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In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

Insights from Transformations Under Way at Four Brookings–Dartmouth Accountable Care Organization Pilot Sites

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Synopsis

"The transition to accountable care is not a simple, one-time contracting process—an 'on-off' switch—but is rather an ongoing journey."

A study in *Health Affairs* examines the experiences of four early adopters of the accountable care organization (ACO) model. Interviews with leaders at each site underscore the critical importance for health care providers to form new collaborative relationships with payers, and the need to link shared savings with performance on quality measures. Policymakers must now seek to ensure that incentives are in place to form multipayer ACOs, and that performance measures used in the public and private sectors are well aligned.

The Issue

There is strong interest among health care stakeholders in creating accountable care organizations, which combine highly coordinated patient care with the promise of shared savings for providers and payers if quality standards are met. Despite ongoing ACO activity in both the public and private sectors, little is known about the initial phases of ACO formation. This Commonwealth Fund–supported study focused on four ACO pilot sites from the Brookings–Dartmouth ACO Collaborative to document early progress, identify the factors that facilitate ACO establishment, and examine policy implications.

Key Findings

In interviews with executives and physician leaders from the four pilot sites, several common themes emerged:

- Each health care organization had to overcome the traditional arms-length relationship between providers and payers and learn to collaborate on shared aims, like developing quality measures and systems for sharing data.
- Experience with performance-based payment schemes varied, but there was universal recognition that linking shared savings with quality measures was necessary for ACOs to cut costs as well as improve quality.
- Most of the physician practices and hospitals in the pilot sites had their own electronic health record systems in place. The ACO model will eventually require these systems to be interoperable, so data can be shared among all providers and payers. ACO sites will also need to have disease registries, data collection systems, and the ability to report performance on clinical quality measures.
- Care management is integral to an ACO. The pilot sites all had disease management programs for certain chronic illnesses, such as asthma and diabetes. In the future, ACO providers will also need to pursue initiatives to improve the quality of patients' care transitions, reduce hospital readmissions, ensure routine end-of-life planning, and provide home care for high-risk patients.

Addressing the Problem

Medicare and commercial payers alike "will need to recognize that the transition from the existing fragmented fee-for-service system to coordinated models of care with shared risk will take time," the authors say. Successful ACO formation requires a "dramatic shift" in provider–payer relationships, from adversarial to collaborative. To that end, data-sharing and analysis of historical claims will help providers and payers agree on performance targets. Finally, while all four organizations examined made important progress with their initial payer–partners, none had formed multipayer ACOs, which can help mitigate antitrust concerns and improve performance across an entire market. Policymakers will need to consider incentives that foster development of multipayer ACOs.

About the Study

The four provider organizations studied had formed ACOs as part of the Brookings–Dartmouth ACO Collaborative. Each established partnerships with a commercial payer and were in the process of implementing an ACO contract as of March 2011. The organizations are: HealthCare Partners, Torrance, Calif.; Monarch HealthCare, Irvine, Calif.; Tucson Medical Center, Tucson, Ariz.; and Norton Healthcare, Louisville, Ky.

The Bottom Line

The transition from a fee-for-service to an accountable care model will take time and effort. Establishing collaborative relationships between providers and payers will be critical, as will linking shared savings with performance on quality measures.

Citation

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