Accountable Care Organizations Series: When Are ACOs?

Section 3022, the Medicare Shared Savings Program (MSSP), was introduced on March 23, 2010, with the passage of the Patient Protection and Affordable Care Act (ACA).1 The ACA signaled the widespread introduction of the term “Accountable Care Organization” (ACO), although the concept of accountability in healthcare delivery has been around since the 1930’s. As the accountable care concept matured, the potential structure of ACOs evolved into several variations including: historical ACOs; Federal ACOs and various incentive programs; and, commercial ACOs.2 While each of these arrangements aim to increase healthcare quality while decreasing the associated costs of providing healthcare services, ACOs emergence in the healthcare industry is driven by diverse factors, leading to various timelines for ACO implementation.3 In the fifth part of the Accountable Care Organizations Series, this article considers the question: When Are ACOs?

HISTORICAL ACOs

Accountable care was linked to better healthcare in 1932 when the Committee on the Costs of Medical Care suggested, among other things, that the focus of medical care should be on coordination with state agencies.3 This construct was realized under the Health Maintenance Act of 1973, which designed HMOs to contain healthcare costs and integrate health systems.5 While this form of managed care crumbled during the 1990’s, in 2000, the Department of Health and Human Services began examining incentive-based payment methods leading to the creation of the Medicare Physician Group Practice (PGP) project.6 The PGP project began on April 1, 2005, and, over a five-year period, provided incentive Medicare payments for care coordination and quality, efficiency, and cost improvements.7 Shortly thereafter, in 2006, the term ACO was coined by Elliott Fisher, a physician and professor of medicine at Dartmouth Medical School, and Glenn Hack Barth, the chairman of the Medicare Payment Advisory Commission (MedPAC).8 Inspired by the results of the PGP project, in June 2009, MedPAC issued Report to Congress: Improving Incentives in the Medicare Program, which included an entire chapter on ACOs.9 The MSSP section within the ACA heavily this report.

FEDERAL ACOs

Under the ACA, the MSSP was originally set to begin January 2012.10 Since releasing the proposed regulations on March 31, 2011, CMS has received a significant amount of criticism leading to the creation of several incentive programs designed through the Center for Medicare and Medicaid Innovation (CMI). Each of the three incentive programs is designed to broaden the types of healthcare organizations that may participate in the MSSP and to ease the transition to become a compliant ACO.11

The Pioneer ACO Model is intended for “mature ACOs” that have already begun coordinating care efforts and has the goal of reducing capital barriers and increasing quality outcomes by working with private payors.12 In order to participate in the Pioneer ACO model, an organization must have submitted a letter of intent and application by June 30, 2011 and August 19, 2011, respectively.13 The Pioneer ACO model added some competition to the application process, as only 30 organizations will be allowed to join this demonstration project.14 Despite extensions for the application period, CMS continues to hope that the project will begin in the fourth quarter of 2011. While the pioneer ACO model aims to lessen burdens by increasing shared savings payments, the payout is still theoretical.15 Recently, the Mayo Clinic, the Cleveland Clinic, Geisinger Health System, and Intermountain Healthcare, the four systems considered the most promising models for ACOs, all declined to apply for the Pioneer ACO program.16

The Advanced Payment ACO Initiative appears to be a more tangible solution for potential ACOs struggling with upfront capital requirements. Through the advanced payment initiative, eligible ACOs would receive money up-front, based on their anticipated shared savings payments. These advanced payments will be paid back once the ACO realizes shared savings. Public comments on the initiative were due June 17, 2011.17

The third CMI Program, the Accelerated Development Learning Sessions, offers advice to existing and emerging ACO leadership teams regarding how to develop and maintain an operational, efficient, and profitable ACO. Participation in the four sessions offered June-November 2011 is completely voluntary, and is not a consideration for Federal ACO status.18

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COMMERCIAL ACOs

Many organizations have already transitioned their private payor contracts to reflect the form of value-based purchasing associated with ACOs. These private “ACO-like” organizations, e.g., UnitedHealthcare, AETNA and Wellpoint, use commercial insurance contracts to emphasize coordination of care and shared savings incentives. Blue Cross Blue Shield Massachusetts implemented its Alternative Quality Contract emphasizing global payments incentivizing achievement of quality goals in January 2009. Some of the largest health systems in the U.S. have been on the path to creating functional ACOs for many years, including Kaiser, Geisinger, Mayo Clinic, Cleveland Clinic, certain medical groups located in California, and even several HMOs.

CONCLUSION

The quick answer to the question “When are ACOs” … is “Now”. Whether applying for Federal status or negotiating with commercial payors, healthcare entities seeking to coordinate care for better quality outcomes and lower costs, should begin coordinating now to remain competitive in the emerging market. In part six of the ACO series, HC Topics will describe the specific hurdles healthcare enterprises will need to overcome to create a functioning and compliant ACO, examining, How are ACOs?

3. “Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?” By Kelly Devers and Robert Berenson, Urban Institute, (October 2009) p. 1
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