The accountable care organization (ACO) model is a new Medicare option for physicians, hospitals, and other providers to share in cost savings. ACOs represent a dramatic change in Medicare policy and an opportunity to transform care delivery and provider alignment.

The Medicare Gain-Sharing Program, part of the newly enacted healthcare reform law, creates the option for healthcare providers to form ACOs. Through an ACO, providers will take responsibility for quality and overall care of their Medicare patients. Medicare will then share with ACO providers the savings from improved quality, fewer hospitalizations, and the elimination of unnecessary costs.1,2

Starting in 2012, the ACO model will be a nationwide option in Medicare fee-for-service (FFS). In addition to shared savings, the ACO option includes freedom of choice for Medicare beneficiaries, national quality measures, evidence-based medicine, patient-centered care delivery, advanced care coordination, and information sharing.

Because the ACO model is designed to break down old barriers for providers to work together to improve care and reduce medical costs, state Medicaid programs and private health insurers will likely join Medicare in supporting the ACO model. Medicare may give preference to ACOs that are participating in similar arrangements with Medicaid, private payers, and other third parties.

Specifically, Section 1899 of the Social Security Act governs the new Medicare Shared Savings Program and the option for providers to form ACOs. The law was created by Section 3022 of the Patient Protection and Affordable Care Act of 2010 (PPACA). The Centers for Medicare & Medicaid Services (CMS) must implement the ACO option no later than January 1, 2012.

Option for Physicians, Hospitals, and Other Providers

A variety of providers will be able to form an ACO:

• Physicians and other professionals in group practices or a network of practices, such as a large medical group, an independent provider association, a network of solo and small group physician practices, and, presumably, a community health center

• Hospitals, physicians, physician groups, and other healthcare professionals via a joint venture or partnership arrangement

• Hospitals that employ physicians and other healthcare professionals, such as an integrated hospital-physician system.

Although the ACO is of keen interest to many hospital systems, an ACO need not include a hospital. Physician participation, however, is mandatory.

CMS may permit other combinations or types of providers to form an ACO. Therefore, other possibilities include hospitals, physicians, and postacute providers, such as skilled nursing facilities and home health agencies.

Provision are ineligible to participate in an ACO if they participate in a Medicare shared-savings demonstration, such as the Physician Group Practice Demonstration project or the new Independence at Home medical practice pilot.3

Medicare Beneficiary Assignment

Assignment of Medicare beneficiaries to ACOs will be invisible to the beneficiary. Receiving services from an ACO will not affect Medicare coverage, benefit design, or a beneficiary’s freedom to choose physicians and other providers. Beneficiaries in Medicare Part A or Part B FFS programs may receive covered services from any Medicare provider, regardless of whether the provider is part of an ACO. Medicare beneficiaries who elect a Medicare Advantage plan are excluded from the ACO program.

Minimum Requirements for ACOs

An ACO must have a patient base of at least 5000 Medicare FFS beneficiaries, with participating providers agreeing to accept responsibility for overall patient care and quality for at least 3 years. In addition, to gain Medicare recognition as an ACO, the provider organization, partnership, or joint venture forming the ACO must meet the following minimum requirements:

• A sufficient number of primary care physicians to serve the ACO’s patient population

• A formal legal structure to receive and distribute shared savings

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• A leadership and management structure that includes clinical and administrative systems
• Provide sufficient information on participating providers and their services to support beneficiary tracking and the determination of payments for shared savings
• Defined processes and systems to:
  • Promote the practice of evidence-based medicine
  • Meet federal criteria for patient-centered care
  • Coordinate care
  • Report the necessary data for CMS to monitor and assess the ACO’s performance compared with federally defined clinical performance measures and cost benchmarks
• Meet federal requirements for electronic prescribing and electronic health records
• Participate in the existing Medicare Physician Quality Reporting Initiative, which is expanding under PPACA.4

Medicare Payment and Shared Savings

Several payment methods are possible for ACOs. Under the primary method, ACO providers will be incentivized to improve clinical performance while controlling Medicare spending through, for example, reducing hospitalizations and eliminating unnecessary costs. Specifically, the ACO will receive additional payments from Medicare if (1) the ACO meets federal expectations for clinical performance, and (2) the ACO’s Medicare per-capita FFS costs are a certain percentage below a benchmark.

CMS will set the clinical performance measures and the proportion of Medicare cost-savings that will be shared with ACOs. The law sets a methodology for setting a benchmark for predicted per-capita Part A and Part B costs. The law allows CMS to create other payment methods for ACOs, such as partial capitation or global fees. Risk-based payments may be limited to highly integrated health systems and ACOs capable of bearing risk.

Learning from Other Gain-Sharing Projects

Providers planning to form Medicare ACOs in 2012 may learn from the Brookings-Dartmouth ACO Collaborative, which currently has 5 private sector pilot ACOs operating in Arizona, California, Kentucky, and Virginia.5-7 Many of the requirements for Medicare ACOs are modeled on recommendations from the Brookings-Dartmouth ACO Collaborative.5,7

Meanwhile, PPACA extended the existing Medicare gain-sharing demonstration through September 2011 and created the Medicare Independence at Home program, a gain-sharing demonstration to test in-home primary care services for Medicare patients with multiple chronic conditions.4

Obstacles

The ACO option and the accompanying shared-savings model raise some potential legal obstacles that must be resolved before 2012. In the rules setting up the ACO option, the Secretary of the Department of Health and Human Services (HHS) will have to waive certain laws and rules that conflict with the gain sharing and provider alignment in ACOs. Specifically, aspects of longstanding federal antikickback and physician self-referral laws must be waived for ACO-participating providers. HHS will need to waive the laws enough for the ACO model to work well but not to create unintended loopholes. The new law provides the HHS secretary with the necessary waiver authority.

In addition, the ACO model may run afoul of federal or state antitrust laws. The Federal Trade Commission (FTC), which oversees and enforces antitrust laws regarding healthcare providers, will have to offer specific guidance. Like the FTC, state attorneys general will have to adapt their traditional antitrust thinking to the new business relationships contemplated under the ACO model.

Next Steps

ACOs offer the potential for a genuine win-win situation for physicians, hospitals, beneficiaries, and taxpayers. The precise details for forming and operating an ACO will be laid out in federal regulations. CMS is expected to release a proposed rule on ACOs in late 2010, with a final rule likely by mid-2011. Developing rules governing ACOs is one of many tasks facing the new CMS Administrator, Donald Berwick, MD.

References