Accountable Care Organizations: Riding the Wave of the Future

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As healthcare reform changes the face of medical practice as we know it, certain initiatives are likely to play a prominent role in emerging practice structures. Among the programs predicted to take center stage are those offered by Medicare's Shared Savings Program, in particular, accountable care organizations (ACOs).

Understanding the ACO Concept

An ACO is defined by the Centers for Medicare & Medicaid Services (CMS) as "an organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of the Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."

A stated goal of the ACO model is one that "promotes accountability for a patient population and coordinates items and services under parts A and B [of Medicare] and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery" (42 USC § 1395jjj[a][1]). With the combined aims of reducing cost while increasing the quality of care, the model seems to be an efficient mechanism to navigate the changing healthcare landscape.

The ACO model has existed for several years as a test program administered by CMS, and rapid growth of this model is anticipated. Of course, the concept of accountable care is not new, because the idea of coordinated care, increased quality, and decreased cost has been a shared goal of many different aspects of the healthcare industry for decades. If you are wondering what authority is out there to indicate this developing trend, look no further than healthcare reform itself. The Patient Protection and Affordable Care Act has identified ACOs as one of the waves of the future that will improve quality of care by encouraging physicians to collaborate with one another.

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At its core, an ACO is an entity formed to tabulate patient care data in a way that Medicare may then determine cost-savings, which the ACO would be eligible to share in. By way of a simplified example, if an ACO were able to evidence a lower rate of hospital admissions as a result of preventive care initiatives, the ACO would allegedly be entitled to a portion of the shared savings.

The beauty of the ACO model is that this structure does not require a practitioner to lose ownership or control over his/her practice. Instead, a practitioner may elect to participate with an ACO, sharing patient care data with the ACO, and to participate with shared savings. The ACO would be a separate entity, apart from your practice. ACOs may be physician owned, hospital and physician owned, owned by a hospital employing physicians, owned by a network of individual practices of physicians, or owned by others, as specified by the Secretary of Health and Human Services (42 USC § 1395jjj[b][1]).

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A barrier to the ACO model has been start-up cost. Because an ACO relies on, at its core, integration of data and patient care, all participants should be operable on collaborative electronic medical record (EMR) systems. Reading the previous statement may leave little to the imagination as to why large hospital systems and large practice groups are better suited to ACO formation than individual, smaller groups coming together and forming an ACO. The large hospital systems and large medical practices are presumably integrated and presumably better suited to absorbing the cost for hardware, software, training, and lag time, with the EMR integration required for the ACO model.

Also, the start-up cost makes an ACO creation less desirable for specialists, such as oncologists, who arguably may have less to gain from this structure than primary care providers, the intended core of the model—each ACO is required to have primary care providers, accounting for more than 5000 Medicare beneficiaries at any given time.

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ment, there are financial advantages to the ACO model. The current payment structure, as practitioners are well aware, is untenable and is bankrupting Medicare. Medicare has had to find ways to incentivize physicians to keep costs down, and the ACO model is one of the answers to this dilemma. Under the Shared Savings Program, the model includes reimbursement for fee-for-service, plus a percentage of shared savings. The intended impact of this model is to provide for a model that enables reimbursement to shift from quantity to quality, with the ultimate aim of reducing costs to the healthcare system.

Choosing "Accountable" Care

For betting individuals, a safe bet is that our current care delivery system is not sustainable, and changes will be coming. We are headed toward a modified system, where quality over quantity and preventive over reactive are valued. To ensure your practice keeps pace with anticipated changes in our healthcare delivery system, regardless of whether you intend to participate in an ACO or similar model, you may wish to consider the concepts set forth herein and better position your practice for accountability, including adopting EMRs and understanding new initiatives such as ACOs.

ACO creation takes a village—ACO creation begins with doctors, lawyers, managers, billers, EMR companies, chief executive officers, accountants, and consultants, and requires significant start-up capital, as discussed above. For those interested in the ACO model, ACO participants must make a 3-year commitment to the program when they sign on; a structure must be implemented for receiving and distributing shared savings; processes must be in place to coordinate care, such as having remote patient monitoring; and the ACO must have at least 5000 beneficiaries who will all receive their primary care coverage through the ACO (42 USC § 1395jjj[b][2]). In order to receive financial incentives, quality-of-care measures must be in place, such as those for clinical processes and outcomes, and experience of care, and, in addition, there are numerous other requirements that must be in place in order to be eligible to participate in an ACO (42 USC § 1395jjj[b][2]).

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It is also relevant to note that ACOs must be formed and operated in compliance with antitrust requirements. Those looking to participate in an ACO need to be wary of the fact that ACOs may be considered harmful to consumers by reducing competition. To assist ACOs, the Department of Justice and the Federal Trade Commission have created a procedure for voluntary expedited review. Before being admitted into the Shared Savings Program, newly formed ACOs may apply to both agencies for an antitrust analysis (www.justice.gov/atr/public/health_care/aco.html). It is advisable to consult with your healthcare counsel to ensure compliance with relevant antitrust laws and policies and to offer your ACO the best protection possible.

Although the climb for an ACO creation is certainly uphill, it is not unhikable. And, with rolling admissions for ACO participants by CMS, the next application period being for a 2014 start date, the number of Notice of Intent to Apply letters is predicted to increase dramatically over the coming years. It is not being suggested that this system is going to be perfect and be the solution to all things wrong with our healthcare system as it stands today. In fact, a lot of information is still unavailable, and it appears that the Secretary of Health and Human Services is going to have a lot of authority over what payments are made. What is clear moving forward is that providers who fail to ready their practices now and leaders in the industry who do not get on board will fall to the back of the pack in the marathon that is healthcare today. ●

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