Accountable Care Organizations

A Message from Mark Briggs, CEO, ABILITY:

"ABILITY applauds accountable care as a strategy to contain Medicare costs, share risk and cost savings, facilitate care coordination, ensure chronic care management, and ultimately improve quality of care with measurable outcomes. ABILITY is uniquely positioned to facilitate the health information planning, development and management of highly connected accountable care organizations (ACOs) thanks to its track record of working with more than half the hospitals in the nation and hundreds of providers that send millions of transactions over the ABILITY network each day. ABILITY delivers the right information at the right time to the right provider and care team with the right technology; therefore creating a strong foundation for medical home and accountable care. We want to work with providers and payers on this next stage of healthcare transformation. We hope this issue brief on ACOs will help guide you in in your journey."

An accountable care organization (ACO) is a network of physician practices, hospitals, and/or payers that collaborate to provide care for a defined population of at least 5,000 Medicare patients for a period of at least three years. The goal: Reduce healthcare fragmentation, duplication, inefficiency, errors and cost overruns through enhanced coordination, health information exchange, chronic disease management, and fulfillment of 65 quality measures, 58 of which overlap with other quality reporting programs.

The stakes for ACOs are high. Physicians and hospitals could retain as much as 60 percent of the money they save Medicare via the Medicare Shared Savings Program as part of 2010's healthcare reform legislation. Or, they could incur significant penalties if they fail to follow proposed rules as outlined by the Department of Health and Human Services (DHHS) in March 2011.

As regulators, legislators, policy analysts, payers and providers search for strategies to respectively slash the national deficit, increase care quality, safety and efficiency, and improve outcomes, Medicare has emerged a prime target. ACOs make providers accountable for the care they deliver with incentives to cooperate and collaborate, save money by avoiding unneeded tests and treatments, and seamlessly exchange health information to improve care coordination and the speed and accuracy of clinical decision-making.

Although ACOs aren't likely to lead to the demise of the fee-for-service system, where providers earn more by ordering more tests and performing more procedures, they are likely to encourage cost savings with incentives for providers to meet quality benchmarks, manage chronic conditions such as congestive heart failure, chronic obstructive pulmonary disease and diabetes, focus on prevention, health promotion and wellness, and keep patients out of costly acute care facilities. Medicare could save up to $960 million in the first three years of the ACO program, according to DHHS, although that estimate represents less than one percent of Medicare spending in the same three-year period.

According to CMS chief Donald Berwick in a recent *New England Journal of Medicine* column: ACOs will "foster change in patient care so as to accelerate progress toward a three-part aim: better care for individuals, better health for populations, and slower growth in costs through improvements in care."

ACO Status

The race is on. Although ACOs aren't scheduled for implementation until January 2012, providers are struggling to respond to the proposed rules and prepare for inevitable rounds of comments and revisions. Physician practices, hospitals and payers have already announced their intention to launch ACOs for Medicare and private insurance patients. Insurers including Humana, CIGNA and United Healthcare have announced plans to build their own ACOs, while hospitals are buying up physician practices with the goal of building ACOs. Some health systems and physician practices are already functioning like ACOs.

The majority of payers and providers are struggling to understand the proposed rules on qualification requirements, payment and quality methodologies, and legal considerations. Among the issues to be fully resolved are application process, eligibility, operations, compliance, reporting and records retention, patient population and beneficiary assignment.

But the ACO rules released in March 2011 are not final. According to the Brookings-Dartmouth Accountable Care Learning Network, providers are likely to offer comments on protections for vulnerable patients, anti-trust and fraud provisions, upfront costs and support for clinical transformation, savings and cost shifting. Public comments are due on June 6, 2011, followed by revisions and publication of the final rules, Department of Justice and sub regulatory guidance. The ACO program will go into effect on January 1, 2012.

What ACOs mean for healthcare

"Focusing on payment systems and thinking about incentives for providers is the right first step in making care affordable and efficient," says Meredith B. Rosenthal, senior author and an associate professor of health economics and policy at the Harvard School of Public Health. "But you can't just change and assume patients will go along with that."

Although physicians will want to refer patients to hospitals and specialists within an ACO network, patients will still be able to choose physicians outside the network without paying extra. ACOs will be under intense pressure to provide high quality care. If ACOs fail to meet ACO standards, they will miss out on shared savings and could lose their contract.

Industry members can count on DHHS to refine its regulatory approach and implementation strategy. Areas of enhancement include ensuring meaningful accountability through performance measures focused on meaningful outcomes, more effective financial support promoting coordination with private and Medicaid ACOs, and a framework that supports ongoing evaluation and timely learning.

To Learn More

For more information on what ACOs may mean for your organization, consider the following resources:

- Healthcare.gov
- CMS.gov, “What Providers Need to Know: Accountable Care Organizations”
- CMS.gov, “Federal Agencies Address Legal Issues Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program”
- CMS.gov, “Improving Quality of Care for Medicare Patients”
- ACO Digest
- Accountable Care News

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About ABILITY
ABILITY works to save lives by facilitating information exchange and knowledge sharing among every participant within the healthcare spectrum – hospitals, physician practices, home care providers, DMEs, and private and government payers. More than 3,000 hospitals across the country use ABILITY network to promote care coordination and collaboration, reduce record fragmentation, participate in new care models, streamline administrative workflow and access the Direct Project network and state and community-based Health Information Exchanges.