



Florida Accountable Care Services, LLC

ACO Learning Network

Accountable Care Organizations Shared Savings Program Frequently Asked Questions

The Patient Protection and Affordable Care Act (PPACA) attempts to improve the health care delivery system through incentives to enhance quality improve beneficiary outcomes and increase value of care. One of these key delivery system reforms is the encouragement of Accountable Care Organizations (ACO's).

ACO's facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs.

Q: What is an "accountable care organization"?

A: An Accountable Care Organization, also called an "ACO" for short, is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of an assigned population of patients.

For ACO purposes, "assigned" means those patients for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the patient, and will not affect their guaranteed benefits or choice of doctor. A patient may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

Q: What forms of organizations may become an ACO?

A: The statute specifies the following:

- 1) Physicians and other professionals in group practices
- 2) Physicians and other professionals in networks of practices
- 3) Partnerships or joint venture arrangements between hospitals and physicians/professionals
- 4) Hospitals employing physicians/professionals
- 5) Other forms that the Secretary of Health and Human Services may determine appropriate.

Q: What are the types of requirements that such an organization will have to meet to participate?

A: Private Payor ACO's have no specific structure outlined, however CMS has proposed a few items which all ACO's set to receive Federal Medicare/Medicaid dollars will have to adhere to. These include the following:

- 1) Have a formal legal structure to receive and distribute shared savings
- 2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)





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- 3) Agree to participate in the program for not less than a 3-year period
- 4) Have sufficient information regarding participating ACO health care professionals a the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
- 5) Have a leadership and management structure that includes clinical and administrative systems
- 6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
- 7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary. Additional details will be included in a Notice of Proposed Rulemaking that CMS expects to publish this fall.

Q: How would such an organization qualify for shared savings?

A: For each 12-month period, participating ACO's that meet specified quality performance standards will be eligible to receive a share (a percentage, and any limits to be determined by the Secretary) of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Private Insurer or Medicare fee-for-service beneficiaries assigned to the ACO. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B.

Q: What are the quality performance standards?

A: Medicare ACO's will have the specifics be determined by the HHS Secretary and will be promulgated with the program's regulations, they will include measures in such categories as clinical processes and outcomes of care, patient experience, and utilization (amounts and rates) of services. Private Payor ACO's will work together with Physicians to determine the best and most appropriate standards to base performance from.

Q: Will Patients that receive services from a health care professional or provider that is a part of an ACO be required to receive all his/her services from the ACO?





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A: No. Patients will continue to be able to choose their health care professionals and other providers.

Q: Will participating ACO's be subject to payment penalties if their savings targets are not achieved?

A: No. An ACO will share in savings if program criteria are met but will not incur a payment penalty if savings targets are not achieved.

Q: When will this program begin?

A: Depending on the Payor. For Private Insurance plans, we can begin as soon as all of the building blocks and the infrastructure is in place within your organization or network of physicians. For Medicare ACO's we should also begin right away with building the infrastructure and creating necessary workflows to implement Medicare payments to the entire system. Medicare itself wants programs established by January 1, 2012. Agreements will begin for performance periods, to be at least three years, on or after that date.

Q: How do I get more specific information?

A: Florida Accountable Care Services is currently holding seminars across the state and has created the only Florida Focused ACO Learning Network to help Physicians understand and prepare for the future of Healthcare.

