North Carolina Medical Society
Leadership in Medicine

DRAFT NCMS POLICY (v. 7)

Accountable Care Organizations

Background: Accountable Care Organizations (ACOs) are an emerging health care delivery model comprised of groups of providers that join together to coordinate and improve quality and efficiency of health care by fostering greater accountability in the delivery of health care. The concept of ACOs arose out of a desire to address the wide variations in the cost and quality of care across the US.

ACOs are umbrella organizations within which many reforms can be implemented including the Medicare Shared Savings Program, bundled payments, partial capitation, patient-centered medical home, electronic health information exchange, quality measurement, patient engagement, etc. To be successful, ACOs must have a strong primary care foundation and the ability to effectively communicate and coordinate care between specialists, other providers, and primary care.

While a number of well-functioning ACOs, such as Mayo Clinic, Intermountain Healthcare, Carillion Clinic, and the Geisinger Clinic, to name a few, have been operating effectively for many years, ACOs are currently the exception not the norm. Enactment of the Patient Protection and Affordable Care Act of 2010 (the Act) and demands by the private sector to control health care costs, however, are likely to increase pressure on the health care community to organize into ACOs.

Section 3022, of the Act, creates the Medicare Shared Savings Program, which encourages the formation of ACOs. As outlined in the Act, the goal of the Medicare Shared Saving Program is:

> [T]o establish a shared savings program that promotes accountability for a patient population and coordinates items and services under parts A & B and encourages investment in infrastructure and redesigned care processes for high quality and efficient services.

As currently envisioned by the Act, services provided by ACO providers to Medicare fee-for-service beneficiaries would still be billed under fee-for-service, but the care would be provided in a more coordinated manner for the shared Medicare patients. ACOs would receive a percentage (to be determined by the Secretary, DHHS) of saving that result from better care coordination, provided quality performance standards are met, including process and outcomes measures, patient and caregiver experience of care, and utilization (such as rates of hospital admissions for ambulatory sensitive conditions--specifics still to

be determined). The amount of savings will be determined based on the estimated per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A & B services, adjusted for beneficiary characteristics, compared to the estimated costs if the services were not provided by the ACO. The amount of shared savings available to ACOs is subject to a total amount limitation (to be determined by the Secretary).

Furthermore, continuous quality improvement will be pursued through the establishment of higher standards, new measures, or both (to be determined by the Secretary). Certain reporting requirements will be required to evaluate the quality of care provided by the ACO that also may incorporate PQRI reporting requirements and incentive payments as well as requirements and incentives for the meaningful use of electronic health records and electronic prescribing (also to be determined).

The Act defines eligibility standards for ACOs and envisions the following groups of providers that have established a mechanism for shared governance, including: group practice arrangements; networks of individual practices of ACO professionals; partnerships or joint ventures between ACO physicians and hospitals; hospitals employing ACO professionals; and others to be determined.

ACOs further must be accountable for quality, cost, and overall care of Medicare fee-for service beneficiaries. The fundamental requirements for eligible ACOs include:

- a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and supplies;
- clinical and administrative leadership;
- processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies
- demonstration of patient-centeredness criteria such as use of patient and caregiver assessments or the use of individual care plans (specific criteria to be determined);

In addition, eligible ACOs must agree to participate for a minimum of three (3) years, include a sufficient number of primary care physicians, cover at least 5,000 Medicare fee-for-service beneficiaries, and provide information on the ACO professionals participating in the ACO.

Proposed rules are expected to be issued in the fall of 2010, and the Shared Savings Program is expected to commence of January 1, 2012.

The development of ACOs is likely to create expectations from other payors seeking to improve quality while containing costs. As the details of these arrangements have the potential to ensure success or failure of these organizations, the NCMS believes that certain minimum criteria must be included especially during the transition from our current health care delivery system to a more coordinated and accountable approach. Physicians considering participation in ACOs should take these factors into account before deciding whether to participate in an ACO. Furthermore, the NCMS believes that it is

imperative for physicians across specialties to work together and to be actively engaged in the formation and leadership of these arrangements.

Recommendation: The ACO Workgroup recommends that the following be adopted and that the remainder of the report be filed:

1. The North Carolina Medical Society supports community physician leadership and coordination of efforts by physicians of all specialties in the formation, governance, and clinical management of Accountable Care Organizations and similar arrangements. ***(policy)***

2. The North Carolina Medical Society supports the delivery of health care through Accountable Care Organizations (ACOs) provided those arrangements are physician-led and comply with the following criteria:

Organization and Governance

- ACOs must have a formal legal structure that allows the organization to receive and disburse shared savings payments to participating providers;
- ACOs must be voluntary, particularly because relationships will be redefined among health care entities that may not have worked together in the past.
- Participating provider groups must be adequately represented on the governing board of each ACO; a majority of the Board, however, should be physicians. The governing board also should include reasonable administrative and financial expertise as well as community representation.
- Each ACO must have sufficient human resource commitment to oversee the day-to-day operations of the ACO, to work with payors, monitor performance, and collect and distribute any shared savings. There should be adequate performance improvement mechanisms to monitor and coordinate utilization of services designed to ensure quality of care and control costs. ACOs should have widespread utilization of health information technology for provision of point-of-care information, data tracking, data aggregation, protocol dissemination, and performance monitoring. All data shall be clinically validated by physicians and severity adjusted.
- Participating providers must be committed to working with other providers in the ACO to continually improve processes, coordination, quality, and efficiency of care and decreasing costs and eliminating waste.
- ACOs should consider governance and tax-status options that best encourage reinvestment of operating margins in quality improvement, incentives and bonuses for providers to optimize care, and that discourage windfall profit taking by large shareholders or originators of the ACO**;** ACOs should preferably be organized as a non-profit entity.

Preservation of the Patient-Physician Relationship

- Adequate and independent physician input is necessary to ensure that appropriate evidence-based care is coordinated and delivered in the manner most beneficial to patients.
- The ACO should promote: evidence-based medicine and patient engagement; reporting on quality, cost, and patient satisfaction measures; and coordination of care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
- Patients must retain the right to choose their physicians to the fullest degree possible.
- Patients should be incentivized to become engaged in health and wellness activities and compliance.
- ACOs must maintain flexibility in regards to site of care to ensure that care is delivered in the most appropriate and cost-effective setting.

Incentive Payments

- Equitable opportunities for collaboration and incentive sharing must apply to all participating providers.
- A clear, sustainable, transparent and fair method should be utilized for setting performance-based incentive payment rates and bonuses, which is physician-driven, based on accurate data and peer-reviewed evidence-based methodology, which is bilaterally negotiated, and which applies to all participants, regardless of employment status. Patient satisfaction, where applicable, should be a factor.
- The ACO must have a mechanism to provide accurate and transparent reporting to the ACO member, who has an opportunity for peer review, feedback to the governing body and appeal rights of payment decisions. ***(policy)***

3. The North Carolina Medical Society supports liability relief and peer review protections (including adequate appeal rights) for Accountable Care Organizations. ***(policy)***

4. The North Carolina Medical Society supports assistance to providers participating in Accountable Care Organizations to procure, implement and maintain interoperable electronic health records system, which will improve the ability to collect data and therefore improve and coordinate care. ***(policy)***

5. The North Carolina Medical Society supports development of one or more physician-led Accountable Care Organization "models" for medical communities in North Carolina that include primary care physicians and specialty physicians, as well as hospitals and other providers where possible. ***(policy)***

6. The North Carolina Medical Society shall provide a forum to bring physicians of all specialties together to educate physicians about Accountable Care Organizations and the urgency of working together and taking the lead in forming into ACOs. ***(action)***

7. The North Carolina Medical Society will work with physicians at the local or regional level to facilitate collaboration between primary care physicians (including Community Care of NC) and specialty physicians to organize physician led Accountable Care Organizations (ACOs) in their area. The North Carolina Medical Society will assist, where helpful, in physician collaboration with hospitals in their area, including possible physician led ACO hospital/physician joint ventures, to promote continuity and coordination of care. ***(action)***

8. The North Carolina Medical Society shall monitor, analyze, comment, and disseminate information on, the proposed rules relating to the Shared Savings Program. ***(action)***

9. The North Carolina Medical Society shall partner with law firms and other consultants to create guidelines for developing and implementing Accountable Care Organizations in North Carolina. ***(action)***

10. The North Carolina Medical Society shall develop or identify guidelines for the equitable distribution of incentive payments to participating ACO providers, including possibly attribution methodology. ***(action)***