

June 2012

FACT SHEET ON ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

Introduction

- The Patient Protection and Affordable Care Act (ACA) includes a number of policies to help physicians, hospitals, and other caregivers improve the safety and quality of patient care and make health care more affordable. By focusing on the needs of patients and linking payments to outcomes, these delivery system reforms have significant potential to help improve the health of individuals and communities and slow cost growth.
- On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new rules (and subsequent rules have been issued) to help doctors, hospitals, and other providers better coordinate care for Medicare patients through a new care delivery model called Accountable Care Organizations (ACOs).
- ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program at the Centers for Medicare and Medicaid Services (CMS) will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care. Patient and provider participation in an ACO is purely voluntary and only Medicare beneficiaries can participate (strictly voluntary) in ACO care delivery structures.

Need and Benefits of Coordinated, Accountable Care

- Today, more than half of Medicare beneficiaries have five or more chronic conditions such as diabetes and hypertension. These patients often receive care from multiple physicians. A failure to coordinate care can often lead to patients not getting the care they need, receiving duplicative care, and being at an increased risk of suffering medical errors.
- On average, each year, one in seven Medicare patients admitted to a hospital has been subject to a harmful medical mistake in the course of their care. And nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days – a readmission many patients could have avoided if their care outside of the hospital had been better coordinated. Improving coordination and communication among physicians and other providers and suppliers through ACOs will help improve the care Medicare beneficiaries receive, while also helping lower costs. According to the analysis of the

final regulations for ACOs, Medicare could potentially save as much as \$960 million over three-four years.

Improving Care for Patients

- Any patient who has multiple doctors probably understands the frustration of fragmented and disconnected care: lost or unavailable medical charts, duplicated medical procedures, or having to share the same information over and over with different doctors.
- Accountable Care Organizations are designed to lift this burden from patients, while improving the partnership between patients and doctors in making health care decisions.
- Medicare beneficiaries will likely have better control over their health care, and their doctors can provide better care because they will have better information about their patients' medical history and can communicate with a patient's other doctors. Medicare beneficiaries whose doctors participate in an ACO will still have a full choice of providers and can still choose to see doctors outside of the ACO. Patients choosing to receive care from providers participating in ACOs will have access to information about how well their caregivers are meeting quality standards.

About Accountable Care Organizations

- An ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others caregivers) that will work together to coordinate care for the patients they serve with Original Medicare (that is, those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries. The ACO would be a patient-centered organization where the patient and providers are true partners in decisions.
- The ACA specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:
 - ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
 - Networks of individual practices of ACO professionals,
 - Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
 - Hospitals employing ACO professionals, and
 - Other Medicare providers and suppliers as determined by the Secretary.

Sharing Savings

- Medicare will continue to pay individual health care providers and suppliers for specific items and services as it currently does under the Original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or to be held accountable for losses.
- CMS will establish a minimum sharing rate that would account for normal variations in health care spending, so that the ACO would be entitled to shared savings only when savings exceeded the minimum sharing rate.
- The amount of shared savings depends on whether on an ACO meets or exceeds quality performance standards. The final CMS rules would provide for additional shared savings for ACOs that include beneficiaries who receive services from a Federally Qualified Health Center or Rural Health Clinic during the performance year.

Measuring Quality Improvement

- The final rule links the amount of shared savings an ACO may receive to its performance on quality standards.
- The rule proposes quality measures in five key areas that affect patient care:
 - Patient/caregiver experience of care;
 - Care coordination;
 - Patient safety;
 - Preventive health; and
 - At-risk population/frail elderly health.

ACOs and Behavioral Health

- For many behavioral healthcare providers, partnering with health homes and ACOs will mean honing significant new skills and capacities. It is critically important that behavioral health providers assess their current ability to qualify for participation in these efforts and address the gaps they find.
- As SBHAs begin to chart a course toward ACOs, they should keep in mind that behavioral health providers are often starting their journey from a different point of origin than their medical counterparts. Behavioral health providers are often under-resourced and under-capitalized compared to other providers like hospitals. Behavioral health is going to require

some special handling and it behooves primary care, hospitals, integrated delivery systems and health plans to help them keep pace.

- While it's true that all interested parties – behavioral health providers included – need to be able to carry their own weight in business terms, any ACO that fails to properly include behavioral health providers is destined to continue struggling with a significant share of otherwise unmitigated chronic care costs so the value proposition should be clear.

Roles for State Behavioral Health Authorities

- SBHAs should advocate that specialty behavioral healthcare providers be included as ACO participants. SBHAs may also want to encourage certain behavioral healthcare providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related.
- SBHAs could help behavioral healthcare providers decide to potentially merge with an ACO or health home, or partner with them on a contract basis, placing providers in the health home. A behavioral healthcare provider may function as a specialty provider receiving referrals from the health home or ACO, with a business agreement that facilitates the referrals. It may also become a health home for people with severe conditions – obtaining recognition as a health home or partnering with an entity (e.g., a federally qualified health center) that has health home status. Which path the provider chooses to take will depend on the types of services it wishes to provide, how it wants to position itself in the larger health system, and the resources it has available.