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Accountable Care Organizations Series: What Are ACOs?

The Patient Protection and Affordable Care Act (ACA), passed on March 23, 2010, sets forth several healthcare reform initiatives designed to increase healthcare access, improve healthcare quality, and contain healthcare costs. An important Medicare delivery system reform initiative, the Medicare Shared Savings Program (MSSP) constitutes a new approach to the delivery of healthcare with the three-part aim of: *"(1) better care for individuals; (2) better health for populations; and (3) lower growth in expenditures."*[1] Section 3022 of the ACA directs the Secretary of Health and Human Services (HHS) to create the MSSP by January 1, 2012, and is intended to encourage the development of Accountable Care Organizations (ACOs) in Medicare.[2] In addition to the general ACO guidelines included in the ACA, a set of proposed rules released March 31, 2011 by the Centers for Medicare and Medicaid Services (CMS) provides more details about this emerging organization. While the final rules are still evolving, these two regulations provide insight into the structure and governance of ACOs. In this second part of the Accountable Care Organizations Series, this article considers the question: *What Are ACOs?*

The structure of an ACO is characterized by the integration between physician partners and the reimbursement model coordinated with the MSSP. The proposed rules on ACOs define accountable care organizations as:

> "*[A] legal entity that is recognized and authorized under applicable state law … and comprised of an eligible group … of ACO participants that work together to manage and coordinate care for Medicare FFS beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO's decision making process*."[3]

ACOs are unique from current integrated health systems in the degree of autonomy given to physicians, the flexibility afforded to physician groups, hospitals, and other networks of providers, and the quality requirements for various reimbursement benefits.[4] The most structured portion of ACOs is their internal organization, which has been consistent between the ACA and the proposed rules released by CMS.

Organizational Models

Several legal entities have been approved to become ACOs based on their ability to coordinate care between primary and specialty providers while being compliant with various regulations. These include: ACO professionals in group practices; networks of individual practices of ACO professionals; partnerships or joint venture arrangements between hospitals and ACO professionals; hospitals employing ACO professionals; and, other groups of providers of services and suppliers as determined by the Secretary of HHS.[5] The proposed rules also include critical access hospitals (CAHs) as an entity eligible for ACO status, due to their role in providing healthcare services to underserved and low income populations, which have high Medicare participation. There is some concern, however, that CAHs will be unable to meet the criteria necessary to become an ACO; therefore, only CAHs that submit bills for both facilities and professional services directly to Medicare are eligible to be an ACO.[6] Additionally, all ACOs are required to have a legal and governance structure that allows them to receive and distribute shared savings payments. Each ACO must be a recognized legal entity with a unique Tax Identification Number, but can form through any state permitted contract (e.g., corporation, partnership, foundation, etc.). Those providers not eligible to formally transition to an ACO may still benefit from the shared savings and vertical integration by working with a legally permitted ACO.[7]

Beyond the formal legal structure necessary to receive and distribute any shared savings, ACOs must meet several other requirements. The organization must have a management structure that includes both clinical and administrative systems, which will include technology, such as electronic medical records and computerized physician order entry systems that allow providers to coordinate care. An ACO must also be large enough to support a sufficient number of primary care physicians to provide care for at least 5,000 beneficiaries. These requirements will be monitored by a governance board, which the ACO may define and organize, but that must be provider driven.[8] Finally, any organization desiring to be an ACO must commit to participate in the MSSP for

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at least three years; must define processes to promote evidence-based medicine, patient engagement, coordination of care, and quality and cost measures; and, must demonstrate that it focuses on patient-centered care.[9] To ensure an eligible organization is willing to conform to these criteria, all ACOs must enter into a legally binding agreement with the Secretary of HHS signed by an executive of the governance board.[10] Once an ACO is established, CMS has set forth various guidelines to promote organizational integrity.

As ACOs are emerging healthcare organizations, CMS anticipates that patients may be confused regarding the services and benefits available. Therefore, under the patient-centeredness requirement, CMS will limit and monitor marketing activities and must approve all direct correspondence with patients, prospective and current. CMS plans to monitor ACOs compliance with all fraud and abuse regulations to ensure the integrity of the MSSP. The proposed rules also give CMS the ability to modify various reporting standards that may need to be changed or added as the MSSP is implemented and subsequently evolves.[11]

Reporting Requirements

ACO shared savings are presented as bonuses directly distributed to ACOs for savings generated from reducing healthcare costs. These bonuses will be determined by the Secretary of HHS and calculated according to a percentage of the difference between an ACOs Medicare expenditures and a benchmark amount, specifically set for each ACO.[12] CMS proposes a six-month period to calculate benchmarks and per capita expenditures for each performance year, which will then be used to calculate savings based on quality and cost data supplied to HHS by each ACO.[13] The proposed rules set out 65 proposed measures for establishing quality performance standards that ACOs must meet for shared savings.[14] These measures are to be collected through several means, including calculation by the ACO through CMS systems and surveys.

Reimbursement Models

ACOs will continue to receive reimbursements under the Medicare fee-for-service program, as any other organizations serving Medicare patients; although providers in an ACO may choose from a variety of payment structures to determine the amount of risk they want to assume.[15] Under the MSSP, physicians will receive bonuses for achieving resource use and quality targets over the course of a year and penalties for failing meet these requirements.[16] The proposed rule sets out two risk models with various incentives for ACOs to receive share savings payments: the one-sided risk model and the two-sided risk model.

The risk associated with forming an ACO lies in meeting quality and performance standards set by CMS based on benchmark expenditures. After significant capital investment, ACOs will only receive shared savings payments if their expenditures are below their CMS established benchmark and above the CMS established minimum savings rate (MSR).[17] Under the one-sided risk model, ACOs will receive shared savings for only the first two years of their three year required participation with the percentage of savings set at 50 percent. Although the opportunity for shared savings is lower under this model, ACOs are also shielded from prospective penalties, known as shared losses, if standards are not met, as they are only liable during their third year of operation. This option is designed for smaller populations with high variation in expenditures, where the risk of forming an ACO may be higher.[18] Within the two-sided risk model, ACOs receive shared savings payments for all three years with maximum sharing percentage set at 60 percent. ACOs under this risk model will also be liable for shared losses for all three years, although CMS has proposed a shared loss cap: 5 percent of the first year benchmark, 7.5 percent year two, and 10 percent year three.[19]

To adjust for normal variation in healthcare spending, CMS will also establish a MSR to be applied to each model. The MSR will be a percentage of the ACOs benchmark expenditures. ACOs opting for the one-sided risk model, necessary for populations with high variance in expenditures, will have larger MSRs as the population served decreases in size. For the two-sided risk model, CMS has proposed a flat two percent MSR.[20]

Conclusion

The key component that most analysts agree will lead to the success or failure of ACOs is flexibility.[21] The ultimate structure requirements for ACOs will not be known until the final CMS rules are released. Judging from the negative response of associations and those healthcare organizations who participated in the ACO pilot program, there will likely be a lot of change between what CMS has released so far and the final regulations. In the next article Health Capital Consultants will take a closer look at the ACO participants themselves to answer the question, *Who are ACOs*?

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