Understanding Accountable Care Organizations

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Introduction

SIGNED INTO LAW BY PRESIDENT OBAMA ON March 23, 2010, The Patient Protection and Affordable Care Act (PPACA) will dramatically overhaul the U.S. healthcare system. It also creates various challenges for solo medical practitioners and small medical practices. However, by participating in larger business models or joining larger medical groups, those physicians can alleviate some pressures from high overhead expense, medical liability premiums, litigation awards, as well as the cost of adopting EHR systems.

ACO participants

The PPACA requires that ACOs be made up of physicians, physician networks, partnerships, or joint venture arrangements between hospitals and physicians, or hospitals employing physicians. The key word in all of these options is "physicians." The federal government finally recognizes that unless physicians are made an integral part of the healthcare delivery system, the cost of care will not be reduced. Therefore, physicians should seriously consider establishing business models that provide high-quality coordinated care in cost-efficient delivery systems. Such systems should financially reward participants through shared cost savings. The goal is for patients to receive high-quality care as service providers become more efficient in providing that care.

Realistic expectations or a dream?

Both the federal government and healthcare community recognize the current system is unsustainable. While no one can predict whether this laudable goal of reducing costs can be achieved, the federal government has determined that incentives to practice "smart" medical care will encourage cost-efficiency, while also improving care for patients in both the public and private sectors.

Fundamental requirements of an ACO

The seven requirements entities must meet to qualify as an ACO organization are as follows:

- Three-year agreement with CMS (Centers for Medicare and Medicaid Services).
- Legal structure to receive and distribute shared saving to participating providers.
- Include primary care providers.
- Serve at least 5,000 Medicare fee-for-service beneficiaries.
- Leadership and management structure that includes clinical and administrative systems.
- Processes to promote evidence-based medicine and patient engagement; measure quality and cost; and coordinate and monitor care (through tele-health and remote patient systems).
- Patient and caregiver assessments or use of individualized care plans.

Essentially, an ACO must have primary care providers who can bring in at least 5,000 Medicare fee-for-service patients for treatment and a business model that promotes quantitative evidence-based statistics for measuring quality and cost.

Use of technology

To accumulate the data necessary to fulfill these goals and criteria, ACOs must invest significant time and resources into electronic systems that monitor and measure all aspects of care and related costs. Who will pay for this? Most solo practitioners and small medical groups lack the resources to invest in electronic medical care delivery systems. Many hope the federal government will continue to provide financial incentives and authorize new incentives. In addition, a number of private insurance companies monitor cost and quality of care. Insurance companies, therefore, may help physicians establish their own in-office electronic monitoring programs.

Payment mechanisms

Medicare fee-for-service payments will continue to be made to healthcare providers. If, however, physicians belong to an ACO, the PPACA will allow shared savings only if (1) quality performance standards are achieved; and (2) estimated average per capita Medicare expenditures are less than the CMS benchmarks. The government is

preparing rules and regulations that define these benchmarks. There is debate over how aggressive the benchmarks should be in the initial years.

As in private insurance carrier agreements, there can be various levels of savings and risk between Medicare and the ACO. For example:

Level I – The ACO bears no financial risk and simply shares in any savings or bonuses for meeting quality requirements.

Level II – The ACO is eligible for a larger share of savings, but would also be liable if costs rise above predetermined targets.

Level III – The ACO is paid through full or partial capitations.

Significant advantages over other business models

It is extremely important to recognize that the PPACA specifically authorizes CMS to waive requirements of certain statutes (Stark, Fraud and Abuse, and Civil Monetary) for ACOs.

Because final rules governing ACOs are not complete, the breadth of waivers should be reviewed to insure the ACO remains in compliance. Why are waivers so important? First, all other healthcare delivery business models are still required to conform to onerous, unrealistic statutes that promote inefficiency and make it difficult to create coordinated, cost-efficient healthcare delivery systems. Under current statutes, there is no incentive to provide care in a cost-efficient manner. In addition, restrictions on owning multiple entities that provide a continuum of care create unnecessary overhead and administrative costs. All these costs can be avoided under one business model with common ownership, where the healthcare provider monitors quality and cost, and rewards participants with savings achieved under the model.

Forming ACOs

There are various ways solo practitioners and small medical groups can create an ACO or other business model that will achieve the same goals of

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an ACO: 1) Merge or consolidate their practices with other practitioners; (2) Join or merge with larger medical groups; (3) Join ACO organizations created by hospitals or other healthcare providers; or (4) Create a larger patient pool to achieve Medicare's 5,000 patient requirement, and assume responsibility for monitoring and measuring quality and associated costs.

Healthcare industry with or without ACOs

Regardless of whether the PPACA is finally determined to be constitutional, the U.S. healthcare industry is forging ahead to create the same business model for all patients (not just Medicare patients). For the first time, technology and software programs have been developed to monitor and measure quality and cost. It is also indisputable that providing a continuum of preventive care, cost-efficient treatment during acute and terminal illness, and post-hospital care, including home care, reduces costs and improves the quality of treatment.

All physicians are urged to embrace this golden opportunity. The federal government, insurance carriers, hospitals and other healthcare providers, finally recognize that physicians are the true gatekeepers of cost-efficient quality care. Your decisions and how you treat patients ultimately affect cost and quality of care.

Mark Twain said it best: "Even if you are on the right track, you will get run over if you just sit there." Good luck on your journey!

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(On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS), proposed new rules under the Affordable Care Act for accountable care organizations (ACOs). There is a 60-day public comment period on this proposed rule. CMS encourages all interested members of the public, including providers, suppliers, and Medicare beneficiaries to submit comments so that CMS can consider them as it develops final regulations on the program.)