

ACCOUNTABLE CARE ORGANIZATIONS OVERVIEW

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What is an Accountable Care Organization (ACO)?



- No set definition.
- National Conference of State Legislatures (NCSL): a structure that combines **health care delivery system reforms** (e.g., medical homes and electronic medical records) + **new forms of provider payments** (e.g., global and episode-of-care payments).
- Means of controlling health care costs and increasing accountability for care.

ACO Components



- Providers share responsibility for cost and quality of care for a defined population.
- Monitors care across providers: physicians, specialists, allied health professionals, hospitals and others.
- Goals for quality and efficiency are set by or negotiated with payer(s).

ACO Components (continued)



- Reliance upon the “patient-centered **medical home**” and other care coordination components.
- Use of **health information technology** to allow communication among caregivers, patients and payers.
- A variety of possible payment structures.

Payment Structures



- Fee for Service (FFS) (usually paired with incentives) — payment per volume of services.
- Capitation — per member, per month (PMPM).
- Partial Capitation — carving out part of the reimbursement scheme to allow for capitation; the rest via FFS or bundled payments.
- Bundled Payments — payment per episode of care.

Mark McClellan — "Core Competencies for Affordable Care" ¹

- **Governance and Leadership** focused on the resources and project management required to implement new models of care.
- **Health IT** that supports quality and accountability measures.
- **Care Coordination** especially for the frail elderly or people living with multiple chronic conditions — across clinicians and sites of care.
- **Care Improvement Programs** that allow teams of nurses, pharmacists and other health professionals to maintain health and prevent costly complications of chronic diseases and major procedures.

¹ Presentation before the NCSL, August 2011.

Antitrust Challenges

- Alongside their potential to reduce costs and improve care by reducing competition, ACOs also have the potential to harm consumers through higher prices and lower quality of care.
- Federal antitrust law generally prohibits providers from joint negotiations.
- The Federal Trade Commission and Department of Justice have issued proposed rules governing criteria under which providers may form ACOs under the Medicare Shared Savings Program.²
- Generally, overcoming antitrust challenges will depend upon the share that an ACO holds of the primary care market in a given area; the jurisdiction in which the ACO operates; and whether it is a public or private organization.

² 76 Fed. Register, No. 75: 21894-21902.

Levels of ACO Types³

	Providers Included	Possible Cost Savings
Level 1	Multiple primary care practices (PCPs)	Prevention, early diagnosis, care management, fewer ER visits
Level 2	PCPs + major specialties (MS)	+ More efficient specialist use
Level 3	PCPs + MS + hospitals (H)	+ Improved complex patient care management
Level 4	PCPs + MS + H + safety net clinics, public health	+ Coordinated health, social service supports

³ Barbara Yondorf, *Accountable Care Organizations*, presentation at NCSL Fall Forum, Dec. 10, 2010, Slide 9.

Medicare ACO Models

- Shared Savings Plan:⁴
 - ▣ FFS + rewards/penalties per cost and quality targets.
 - ▣ Medicare beneficiaries assigned according to where plurality of primary care services received in past year.
 - ▣ 65+ quality measures.
- Pioneer ACO Model:⁵
 - ▣ FFS + rewards/risk shared according to negotiated rates, with later possibility of partial capitation + risk/savings sharing.
 - ▣ Medicare beneficiaries assigned according to where plurality of health services billed in past three years.

⁴ Centers for Medicare and Medicaid Services (CMS), proposed rule. 76 Fed. Reg. No. 67: 19556-60.

⁵ CMS, Request for Application form, Pioneer ACO Model [cited on Aug. 14, 2011],

<http://innovations.cms.gov/wp-content/uploads/2011/05/Pioneer-ACO-RFA.pdf>.

Medicare ACO Models (continued)



- Physician Group Practice Demonstration Project (2005-2010; extended with PPACA): 10 sites
 - ▣ FFS + bonus payments (which are reduced for excessive spending).
 - ▣ \$32 million in shared Medicare savings from 2005-2010.

Examples of ACOs currently operating

- Grand Junction, CO:⁶
 - ▣ Mesa County IPA + Rocky Mountain Health Plans (insurer) + St. Mary's Hospital & Regional Medical Center + the Marillac Clinic.
 - ▣ Pay-for-performance.
- Advocate Physician Partners (Northern IL)⁷ — 3,500 employed and independent physicians + hospitals:
 - ▣ Pay-for-performance.
 - ▣ Dominated by solo and small-group practitioners.
 - ▣ Partnership handles credentialing.

⁶ Julie Barnes, Len Nichols, Micah Weinberg, *Grand Junction, Colorado: A Health Community That Works*, New America Foundation Policy Paper, August 12, 2009.

⁷ Mark Shields, Pankaj Patel, et al., *A Model for Integrating Physicians into Accountable Care Organizations*, *Health Affairs* 30:1, January 2011.

ACO Examples (continued)



- Community Care (NC)⁸ — 14 independent networks w/capitation that includes care coordination.
- “Patient Choice Care System”⁹ — self-insured employer groups in MN, ND and SD.

⁸ See Community Care of North Carolina web site [cited Aug. 14, 2011], www.communitycarenc.com.

⁹ Ann Robinow, *Patient Choice Health Care Payment Model*, presentation to the Network for Regional Healthcare Improvement Payment Reform Summit, Pittsburgh, July 31, 2008, Slide 3 [cited by Health Cost Containment and Efficiencies, NCSL Brief, May 2010].

Possible State Roles¹⁰

- ❑ **Authorize creation.**
- ❑ **License, certify.**
- ❑ **Authorize Medicaid, CHIP contracts.**
- ❑ **Address antitrust issues.**
- ❑ **Address rural issues/geographic dispersal challenges.**
- ❑ **Fund enhanced payments, coordination fees.**
- ❑ **Handle provider, consumer complaints.**
- ❑ **Collect, analyze data.**
- ❑ **Evaluate effectiveness.**

¹⁰ Barbara Yondorf, *supra*, Slide 18.