

Everything You Need to Know About Accountable Care Organizations *(In Plain English)*

What is an accountable care organization, or ACO?

Simply stated, an ACO is a group of healthcare providers who agree to take on a shared responsibility for the care of a defined population of patients while assuring active management of both the quality and cost of that care.

Why should you care about ACOs?

Whether you participate in an ACO or not, there are clear signals that the payment environment will move away from pure fee-for-service, or FFS, and toward a formula that promotes value for patients and efficiency for the system overall. Success in the future will require that you monitor and manage quality and efficiency. As a family physician, you should work toward implementing the patient-centered medical home, or PCMH, which includes the use of patient registries, team care, care coordination and health information technology. These capabilities will be rewarded in the new payment environment with enhanced payments and incentives.

Are there different types of ACOs or ways to structure an ACO?

At this point in time, ACOs are a conceptual model for improving health care quality and efficiency through clinical and financial integration. ACOs will take different forms depending on local market conditions and levels of existing competition among providers. Unless an ACO is able to reduce fragmentation of care, waste and variability, it will not be successful in the long term. Thus far, the only attempt to define or limit the design of an ACO is the Medicare ACO Shared Savings Program. CMS has proposed specific rules of conduct for this program.

What is an IPA?

IPA stands for independent practice association and is typically a group of physician practices that have a contractual agreement to work together to provide health care for patients in a health plan network or integrated system. IPAs are important because they have existing infrastructure, management, information technology and organizational components that can serve as the basis for a physician-sponsored ACO.

How do you get paid in an ACO?

Ideally, the ACO receives a global payment for services to the defined patient population it serves. Payment and incentives within the ACO should be structured to foster a shared sense of responsibility for both cost and quality. The AAFP supports a blended payment model which includes a fee-for-service component, a care-management fee and performance incentives based on clinical measures. The three components must be relatively balanced — such as 50 percent fee-for-service, 20 percent care-management fee and 30 percent performance incentives — to achieve the desired results.

What is shared savings and how will the savings be distributed to providers?

The entire ACO buzz is really about controlling or reversing the cost trends in health care. The idea of shared savings is that by working together, a group of providers can deliver care of equal or better quality while reducing the cost to below current projections. There should be some savings to be shared between the payer — the government or the employer — and the providers. How that savings is calculated and distributed to the various players should be specified in the contracts between the parties. If shared savings are the only source of funding for incentives or infrastructure support, there is a danger that the amount of money for those purposes will diminish over time.

How is an ACO different from managed care and capitation models that were prevalent in the 1990s?

There are similarities, especially when it comes to the goal of cost savings. But much has changed in terms of information technology and performance measurement that now allow for better monitoring of quality. If the ACO receives a global payment for the care of a defined population, it is essentially a capitated payment. The other important difference is the clear distinction between “insurance risk” and “performance risk” in the current discussion of ACOs.

What kind of risk are we talking about?

It is important to distinguish between insurance risk and performance risk or utilization of unnecessary services. Insurance risk spreads the financial burden of disease, accident or injury over a large number of people. Insurance companies or health plans are regulated by state law and have required financial reserves to take on the insurance risk. Providers should not take on insurance risk but should be responsible for managing the rates of utilization of services along with the quality and availability of those services.

What is risk adjustment in the context of ACOs?

Risk adjustment helps to determine if a particular population of patients is sicker than another similar group. We have all heard physicians say, “My patients are sicker, and that is why they cost more.” Risk adjustment is an objective way to determine the illness burden of a group of patients. A simple example of risk adjustment might be differential payment levels based on age and gender. Proper risk adjustment should discourage ACOs or providers from shunning sicker patients or “cherry picking.”

Can an insurance company or a health plan be an ACO?

Insurance companies or health plans will be important partners for any ACO effort because of the information technology infrastructure, data analysis and actuarial capabilities they already have in place. Since the central function of an ACO is to deliver care to patients in an efficient and effective way, it makes more sense for the ACO to be physician-led. In some jurisdictions, insurance companies and health plans are prohibited from providing direct patient care.

How does the PCMH fit into an ACO?

It is best to think about the PCMH as an essential component of any ACO. Primary care provides access, disease prevention, disease management and care coordination services that leverage overall cost savings for the system. Other components could include specialty care, imaging, laboratory services, hospital care and information technology support. Each component must be integrated, coordinated and contribute to the overall efficiency of the ACO enterprise. Moving your practice to the PCMH model is a great way to assure that you can demonstrate both quality and efficiency to any ACO in your community seeking primary care services.

You have a small practice and don't want to sell to the hospital; what are your choices?

It is unlikely that in a particular market, all the patients will belong to an ACO or a single health plan. You may well be able to continue on in much the same way you have until now. The provisions of the current law stipulate that Medicare patients have a full choice of providers and your long term patients are likely to stay with you. There also will be slower growth of ACO activity in rural or inner-city markets. You are likely to see most of the early ACO activity in highly competitive markets.

How can you be sure you won't be left out of the ACO in your community?

There are no guarantees in this game, but you can increase your likelihood of participating if you move toward the PCMH model of care in your practice. The PCMH features that the AAFP supports are exactly the same features that will make your practice attractive to an efficient, integrated system like an ACO.

How is efficiency measured, and where can you find out how you are doing?

Efficiency can be measured in a number of ways, but it is convenient to think about an episode of care. If you see a patient for pneumonia, the tests you order — as well as imaging type and frequency, antibiotic choice and hospital versus ambulatory care — all affect the cost of that episode of pneumonia. In addition, numbers like the average total cost per patient, length of stay, bed days per 1000 patients, emergency department visit rates and hospital readmission rates will all be important determinants of efficiency. Health plan medical directors often have access to this type of information and should be willing to share it with you. It is most valuable if they can also show how you compare to aggregate numbers for peers in the community.

What should you consider when approached to sell?

The right answer to this question will depend on the current status of your practice and the local market conditions. Look for indications that the entity approaching you appreciates the value of primary care and is not just looking to expand its referral base for specialty and hospital services. Is the entity willing to support infrastructure improvements such as electronic health records, registries, care coordination and team care? Will your pay be based only on relative value unit production or will there be more balanced incentives? Will there be some way for you to participate in profits from the overall efficiency of the organization? As with any potential new position, look carefully at the total benefit package including insurance coverage, disability coverage, retirement plan, time away from the practice for vacation and CME opportunities, work hours and call schedules. Unfortunately, the practice itself will be valued based on accounts receivable, facilities, furniture and equipment, all priced at discounted or depreciated levels.

Can you form an ACO with other physicians?

Sure but it takes a lot of time and effort to get everyone on the same page and with the same goals in mind. If you are already associated with a coverage group or an IPA with some infrastructure, you can at least have a running start.

What is a virtual ACO?

The CMS ACO Shared Savings Program has been called a “virtual ACO” because patients and physicians are assigned to the ACO based on retrospective analysis of claims submitted. In this model, there is no requirement for contractual agreements among the participants in the ACO. In the private sector, a virtual ACO might be characterized as a group of providers, loosely organized to achieve the goals of quality care and reduced cost. They would be united primarily by the computer analysis that helps to determine the relative contributions to efficiency and the distribution of the savings.

How will the Stark Law and anti-kickback laws impact ACOs?

The federal government realizes that consolidation of health care services within a market carries a high risk of monopolistic behaviors with resulting higher costs and controlled access. On the same day that CMS published the proposed rules for ACOs, the Justice Department and the Federal Trade Commission also published rules that allow a certain level of consolidation and market share for health care organizations.

Are ACOs just a passing fad or are they here to stay?

ACOs may or may not be here to stay, but the imperative to control health care costs and improve the overall efficiency and effectiveness of our health care system will remain in either case. The AAFP encourages all family physicians to engage in clinical performance measurement and to move their practices toward the PCMH model. The payment system must change, and comprehensive, capable primary care practices will be valued higher than those practices that do not move toward the medical home model.

What is the AAFP doing to help payment reform?

The AAFP has been a tireless advocate of fair payment for primary care and the recognition that the PCMH should be at the center of a redesigned health care system. Our current policy promotes a blended payment approach, combining fee-for-service, a care-management fee and clinical performance incentives. AAFP members and staff have participated on numerous work groups for both quality measures and payment issues. The AAFP also has been an active contributor to the Patient Centered Primary Care Collaborative, an organization that has advocated for health system reform that puts primary care in a central role with appropriate payment.

Can you be in more than one ACO?

A primary care physician should be able to participate in more than one ACO if patients clearly designate you as their primary care physician. The current CMS ACO Shared Savings Program limits primary care physicians to one ACO. That's because CMS uses a retrospective analysis of claims data to figure out where the patient received his or her primary care and then links the primary care physician to a single ACO to complete the cost analysis.

How are the patient panels determined?

Ideally, patients should be required to choose a primary care physician or usual source of care so that the attribution of quality measures and expenses for that patient is easily determined. The CMS ACO Shared Savings program does not require patients to designate a particular primary care provider and relies on the use of a statistical analysis of paid claims data to determine primary care physician attribution. As a result, patient panel lists from CMS are likely to be less accurate and cannot be considered current.

Are the monetary incentives sufficient to drive transformation in practice patterns purely on the basis of economics?

If the underlying payment methodology for physicians is still predominantly fee-for-service, the answer is "no." Fee-for-service payment has clearly been shown to drive volume of services without regard to quality or necessity. If 90 percent of physician compensation comes from fee-for-service, 5 percent for a care-management fee and 5 percent for efficiency and quality, there will be no substantial change in behavior. A more balanced ratio is required; for example, compensation should be a mix that is more like 50 percent fee-for-service, 20 percent for a care-management fee and 30 percent for quality. The money available to individual physicians as a result of shared savings is likely to be a small percentage of their total compensation and may come at a time far removed from the point-of-care decisions. As a result, the amount of money may have little effect on current behaviors and choices.

What actions should you take immediately?

Keep seeing patients to optimize your revenue in the current payment environment. Proper coding, good billing procedures and attention to accounts receivable are still critical in a transition period. At the same time, you should be making the changes and installing the systems suggested by the PCMH model so that you can respond quickly as the incentives change. Pay attention to what is happening in your market, and determine which players seem to value primary care as more than just a referral hub for hospitals and specialists. Read as much as you can about evolving models of payment and be aware of incentives currently available in your market.

Where can you get help with all this change?

The AAFP has resources available to help members that include important information about how to run a practice. TransforMED, a subsidiary of the AAFP, is available to assist practices looking to transform to a new model of care that is based on the concept of the patient-centered medical home or provide assistance and guidance around ACO development.

Link for how to run a practice: <http://www.aafp.org/practicemgt>

Link to TransforMED: www.transformed.com

Link to AAFP PCMH pages: <http://www.aafp.org/pcmh>

Link to ACO information: www.aafp.org/aco