

Accountable Care Organizations - The Basics



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The federal health reform legislation (Patient Protection and Affordable Care Act) has brought a new term to the forefront of health policy - Accountable Care Organization (ACO). Although the concept is promoted in the new legislation, thus far it has been a very large, very vague elephant in the room. Many are vying to help define and implement ACOs including both physician and hospital groups. The description below is meant to introduce the basics of ACOs and begin the discussion on how emergency medicine will interact with the inevitable development of these groups.

The idea of an ACO has been in the works over the last several years with a white paper published on the subject in 2008 by the Robert Wood Johnson Foundation¹². Credit for coining the term “ACO” is generally given to Dr. Elliott Fisher, MD of the Dartmouth Institute for Health Policy and Clinical Practice. The basic idea is to provide a platform for reform of both the payment and delivery systems of healthcare allowing organized providers to experiment with different payment methods within the fee-for-service Medicare program. Ultimately, fee-for-service could be moved to coordinated (integrated) care such as bundle payments with the premise that this would help avoid duplicate, conflicting or excessive services to provide better patient care.

General Requirements to Become an ACO

Regulations further defining ACOs are expected to be released later this year or possible early next year by the Department of Health and Human Services (HHS). The general requirements are:

- Three year contract with Medicare
- Able to care for an assigned Medicare population of at least 5,000 patients
- Formal legal and management structure to receive and distribute shared savings
- Demonstrate able to meet quality and reporting standards to be developed by HHS
- Include primary care physicians, specialists as determined by HHS
- Meet patient-centered criteria as determined by HHS

- Defined processes to address coordination of care, reporting quality measures and promotion of evidence-based medicine

Patient Protection and Affordable Care Act (PPACA) and ACOs

What is the primary incentive to become an ACO? Shared savings. The PPACA enacts a Medicare shared savings program for ACOs starting no later than January 2012. Spending benchmarks will be set for each ACO based on assigned beneficiaries' past Medicare expenditures. An ACO will receive shared savings if spending growth for the population is below average per capita spending growth for all Medicare beneficiaries AND they also meet the HHS quality performance standards (yet to be defined). The HHS is authorized but not required to use other payment models such as partial capitation (some range of Medicare services for a fixed monthly payment per beneficiary). The PPACA also authorizes experimentation with ACOs and Medicaid and a demonstration project for a pediatric ACO.

Sound ambiguous and undefined? It is - and therein lies an opportunity for many preexisting delivery systems as well as new systems to benefit from the legislation. As of now, there are several delivery systems which could become ACOs:

- 1) Integrated delivery systems (e.g. Kaiser)
- 2) Multispecialty group practices (e.g. Mayo Clinic)
- 3) Physician-hospital organizations (e.g. Advocate Health - Chicago)
- 4) Independent practice associations (e.g. Monarch Healthcare)
- 5) Virtual physician organizations - often rural (e.g. Community Care of North Carolina)
- 6) 1206(l) medical foundations (nonprofit corporation that is exempt from taxation in accordance with 501(c)(3) of the Internal Revenue Code)

Many organizations in California have begun the process of defining principles guiding the implementation of ACOs including California Chapter of the American College of Emergency Physicians (Cal/ACEP), California Medical Association (CMA), California Hospital Association (CHA)

and California Association of Physician Groups (CAPG). The Department of Managed Healthcare (DMHC) will likely regulate ACOs within California and are currently reviewing this issue. Blue Shield has already implemented a pilot ACO in California with plans to expand statewide.

ACOs have also highlighted much broader issues such as the debate surrounding the corporate bar in California which ban hospitals from directly employing physicians. The City of Hope Medical Group physicians have already filed a lawsuit against City of Hope Medical Center for violation of the state's prohibition of corporate practice of medicine by their attempt to create a medical foundation effectively disbanding the medical group. Other groups such as CAPG are advocating for waivers of the Knox-Keene licensure to provide incentives to move ACOs forward. The Knox-Keene license granted by DMHC provides important protections for patients in California by guaranteeing organizations meet certain minimum standards. Cal/ACEP has actively opposed this idea in recent Medical waiver bills in the California state legislature advocating for removal of a provision which allowed county programs to be exempt from Knox-Keene licensure when shifting patients from Medical fee-for-service to Medical managed care programs.

Emergency Medicine and ACOs

There is very little, if any, mention of how emergency and acute care services will work together with ACOs. Several obvious preliminary questions come to mind. How will ACOs support EMTALA mandated care? Where does emergency medicine fit in bundled payments/coordinated care? Who will regulate ACOs and what regulations should ACOs be subject to? How do we advocate for no exceptions (waiver) of Knox-Keene? Will all current laws for emergency patients be maintained with ACOs - e.g. interfacility transfers? None of these questions have answers yet. In this case, the lack of definition creates an important opportunity for emergency physicians to define emergency medicine and the important patient care we deliver every day. We are also being called upon to advocate for our patients on much larger issues such as EMTALA and Knox-Keene. Our benchmark for success is a system where ACOs are physician-led groups focusing on patient care and access.

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