

## Accountable Care Organizations and the Future of Healthcare

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The late John Wooden, who will forever be known as the wise man of college basketball, once said that “Teamwork isn’t a preference, it’s a requirement.”

Wooden was talking about hoops, of course, but he easily could have been referring to America’s current healthcare delivery system, which is in desperate need of greater integration and coordination.

Indeed, without collaborative efforts that provide safe, efficient, effective, timely and equitable

patient-centered care, the U.S. healthcare crisis will not ease or end – regardless of the actions of our current and future leaders.

This isn’t a new thought. Many healthcare experts have been saying this for years – and a number of healthcare organizations have tried to work in institutional harmony – in an attempt to create greater value for patients in the form of increased quality and lower costs.

Changing the delivery system’s core metric from volume to value

is difficult, however, because the fee-for-service model creates often opposing incentives.

So, cost-effective integration is the right concept, and it can take us in a new and improved direction; yet, as we learned during the 1990’s, with the rise of managed care, cost-effective integration has to be flexible to really attract patients, and it also has to empower providers to deliver measurable quality outcomes.

These complex, and often conflicting, goals can be achieved with Accountable Care Organizations. The recent healthcare legislation included numerous payment reforms penalizing poor quality and rewarding attempts to better coordinate care. The measure also introduces demonstrations for global payments and mandates a pilot ACO program (the Medicare Shared Savings Program).

An ACO brings together a group of healthcare providers – primary care physicians, specialists and hospitals, for example. Then it offers them incentives and rewards for being accountable to a specific population, hitting specific spending targets, and delivering clinical outcome improvements. When an ACO meets or exceeds its goals,

it is rewarded with a share of the overall savings. The downside is that there could be penalties if it fails to reach its objectives.

The underlying thinking behind ACOs is that by placing accountability at the provider level we will be able to meaningfully influence and deliver integrated patient-centric healthcare in this country. In other words, what the ACO attempts to do is pay providers to work together and share accountability, avoid supplier-stimulated demand, and deliver the right care at the right place and the right time for the best price for consumers. The ACO concept relies on peer review and peer pressure – plus back-end rewards – to make sure that the best healthcare practices, in terms of cost and outcomes, are identified and implemented.

At this point, participation in an ACO is voluntary and progressive. But providers should understand that in the wake of recent reform legislation, reimbursement will likely soon be tied to this type of healthcare structure. Those not participating will face decreased reimbursement.

All of this may sound great in theory, but an objective assessment of the ACO model raises a number of challenging questions, including:

- What is the appropriate structure for an ACO?
- Who should be allowed to “play”?
- Should ACOs be physician-managed and/or controlled?
- Should the physicians be employees of the ACO or contracted partners? In certain states, employment may violate state law.

- How does an ACO put the necessary financial models and reporting tools and capabilities in place?
- How does an ACO effectively balance provider rewards with requirements and responsibilities?
- How does an ACO make certain that the patient-physician relationship is enhanced and enriched and not adversely af-

ected – especially if penalties for under-performance come into play?

- How does the insurance or at-risk component fit into this equation?
- How do ACOs align seamlessly with Medicare?
- How does an ACO ensure that the population it’s responsible for is sufficiently diversified to mitigate risk?



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These tough questions must be answered – and soon – because the ACO model is going to take hold. The good news is that many of the prerequisites are falling into place. We are seeing expanded transparency around healthcare costs and quality; electronic medical records are nearing an important tipping point; and comparative effectiveness and evidence-based pathways are in increasing use.

As the ACO model gains traction, however – and as it becomes an efficient, effective and provider-driven, patient-centric cornerstone of the U.S. healthcare delivery system – we will need a series of

major re-education efforts to fully succeed. And this re-education will have to take place on both the provider and consumer sides.

Patients and providers will have to adjust in their relationships. Medical students will have to learn about the nuances of healthcare cooperation and partnership. And the ACOs, themselves, will have to become learning – as well as medical – enterprises that consistently gather, share and employ data to improve the quality and safety of patient care.

The path is difficult, but the direction is clear: If we're going to truly reform healthcare in Amer-

ica, we must adopt these critical changes. And we have to embrace John Wooden's wise words, too. Teamwork among providers is an absolute necessity in order to deliver optimal care and protect patient well-being in communities all across our country in the coming decades.

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