ACCOUNTABLE CARE ORGANIZATIONS

What are Accountable Care Organizations?
Accountable Care Organizations (ACOs) are defined as groups of physicians, hospitals, and other caregivers that work together to improve the quality and efficiency of patient care. The concept of Accountable Care Organizations (ACOs) was first described by Elliott Fisher, M.D., and colleagues in a 2007 ***Health Affairs*** article. This article described the concept of "virtual" organizations composed of hospitals and the physicians who worked in those hospitals.[1] This concept was built on the premise that providers would be linked in a manner that would allow them to share accountability for the cost and quality of care for their patients.

Who is developing the concept?
The Centers for Medicare and Medicaid Services (CMS) is responsible for developing and administering this program. The law requires:

> ". . . groups of providers meeting the criteria specified by the Secretary may work together to manage and coordinate care for Medicare beneficiaries through an [ACO]."

The ACO may receive payments for shared savings if the ACO meets certain quality performance standards and cost savings requirements established by the Secretary.

Legislatively, ACOs were included in the 2010 ***Patient Protection and Affordable Care Act*** (PPACA). This law promotes integrated systems to test new reimbursement methods intended to create incentives for health care providers to enhance health care quality and lower costs. The Medicare Shared Savings Program under Section 3022 of PPACA establishes the formation and operation of ACOs and Section 3021 establishes a Center for Medicare and Medicaid Innovation (CMMI) within CMS that is to pilot a pediatric ACO demonstration project.

Some of the concepts of the ACO are currently being tested in the CMS five-year Medicare Physician Group Practice demonstration that began in 2005. The data is not fully available from this effort, but it is expected that CMS is looking to these 10 group practices for lessons learned.

Some general features an ACO program is expected to include is:

Invisible enrollment – Patients who receive care from ACO providers would be treated as "assigned" to the ACO. But, during the early phases of the program it is expected that they would not be formally enrolled. They would be free to take services from other providers, even outside the ACO. In reality, some patients might not even be aware they are "in" an ACO. Though, during the regulatory comment and discussion period, consumer groups have argued that patients should be aware that they are enrolled in an ACO.

Performance Measurement – The payer would collect information on utilization, costs, quality measures and other population health features. Providers in the ACO could be required to meet minimum quality standards in order to continue to participate in the ACO. It is expected that quality reporting requirements would encourage the use of ACO-wide information systems, a key factor in developing coordinated care.

Shared Savings – Spending for the population of patients in an ACO could be compared to historic costs for the same patients and/or costs for patients from the same community not in the ACO. How incentive payments given to the ACO will need to be distributed will likely be determined by each ACO. ACO incentives are expected to be more generous in the beginning and become more tied to outcomes and/or other measures as payers gain more experience with this payment system.[ii]

Who is Eligible?
According to PPACA, the following practices are considered eligible to participate as an ACO:

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.

How will it Work?
CMS is charged with developing an ACO demonstration project by January 2012, with the goal of promoting accountability, coordinating services under Medicare Parts A (hospital services) and B (physician services), and encouraging investment in infrastructure and redesigned care processes. Provider participation in the ACO project will be voluntary. Based on information currently available, to be eligible, a group of providers should be able to:

- assume accountability for the quality, cost, and overall care of fee-for-service beneficiaries assigned to it;
- agree to participate for three years (and not participate in any other Medicare or Medicaid shared-savings demonstrations);
- have a legal structure that allows for the collection and distribution of payments to providers and suppliers;
- have a sufficient number of primary care providers to care for the no-less-than 5,000 Medicare beneficiaries assigned to it;
- have a clinical and administrative leadership and management structure; and
- have defined processes to provide evidence-based medicine, report on quality and cost measures, and coordinate care.

PPACA gives CMS discretion in terms of how payment to ACOs could be structured. Payment options might include partial capitation, which may be limited to highly integrated provider systems and those capable of bearing risk. In such cases, fee-for-service payments would continue but the ACO would share a portion of any savings achieved in excess of a defined threshold. CMS is seeking to test this care delivery model through two mechanisms – the PPACA legislated Shared Savings Program and the newly created Center for Medicare and Medicaid Innovation (CMMI). In a November 17, 2010 Federal Register notice of proposed rulemaking, CMS stated:

> "We are developing rulemaking for the establishment of the Shared Savings Program under section 3022 of the Affordable Care Act. In addition, section 3021 of the Affordable Care Act establishes a Center for Medicare and Medicaid Innovation (CMMI) within CMS, which is

> authorized to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. We are considering testing innovative payment and delivery system models that complement the Shared Savings Program in the CMMI. In both of these efforts, we are seeking to advance ACO structures that are organized in ways that are patient-centered and foster participation of physicians and other clinicians who are in solo or small practices."[iii]

CMS is actively working on their proposal, but have been slowed by Federal Trade Commission (FTC) concerns and the complexity of the program.

Timing

The announcement of this innovative demonstration program was originally expected to occur sometime at the end of 2010 or beginning of 2011. The law requires CMS to develop an ACO demonstration project by January 2012. In order to meet this deadline, time will be needed to announce the demonstration, accept grant applications and determine the grantees. Therefore, since no definitive announcement has been made, the health policy community has had growing concerns about timing.

In a February 3, 2011 article in ***Inside Health Reform,*** it was reported that CMS Director Don Berwick said "CMS still plans to use a demonstration to let accountable care organizations include Medicare beneficiaries and patients with private insurance."[iv] This statement reassured the health policy community who had expected the ***Federal Register*** notice defining the parameters of the program to be published at the end of 2010.

Federal Trade Commission Concerns

On October 5, 2010 the FTC held a workshop to discuss ACOs and the implications they bring to antitrust, physician self-referral, anti-kickback and civil monetary penalty laws. The public comments from this meeting are available online. The important legal concerns that the ACO demonstration project raised are considered by some to be one of the primary reason for the delay in the announcement of the demonstration project by CMS. It has been reported that CMS and FTC are working together to address these issues prior to the announcement. PPACA provides CMS authority to ease some of Medicare's rules for financial relationships among providers, but given the ongoing legal concerns raised by those opposed to PPACA, CMS is expected to move carefully to address any of the FTC's concerns prior to announcement of the demonstration.

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[i] Fisher E, Staiger D, Bynum J, Gottlieb D. Creating accountable care organizations: the extended hospital medical staff. Health Affairs. 2007; 26(1): w44-57.

[ii] Robert Wood Johnson Foundation. Health Policy Brief: Accountable Care Organizations. Under the health reform law, Medicare will be able to contract with these to provide care to enrollees. What are they and how will they work? Health Affairs, July 27, 2010.

[iii] U.S. Department of Health and Human Services, Center for Medicaid and Medicare Services. Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program: Proposed Rules. Federal Register, Vol. 75, No. p. 70165

[iv] Wilkerson, J. Berwick Indicates CMS Still Plans To Mix Private Payers, Medicare in ACO Demo. Inside Health. Accessed February 3, 2011 at:
http://www.ahiphiwire.org/FocusMed/News/Default.aspx?doc_id=749955&utm_source=2/3/2011&utm_medium=email&utm_campaign=HiWire_Newsletter&uid=TRACK_USER