Now to Prepare?

1. Identify a champion in your organization who will take responsibility for leading this change.
2. Assess your current situation and the gap to become an ACO. Understand the current care paths patients take, the degree of variation, and key providers and care locations.
3. Identify key stakeholders and hold forums to discuss proposed changes and your organization's current needs to implement them. Build a shared need to work together to accomplish the vision.
4. Create or modify a structure that will allow:
   a. Joint decision making
   b. Allocation of incentive payments
   c. Coordination/integration of the clinical team
   d. Disease registries and data warehouses for reporting, tracking, and managing care
   e. Documentation of standard protocols and systems that alert physicians and other clinicians when actions vary from the standard
5. Create or modify the infrastructure to support the new needs:
   a. Leadership that includes clinical, financial, and administrative champions
   b. IT tools
   c. Peer review participation and structure
   d. Evidence-based medicine protocols
   e. Current, reliable, and accessible data for tracking
6. Start with specific patient populations (e.g., Medicare FFS patients with chronic diseases or high-volume and high-cost procedures) to pilot within your organization. Build on employed/staff physician groups to pilot new care delivery processes. Explore pilot projects with commercial payers.
7. Develop an action plan with responsibilities and timing.
8. Once your organization has a process and structure in place, negotiate with other payers for incentives to lower costs and demonstrate quality.
9. Stay informed. The legislation is constantly evolving.