ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Analysis of the April 7, 2011 Federal Register (FR) Notice

BACKGROUND INFORMATION

The focus of an ACO is primary care which is defined as "…the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and community." (FR, p. 19535). To participate, ACOs must have sufficient primary care providers to care for at least 5,000 beneficiaries and must agree to a minimum of 3 years of participation. Primary care providers include physicians, nurse practitioners, physicians' assistants, and clinical nurse specialists. The primary care specialties identified are family practice, internal medicine, pediatrics, geriatrics, and (possibly) obstetrics.

ACOs are not a capitated payment arrangement or a managed care organization. Rather, "providers of services and suppliers can continue to receive traditional Medicate fee-for-service payments under Parts A and B, and be eligible for additional payments based on meeting specified quality and savings requirements." (FR, p. 19528) In some cases, ACOs will also share the financial risks if cost savings are not achieved. Patients are not limited to providers within an ACO and may not even be aware that they are assigned to an ACO since it will be a retrospective assignment/alignment based on where they received the plurality of their primary care in a given year.

The following are eligible to participate as ACOs:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Such other groups of providers of services and suppliers as the Secretary determines appropriate

The highest-level goal of the program is achievement of the "three-part aim" which consists of (FR, p. 19533):

1. "Better care for individuals—as described by all six dimensions of quality in the Institute of Medicine report: Safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;"
2. "Better health for populations with respect to educating beneficiaries about the upstream causes of ill health – like poor nutrition, physical inactivity, substance abuse, economic disparities – as well as the importance of preventive services such as annual physicals and flu shots;" and
3. Lower growth in expenditures by eliminating waste and inefficiencies while not withholding any needed care that helps beneficiaries.

HOW THIS MIGHT IMPACT EMERGENCY PHYSICIANS

Emergency physicians are not identified as a primary care specialty so it does not appear that an emergency physician group could qualify as an ACO. In addition, since the focus is primary care, the mission of emergency medicine is not aligned with the mission of an ACO. Thus, it appears that the impacts on emergency medicine would be indirect.

At the provider level, there are general performance measures that could impact the ED physicians (patient satisfaction with providers, shared decision making, meaningful use of information technology, etc). However, these are stated to apply to the primary care providers, not all providers in the ACO organization. These are measures that are already trended in most hospitals but there would likely be new emphasis on compliance to meet established performance thresholds since there are financial consequences associated with compliance.

In addition, the hospital could require the ED to help attain performance goals by performing assessments and interventions on ED patients. This is already happening in some institutions because of CMS "Pay for Performance" measures (i.e. EDs screening and administering influenza and pneumococcal vaccine regardless of the patient's presenting complaint.) Table 1 in the Federal Register (pp. 19571 – 19591) describes 65 proposed quality measures. Many are clearly not applicable to the ED (mammography, LVF testing for patients admitted with CHF, etc.) but many could be extrapolated to the ED (depression screening, tobacco screening and cessation intervention, etc.) While these factors are undoubtedly important for overall health and specifically pertinent to some ED presentations, screening all patients for conditions unrelated to their chief complaint consumes time and resources. Overcrowded EDs are often stretched to provide essential emergency care and screening patients for unrelated conditions could be considered "mission-creep."

Some of the quality indicators pertain to hospitalization of patients for exacerbations of chronic conditions like diabetes or COPD. It is possible that the ED could encounter obstacles when trying to admit these patients and be pushed to "fix" these patients in the ED rather than admitting them for inpatient care. This could lead to longer ED lengths of stay or inappropriate discharges.

ED visits are also cited as a possible outcome measure, i.e. did a visit occur because the patient was unable to get a timely clinic appointment? ED care is identified as "more expensive" (FR, p. 19614) than that provided by other providers. Though not explicitly stated, one goal of an ACO would be to decrease ED visits by providing primary care elsewhere and decreasing preventable exacerbations of chronic illness.

There is a potential financial impact to emergency physicians who are employed by a hospital that is part of an ACO. Financial gains or losses would affect the entire organization could ultimately trickle down and affect reimbursement to ED physicians.

WHAT IT SAYS ABOUT PHYSICIANS BEING EMPLOYED BY HOSPITALS OR OTHER

NON−PROFESSIONAL ENTITIES

The only mention of this concept is neutral and occurs in the listing of groups that are eligible to participate as an ACO (see list above). There is no expressed preference for any employment model but there is a stated intent "…to encourage participation by non-for-profit, community-based organizations." (FR, p. 19540).

Of interest, "an established mechanism for shared governance" is a requirement for participation as an ACO. This shared governance must provide all ACO participants with "appropriate proportionate control" in decision-making and ACO participants must have at least 75% control of the governing body. The governance structure must also include clinical management and oversight "by a senior-level medical director who is a board certified physician, licensed in the State in which the ACO operates, and physically present in that State." There is also a proposed requirement for beneficiary participation in the governing process.

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