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Healthcare re-FORUM

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A First Look at Accountable Care Organizations

The Patient Protection and Affordable Care Act (PPACA) calls for the creation of an Accountable Care Organization (ACO) program by January 1, 2012, to be administered by the Centers for Medicare & Medicaid Services (CMS). ACOs will be responsible for the quality, cost and overall care of Medicare patients, and will be expected to meet specific organizational and quality performance standards to be eligible to receive a percentage of the expected cost savings. ACOs will also be able to contract with private health carriers.

What are Accountable Care Organizations?

ACOs predate the PPACA as a healthcare model, but have been limited to a small number of healthcare systems across the country. The concept has recently drawn attention after being identified by the PPACA as one of Medicare's pilot programs. Providers who participate in ACOs strive to improve care outcomes, as well as reduce waste, duplication and inefficiencies. ACOs offer participating providers the infrastructure to integrate care and embrace emerging reimbursement methods such as bundled payments, medical homes, gainsharing (i.e., cost and revenue sharing) and pay for performance. Because the ACO model is designed to help providers work together to improve care and reduce medical costs, state Medicaid programs and private health insurers may join Medicare in supporting the ACO model. The reality is there are fewer dollars available for healthcare, and ACOs may help the healthcare dollar go farther.

Medicare's Shared Savings Program

Helping to fuel growth of ACOs is the Medicare Shared Savings Program, which allows providers within ACOs to share both accountability for treating Medicare patients, and any realized cost savings if they meet defined quality standards. ACO networks must include primary care providers, employ evidence-based medicine and achieve levels of integration such as sharing patient information and joint governance.

Who Can Become an Accountable Care Organization?

The PPACA specifies the types of groups that can become an ACO:

- Physicians and other professionals in group practices or networks of practices
- Partnerships or joint venture arrangements between hospitals and physicians/professionals
- Hospitals employing physicians/professionals
- Other forms that the Secretary of Health and Human Services may determine appropriate

The PPACA also specifies the requirements for an ACO, which must:

- Participate for a minimum of three years
- Provide an adequate number of primary care providers to service enrolled patients (minimum of 5,000 per ACO)
- Maintain a defined legal structure to receive and distribute shared savings
- Have a formal management structure for both clinical and administrative services
- Have sufficient recordkeeping to account for patients and determine appropriate payments (patients are not "locked in" to a provider)

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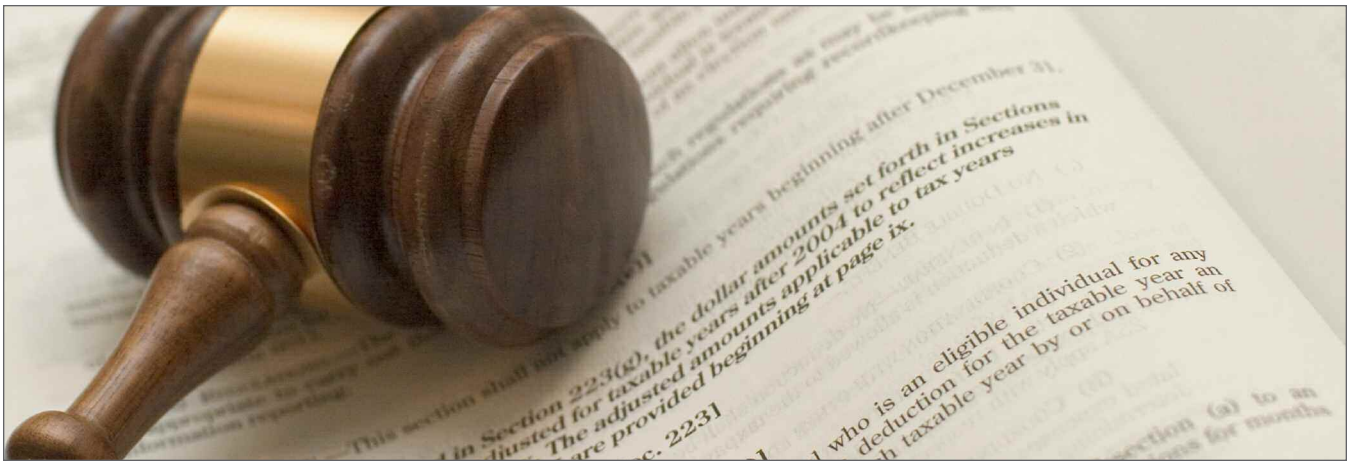

- Have defined processes to:
  - Promote evidenced-based medicine
  - Coordinate care
  - Report the necessary data to evaluate quality and cost measures, including the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx) and Electronic Health Records (EHR)

Further definition of the requirements is expected to be forthcoming.

Other delivery system changes are specified in the PPACA that will ultimately impact ACOs, such as:

- Creating a demonstration project for a pediatric ACO
- Expanding CMS' initiative to bundle payments around episodes of care (i.e., periods of care by a healthcare facility or provider for a patient's specific medical problem or condition)
- Funding the Patient-Centered Outcomes Research Institute to develop evidence-based medical treatments
- Extending the existing Gainsharing Demonstration Project (January 1, 2007, through December 31, 2009), which involved arrangements between hospitals and providers under which the hospital shared savings with a provider due to collaborative efforts to improve quality and efficiency of services, through 2014
- Establishing the new Center for Medicare and Medicaid Innovation to test new payment and delivery models (funded by $10 billion over the next decade)

ACOs and Private Carriers

Private health plans are encouraging physicians and hospitals to work together as ACOs by experimenting with bundled payments for episodes of care. Bundled payments can create additional revenue for providers if they make their healthcare delivery system more efficient through controlling the use of resources and measuring clinical outcomes. Because providers who participate in an ACO look for ways to reduce costs and improve outcomes, they will ultimately serve the best interests of the ACO, patient and carrier.

The September 17, 2010, *Federal Register Notice* includes a request for input about the direction in which ACOs will evolve within the framework of established regulations and the oversight of responsible federal agencies: http://oig.hhs.gov/authorities/docs/2010/FR9-17-10.pdf

Future Topics:

- Provisions Affecting Part-time Employees
- Additional Guidance Issued for Mandates Effective September 23, 2010