The ABCs of ACOs: A Quick Primer for Physicians

By Martin Merritt

Many are still confused about accountable care organizations. Here's how they came about, and how the Medicare ACO program works.

Source: Physicians Practice

Under the Affordable Care Act (ACA), doctors, hospitals, and other healthcare providers are expected to better coordinate care for Medicare patients through accountable care organizations (ACOs). Yet many are still confused about what ACOs are, and what participating in one entails.

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Here's a quick primer:

The Origin of ACOs.

According to CMS, accountable care organizations grew out of the Dartmouth Atlas Project work on geographic variations in cost and quality. The Medicare Payment Advisory Commission (MedPAC) featured the concept in its June 2009 report to Congress during the development of this healthcare reform provision. Congress drew from these expert sources as well as from the Physician Group Practice (PGP) demonstration project at CMS.

On Oct. 20, 2011, CMS finalized rules for participation in the Medicare ACO program, also known as the Medicare Shared Savings Program (MSSP).

How ACOs Work.

ACOs create incentives for providers to work together to treat an individual patient across care settings — including medical practices, hospitals, and long-term care facilities. The MSSP rewards both the reduction in costs and improvement in patient outcomes using various metrics to measure success.

ACOs may choose to participate in one of two tracks:

Track 1: First (3-year) agreement period of one-sided shared savings, or

Track 2: First (3-year) agreement period of two-sided shared savings/losses

A one-sided shared savings agreement is one in which the ACO does not share risk of loss, while a two-sided shared savings agreement is one in which the ACO shares in savings and losses.

Track 1 is intended to provide an on ramp for organizations to gain population management experience before transitioning to risk arrangements.

Track 2 is intended for more sophisticated participants. All ACOs that elect to continue in the program after the first three-year agreement period must continue in the two-sided model. In other words, after three years, ACO’s are rewarded for saving money, but will not be paid for care exceeding expectations.

ACO Predictions.

In my opinion, for all the complexity involved, the survival of ACO’s may be dependent upon a human factor which is impossible for Congress or HHS to control. Different healthcare organizations will have to get along with one another. There will be growing pains, trial and error, and some will decide the program is not for them. It will certainly be years before we have any concrete evidence of the ACO model’s viability.
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