ACO Information

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ACCOUNTABLE CARE ORGANIZATIONS – PHYSICIAN QUESTIONS AND ANSWERS

The following information is provided at the request of UOP physicians seeking more information about Accountable Care Organizations (ACOs) and the relationship between physicians and ACOs. Please be aware that this is a rapidly evolving program and we will send you updates as significant changes occur.

The Affordable Care Act (ACA) improves the health care delivery system through incentives to enhance quality, improve beneficiary outcomes and increase the value of care. One of the key delivery system reforms is the encouragement of Accountable Care Organizations (ACOs). ACOs will facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs.

The key feature of the ACO concept to is to make providers responsible for the quality and cost of care. This represents a change from the current system which makes health insurance companies responsible for quality and costs. In its purist form, the ACO concept replaces the fee-for-service system with a capitated/bundled payment system that rewards high quality, cost efficient providers with some form of shared savings or bonus payment.

ACOs have emerged as a powerful concept, but many issues and questions concerning the formation and operation of ACOs remain unresolved at this time. Below is a basic overview of the major concepts of an ACO and the relationship between physicians and an ACO.

Q. What is an "Accountable Care Organization"?
A: According to Federal Law an Accountable Care Organization, also called an "ACO" for short, is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it. At this point the State of Michigan has not passed any state level ACO legislation.

Q: What forms of organizations may become an ACO?
A: The federal statute specifies the following:
1) Physicians and other professionals in group practices
2) Physicians and other professionals in networks of practices
3) Partnerships or joint venture arrangements between hospitals and physicians/professionals
4) Hospitals employing physicians/professionals
5) Other forms that the Secretary of Health and Human Services may determine appropriate.

Q: When will this program begin?
A: The Center for Medicare & Medicaid Services (CMS) plans to establish the program by January 1, 2012. Agreements will begin for performance periods, to be at least three years, on or after that date. Until then, CMS will be conducting a limited number of demonstration projects. Some analysts believe that it will take 5 to 10 years for ACOs to fully develop.

Q. Will the ACO concept be extended to patients of private health plans such as Blue Cross, HAP, Priority, etc…?
A: It is anticipated that the ACO concept will be extended to patients of private health plans after the results of the demonstration projects and CMS establishes the program in 2012. In the meantime private health plans are likely to conduct their own demonstration projects on a limited scale.

Q: What are the requirements that an ACO must meet?
A: The federal statute specifies the following:
1) Have a formal legal structure to receive and distribute shared savings
2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
3) Agree to participate in the program for not less than a 3-year period
4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
5) Have a leadership and management structure that includes clinical and administrative systems
6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.
Additional details will be included in a Notice of Proposed Rulemaking that CMS expects to publish this fall.

Q. What is the most effective form of ACO – a physician based or hospital based ACO?
A. Given the focus of an ACO to improve quality and reduce costs, and the fact that employment of the patient centered medical home (PCMH) will be an integral part of an ACO, many analysts believe that a successful ACO must be physician driven with a primary care/multi-specialty orientation. Utilization of the PCMH model is seen as an effective way to control unnecessary hospital expenditures for preventable admissions and readmissions, by effectively controlling chronic disease patients. In a physician governed ACO, physicians' are free to contract with multiple hospitals and ancillary providers in order to achieve high quality at a cost savings through competition for inpatient, outpatient and ancillary services.

Conversely, hospital based ACOs will operate similar to PHOs in which there is an effort to drive patients to the hospital for inpatient, outpatient and ancillary services. Under such a system, market forces will be limited as patients are unitarily concentrated within one system leading to the likelihood of higher pricing and lower quality. Additionally, patient choice of facility will likely be limited as the financial model will be designed to limit a physicians right to refer outside the system.

Q: How will physicians participating in an ACO be compensated.
A. Provider payment in an ACO is designed to incentivize clinical and financial integration in order to reduce costs and improve quality. Depending on the capacity and organizational structure of the ACO, there are several different methods of compensation along with several different levels of financial risk that participating providers can share.

In the partial capitation model, participating providers share in a greater proportion of savings but also voluntarily bear some of the downside risk. In an ACO where a case-based payment structure is employed, payments are "bundled" for a limited set of procedures into a single payment that is divided among the providers. In a modified fee for service model, when providers achieve quality goals and beat their spending benchmarks, they will be rewarded with a portion of the savings as a bonus. The bundled case based program or the fee for service program can be structured to limit downside financial risk.

In all circumstances the ACO leadership will determine the provider payment and bonus methodology. Accordingly in a physician driven ACO, physicians will set the fee schedule and determine the fees paid to all providers, including the hospital and ancillary providers. Conversely, in a hospital driven ACO the hospital will have significant if not the sole determination of provider payments.

In connection with the Federal ACO program, for each 12-month period that participating ACOs meet specified quality performance standards, they will be eligible to receive a share (a percentage, and any limits to be determined by the Secretary of HHS) of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B. The ACO will share in savings if program criteria are met but will not incur a payment penalty if savings targets are not achieved

Q: What will be the quality performance standards in an ACO?
A: Under the federal program the specifics will be determined by the HHS Secretary and will be promulgated with the program's regulations, they will include measures in such categories as clinical processes and outcomes of care, patient experience, and utilization (amounts and rates) of services. In connection with a private health plan ACO, it is likely that the quality initiatives will focus on similar measures to those found in HMO plans -- chronic disease patient management, health screenings, well care visits and immunizations.

In order to monitor and improve quality, an ACO should provide its physicians with the tools that many physician organizations contracted with HMOs provide their members -- technical assistance, quality-improvement collaboratives, coaching, technology, performance information, etc….

Q. Do physicians need to join an ACO now?
A. Not if you are part of a physician organization that has expressed the interest in achieving status as an ACO. Most successful physician organizations that offer HMO contracts already employ many of the procedures and methodologies that have been adopted as best practices by ACOs and are well on the way to be designated as such. Moreover, because CMS will not begin formal contracting with ACOs until January 2012, there should be no rush to join an organization – the focus should be on joining an organization that best suits your practice.