

Joint Principles for Accountable Care Organizations

An Accountable Care Organization (ACO) is defined as a group of physicians, other healthcare professionals*, hospitals and other healthcare providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients across the age spectrum and who are held accountable for the quality and cost of care provided through alignment of incentives. These principles state that primary care should be the foundation of any ACO and that the recognized patient and/or family-centered medical home is the model that all ACOs should adopt for building their primary care base. The goals of an ACO structure are to improve the quality and efficiency of care provided and to demonstrate increased value from health care expenditures. The Medicare Payment Advisory Commission (MedPAC) has called for the testing of this care delivery organizational model and the recently passed healthcare reform legislation allows physicians and other healthcare professionals to organize as ACOs under Medicare beginning in 2012. The same legislation also establishes a pediatric demonstration project that allows qualified pediatric providers to choose to be recognized and receive payments as ACOs under Medicaid. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association support the establishment of ACOs within public and private settings that are consistent with the following principles:

Structure

1. The core purpose of an Accountable Care Organization is to provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical Home for the defined population it serves, which includes assurances that care is delivered in a culturally competent and patient and/or family-centered manner.
2. The Accountable Care Organization should demonstrate strong leadership from among physicians and other healthcare professionals, including significant and equitable representation from primary care and specialty physicians, in its administrative structure, policy development, and decision-making processes; clinical integration in the provision of care; and processes to facilitate operation as a true partnership among physicians and all other participants.
3. Organizational relationships and all relevant clinical, legal, and administrative processes within the Accountable Care Organization should be clearly defined and transparent to physicians, other related healthcare professionals, and the public. This includes methods of payment including the application of any risk adjustment strategies for both pediatric and adult patients, quality management processes, and processes to promote efficiency and value in delivery system performance.
4. Accountable Care Organizations should include processes for patient and/or family panel input in relevant policy development and decision-making.
5. Accountable Care Organizations should include a commitment to improving the health of the population served through programs and services that address needs identified by the community including, for example, interfacing with state Title V programs, early intervention programs, Head Start offices, and public education entities.
6. Accountable Care Organizations should provide incentives for patient and/or family engagement in their health and wellness.

* These principles use the term “other healthcare professionals” to represent non-physician direct patient care providers licensed to deliver primary care and other healthcare services (e.g. nurse practitioners, physician assistants, licensed clinical social workers, and clinical psychologists).

7. Participation by physicians, other healthcare professionals, and patients/families in an ACO should be voluntary. However, if patients are assigned to an ACO, they should be encouraged to select a primary care physician.
8. Nationally-accepted, reliable and validated clinical measures focused on ambulatory and inpatient care should be used by Accountable Care Organizations to measure performance and efficiency and evaluate patient experience. These measurement processes should be transparent, and informed by input from primary and specialty care physicians and other healthcare professionals participating in the Accountable Care Organization. .
9. Accountable Care Organizations should implement clinically integrated information systems to provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions and sites of care.
10. The structure and related payment systems of the Accountable Care Organization should be implemented and monitored to prevent "adverse unintended consequences," such as poor access to physicians, denial of needed care, or discrimination against the treatment of the more medically complex or difficult-to-treat patients.
11. Primary care physicians, specialty physicians, and other healthcare professionals should have the option to participate in multiple Accountable Care Organizations.
12. Barriers to small practice participation within the Accountable Care Organization should be addressed and eliminated. These barriers include the small size of their patient panels and their current limited and future access to capital, health information technology infrastructure needs, and care coordination and management resources.
13. Accountable Care Organizations should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
14. Accountable Care Organizations should promote processes to reduce administrative complexities and related unnecessary burdens that affect participating practices and the patients/families to whom they provide service.

Payment

15. Payment models and incentives implemented by Accountable Care Organizations must align mutual accountability at all levels, fostered by transparency and focused on health promotion and healthy development, disease prevention, care management, and care coordination.
16. Payment models and incentives implemented by Accountable Care Organizations should adequately reflect the relative contributions of participating physicians and other healthcare professionals to increased quality and efficiency and demonstrate value in the delivery of care.
17. Payment models should recognize effort required to involve family, community/educational resources and other pertinent entities and activities related to care management/care coordination of patients with complex conditions.
18. Recognition as an Accountable Care Organization and rewards for its performance should be based on processes that combine achievement relative to set target levels of performance, achievement relative to other participants, and improvement that have been developed with significant input from primary and specialty care physicians and other healthcare professionals. .
19. Practices participating within the Accountable Care Organization that achieve recognition as medical homes by NCQA, other nationally accepted certification entities,

and/or related processes (e.g. state government recognition) should be provided with additional financial incentives.

20. The structure of the Accountable Care Organization should adequately protect ACO physicians and other healthcare professional participants from “insurance risk,” unless clearly agreed as a requirement for participation.
21. Accountable Care Organizations can employ a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while reducing overall costs including but not limited to blended fee-for-service /prospective payment, shared savings, episode/case rates and partial capitation.