

American College of Physicians

Policy Statement Pertaining to the Development of the Accountable Care Organization Model

Approved by Board of Regents April 2010

Introduction

An Accountable Care Organization (ACO) is a formally organized entity, consisting of physicians and other relevant health service professionals that are responsible through contracts with payers for providing a broad set of health care services to a specific population of people. This entity is accountable for organizing and aligning health care services to deliver seamless, coordinated care whether the ACO is contained within a single corporate structure or is an organized network of independent but associated health care professionals. A key goal of the ACO structure is to reduce, or at least control, the growth of health care costs while maintaining or improving the quality of care patients receive. This goal is best achieved when payment systems value and support patient-centered health care delivered from a robust primary care base that interacts with a neighborhood of specialty and subspecialty physicians and other health care providers in a coordinated and integrated manner. The Medicare Payment Advisory Commission (MedPAC) ⁱ recommends widespread testing of this care delivery and payment model and Congress intends to mandate testing through health care reform legislation. The ACO model generally fulfills most of the payment reform criteria recommended in the American College of Physicians (ACP) policy paper “Reforming Physician Payments to Achieve Greater Value in Health Care Spending.” ⁱⁱ The ACP supports the public and private sector testing of the ACO model that is consistent with the policy statements below.

Policy Statements

- ACOs should be structured to provide patient-centered, high quality, efficient, coordinated, seamless, team-oriented care to its defined patient population.
- ACOs should promote the delivery of services consistent with the principles of the Patient Centered Medical Home (PCMH) and ACP policy on the PCMH – Neighbor* and reward practices that achieve this recognition.
- ACO demonstration and pilot projects should recognize the importance of transitions of care between different sites of service.
- Physician practice participation within ACO demonstration and pilot projects should be voluntary.
- Practicing physicians, including representatives of all major specialties, subspecialties and primary care, should have significant representation in the administrative structure, policy development, and decision-making processes of ACOs.
- ACOs should include processes for patient panel input in policy development and decision-making.
- ACOs that include hospitals and similar large treatment settings must have processes that protect participating primary care and specialty/subspecialty physician practices from the

undue influence of these larger settings in administrative, policy setting and payment distribution decisions.

- Organizational relationships and all relevant clinical and administrative processes within the ACO should be clearly defined and transparent to physicians, other related health care professionals, and the public. This includes methods of reimbursement, quality management, and assessments of delivery system performance review.
- ACO structure should recognize the importance of administrative simplification to the participating practices.
- Performance measures used by ACOs to determine clinical quality, efficiency, and patient experience of care should be nationally recognized and consistent with ACP policy as reflected in the “Linking Physician Payments to Quality Care”ⁱⁱⁱ and the “Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of their Ratings”^{iv} policy papers.
- Priorities for quality improvement should be aligned with a multi-stakeholder national organization such as the National Priorities Partnership.
- Meaningful use of health information technology (HIT) and health information exchange are integral parts of the ACO model. Therefore, certified EHR technology that supports system integration should be accessible to and used by all practices (including small practices) affiliated with the ACO.
- ACO payment models should recognize the practice expenses and administrative costs associated with participation in an ACO model including the costs of implementing and maintaining HIT.
- ACOs should contain a sufficient number of primary care physicians, subspecialists/specialists, and other health care professionals to effectively meet the needs of the patient population served.
- Barriers to small practice participation within ACO demonstration and pilot projects should be addressed and minimized. These barriers include the small size of their patient panels and their limited capital, HIT and care management resources.
- ACO demonstration and pilot projects should have processes in effect to help participating practices adjust to the new ACO culture and educate them in the skills necessary to succeed under the model.
- ACO demonstration and pilot projects should form relationships with the relevant professional societies towards the goals of enlisting participation of physician practices and supporting their functioning within the project.
- Payment models used within the ACO demonstration and pilot projects should:
 - Recognize and reward performance based on a combination of the meeting of absolute and improvement-based quality and efficiency benchmarks.
 - Adequately reflect the participating practice’s contribution to increased quality and efficiency.
 - Ensure that a significant portion of any savings attributable to the ACO’s activities be shared by the participating practices.
 - Protect ACO participants from “insurance risk” (e.g. degree of illness/severity in the population).
- ACO demonstration and pilot projects incentive structures should not discriminate against the treatment of the more medically complex or difficult-to-treat patients.

- ACO demonstration and pilot projects should align incentives for improving quality while reducing overall costs by testing a wide variety of payment approaches including but not limited to blended fee-for-service /prospective payment, shared savings, episode/case rates and partial capitation.
- ACO demonstration and pilot projects should be adequately protected from existing antitrust, gainsharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.

* PCMH-N policy is currently being developed and through the Council of Subspecialty Societies (CSS) and vetted by the Medical Service Committee. The Medical Service Committee expects to recommend a PCMH-N policy for consideration by the Board of Regents in July 2010.

ⁱ Medicare Payment Advisory Commission. Report to Congress-Improving Incentives in the Medicare Program. June 2009 40-57.

ⁱⁱ American College of Physicians. . Reforming Physician Payments to Achieve Greater Value in Health. Care Spending. July 2009.

ⁱⁱⁱ American College of Physicians. Linking Physician Payments to Quality Care. October 2005.

^{iv} American College of Physicians. Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of their Ratings. April 2007.