Illinois Hospital Association

HEALTH CARE REFORM ISSUES AND ANSWERS

an informational series for hospital leaders

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The Essentials of Accountable Care Organizations

I. THE AFFORDABLE CARE ACT (ACA)

The Patient Protection and Affordable Care Act (ACA) provides for the formation of Accountable Care Organizations (ACOs) under the Medicare program to foster the development of redesigned health care delivery and payment systems that emphasize accountability and value. An ACO is a group of health care providers who share responsibility for managing and coordinating efficient quality care for a specific patient population.

A. Who can participate in an ACO? ACOs may be formed by physician groups; networks of individual practices; hospital-physician joint ventures and partnerships; and hospitals employing physicians and other health care professionals. The Secretary may authorize other organizational arrangements.

B. How does an entity qualify as an ACO? An ACO must become accountable for the overall care of its Medicare beneficiaries, and:

- ✓ Agree to a minimum three-year participation period;
- ✓ Have a formal legal structure to receive and distribute payments and any shared savings;
- ✓ Have sufficient primary care professionals to care for at least 5,000 beneficiaries;
- ✓ Provide the Secretary with information on the health care professionals participating in the ACO;
- ✓ Have a leadership and management structure in place that includes clinical and administrative systems;
- ✓ Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care; and
- ✓ Demonstrate that the ACO meets patient-centeredness criteria.

C. What are the key competencies of an ACO? Organizations considering participation in ACOs must possess strong leadership; a culture of teamwork; relationships with other providers; information technology for population management and care coordination; infrastructure for managing and monitoring quality; the ability to assess and manage financial risk; and resources for patient

education and support (AHA, 2010). There are challenges in establishing an ACO. Sufficient size is important to ensure actuarial stability, as is an adequate network of providers. MedPAC suggests no fewer than 50 physicians to care for 5,000 patients. Adequate capital is critical. On average, participants in the Medicare Physician Group Practice Demonstration expended approximately $500,000 on initial pilot expenses and more than $1 million on annual initiatives (Sg2 2010). Certainly ACOs may be established with lesser expenditures, but hospitals will need to assess what investment they need to make, including investment in infrastructure and IT.

D. What is the Medicare ACO Shared Savings Program? Beginning January 1, 2012, the ACA permits the Centers for Medicare and Medicaid Services (CMS) to establish the ACO Medicare Shared Savings Program. Under this demonstration program, ACOs that coordinate care for an assigned group of Medicare beneficiaries and meet quality performance standards will be eligible to share in the savings realized for the Medicare program. CMS is expected to issue rules governing the demonstration program in December or January.

E. How will savings be shared? For each 12-month period, ACOs that meet quality performance standards will receive a percentage of the savings resulting from efficient care to assigned Medicare beneficiaries. The per capita expenditures for those beneficiaries must be sufficiently below a specified benchmark amount. The benchmark for each ACO will be based on the most recent three years of per-beneficiary expenditures for Parts A and B services, adjusted for beneficiary characteristics. The Secretary will set the percentage and any payment limits. We expect there will be three ACO levels: (1) The basic level ACO will share in savings if program criteria are met, but will not incur a payment penalty if savings targets are not achieved; (2) The next level will be at risk for not achieving target savings; and (3) the Secretary may also allow a third tier ACO which would be paid under partial capitation or other payment models and would assume more risk than lower tier models. We can assume that the use of medical homes and bundled payment arrangements will increase as components “accountable care.”

F. How will legal barriers be addressed? A key advantage of the Medicare ACO demonstration is that the ACA allows the Secretary to waive the application of certain laws (such as Self-Referral, Anti-Kickback and the Civil Monetary Penalty laws) that, among other restrictions, limit the ability of providers who are not financially integrated to share financial risk. A recent CMS/FTC session to solicit input on addressing such barriers indicated the agencies plan to facilitate ACO development, and consider the participants’ calls for broad waivers which were generally seen as preferable to additional safe harbors in allowing needed flexibility.

II. OTHER ACO MODELS

Some private payers are currently partnering with health care providers to form ACOs that may cover commercial patients and link payment to satisfying defined

quality or efficiency benchmarks. There are a variety of ways to configure such arrangements in the Illinois market. For example, it has been widely reported that Advocate Health Care and Blue Cross and Blue Shield of Illinois recently announced reaching such an agreement. Other possibilities include rural models that utilize community provider networks designed to achieve a patient population large enough to support performance measurement, such as Vermont has been developing. Medicare has recently implemented two large regional demonstrations in Indiana and North Carolina that include a wide range of providers and multiple payers, including Medicaid, Medicare, state employees' health benefits programs, and private insurers. CMS may, in qualifying ACOs for its Shared Savings Program, give preference to ACOs that are participating with other payers.

At this stage, it is important to consider that there is no "one size fits all" ACO model. Each hospital must consider what it needs to do to succeed in an "accountable care" environment. As one consulting firm has observed:

> *…Resist the temptation to believe that there is a standard ACO model… For now, the steps you take to become more "accountable" to consumers and payers are more important than the organization model.* (Sg2, 4/2010)

Regardless of hospitals' decisions about ACO participation, every hospital will be challenged to become more accountable by providing higher quality care at a lower cost. All payers will be seeking better value for the dollars they are spending. Hospitals will be rewarded for value, not volume. Whatever delivery system models hospitals choose to increase value, they will require greater clinical integration, coordination of care with other providers across the continuum, and greater accountability for the health status of populations. In deciding whether or to what extent to participate in ACOs, hospitals should consider the following:

- Will establishing an ACO benefit the community you serve?
- Do you have an organizational structure conducive to creating the ownership, employment, joint venture and/or network affiliations necessary to achieve clinical integration?
- Is your current board comprised of a mix of individuals ready to provide oversight in an era of accountable care? (BNA, 2010).
- Does your community have a sufficient population base to support an ACO?
- Do you have the necessary provider and service mix?
- Is there sufficient financing for start-up costs?

To learn more about accountable care and ACOs, plan to attend the IHA webinar, "Clinical Integration: The Pathway to Accountable Care," on December 1, 2010 from 10:00 – 11:30 a.m.
For more information, please contact Ann Guild at 630-276-5496 or
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