

In the Spotlight: Health Care Reform and Accountable Care Organizations

As part of the attempt to control cost and improve quality of medical care, Section 3022 of the Affordable Care Act (ACA) established Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program on a voluntary basis. The law [describes](#) ACOs as an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare fee-for-service beneficiaries. The same model will be applied to pediatric Medicaid beneficiaries as a demonstration project. Within the ACA, there are several provisions requiring that ACOs coordinate care. [The ACA](#) directs the HHS Secretary to "establish a shared savings program that ... coordinates items and services under [Medicare] parts A and B. ... Under such program (A) groups of providers of services and suppliers ... may work together to manage and coordinate care." These provider-based organizations, comprised of multiple levels of providers and responsible for the full continuum of care, are held accountable for the cost and quality of care and share in savings from it. The regulations, which will clarify the quality standards and reimbursements methods, are expected in late 2010. The Medicare Shared Savings program will begin January 1, 2012 and, in order to participate, ACOs will have to commit to participating for at least three years in the program. By coordinating care and offering shared savings, ACOs have potential to improve health outcomes while eliminating unnecessary services. However, there are few current models and some concern that ACOs, if not implemented correctly, could create a kind of monopoly that would result in higher prices and little to no quality improvement, undermining the intent of the program.

Potential Benefits

The ACA has touted the many potential benefits of ACOs, including improved quality, addressing the physician shortage, and more efficient care. Currently, patients visit a variety of physicians in a variety of locals that often result in preventable events, duplication of care and inadequate follow-up. Under an ACO, a group of multispecialty physicians would be held responsible for keeping a patient well, improving coordination and, therefore, quality of care. Additionally, ACOs could be a partial solution to the growing physician shortages around the country. Through the team-based approach of ACOs, primary care physicians would be able to care for more patients than when practicing alone. With more payment incentives tied to results, more medical students may be encouraged to pursue primary care. ACOs have the potential to lower medical costs through greater coordination of care, less duplication of services, and eliminate preventable events, like hospital readmissions. And, despite concerns outlined below, there is opportunity for the hospitals should they choose to participate; [some experts](#) advise that hospitals participate sooner than later. Other benefits include investments in health information technology systems, care coordination, and other infrastructure.

Potential Concerns

Despite the many potential benefits, there are a few concerns about the impact ACOs could have if they are not implemented carefully and correctly. Primarily, concerns revolve around the potential for undue market power in ACOs. Should ACOs acquire enough market power to force out other competitors, they could actually increase the prices of medical care. While some hospitals are eager to participate in the ACO structure, others have noted challenges associated with a changed pay structure. Because beneficiaries may visit any hospital regardless of whether or not it is participating in an ACO, participating is not expected to boost a hospital's revenues substantially. New penalties to hospitals for any short-term preventable readmissions increase financial pressure on hospitals, which also may discourage participation.

How a plan may qualify

For each 12-month period, participating ACOs that meet quality performance standards will be eligible to receive a share of any savings if the expenditures of their assigned Medicare beneficiaries are a certain percentage below their benchmark amount, to be determined by the Secretary. The percentage and any limits of savings received by

physicians will also be determined by the Secretary of HHS. 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 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.

As specifics are being developed, CMS issued a [request for information \(RFI\)](#) on November 10, 2010. The RFI requests input on issues such as how to include smaller provider practices, which quality measures should be used, and any other payment models that should be considered. Comments were submitted on December 1, 2010.

What other plans are doing

Though it is currently unclear what federal qualifications would be considered an ACO structure, there are a variety of structures that could represent ACOs. In fact, several Blue plans have entered into agreements with hospitals and physicians to provide patients with a medical home that is responsible for keeping a patient healthy, the underlying concept of ACOs. Other insurers, such as Cigna, Aetna, UnitedHealth, and Humana, have also begun to set up delivery systems that resemble ACOs. Below is a chart, developed by *Health Affairs* journal, explaining how other models of delivery are similar to the ACO structure:

EXHIBIT 1

Delivery Systems That Could Become Accountable Care Organizations

Model	Characteristics	Current Examples
Integrated delivery systems	<ul style="list-style-type: none"> Own hospitals, physician practices, perhaps insurance plan. Aligned financial incentives. E-health records, team-based care. 	Geisinger Health System Group Health Cooperative of Puget Sound Kaiser Permanente
Multispecialty group practices	<ul style="list-style-type: none"> Usually own or have strong affiliation with a hospital. Contracts with multiple health plans. History of physician leadership. Mechanisms for coordinated clinical care. 	Cleveland Clinic Marshfield Clinic Mayo Clinic Virginia Mason Clinic
Physician-hospital organizations	<ul style="list-style-type: none"> Nonemployee medical staff. Function like multispecialty group practices. Reorganize care delivery for cost-effectiveness. 	Advocate Health (Chicago) Middlesex Hospital (Connecticut) Tri-State Child Health Services (affiliated with the Cincinnati Children's Hospital Medical Center)
Independent practice associations	<ul style="list-style-type: none"> Independent physician practices that jointly contract with health plans. Active in practice redesign, quality improvement. 	Atrius Health (eastern Massachusetts) Hill Physicians Group (southern California) Monarch HealthCare (southern California)
Virtual physician organizations	<ul style="list-style-type: none"> Small, independent physician practices, often in rural areas. Led by individual physicians, local medical foundation, or state Medicaid agency. Structure that provides leadership, infrastructure, resources to help small practices redesign and coordinate care. 	Community Care of North Carolina Grand Junction (Colorado) North Dakota Cooperative Network

SOURCE S.M. Shortell, L.P. Casalino, and E.S. Fisher. "How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations." *Health Affairs* 29, no. 7 (2010): 1293-98.

BCBSNC Views

Blue Cross and Blue Shield of North Carolina supports the ability of insurers and providers to implement innovative payment models to promote quality-based care. As the regulations for ACOs are developed, we encourage flexibility in fee schedules for providers so that plans may fully participate in a patient-centered way. Additionally, the continued development of health information technology is, and will continue to be, a very important part of making ACOs work.

For More Information

NCQA Accountable Care Organizations Public Comment Link: <http://www.ncqa.org/tabid/1266/Default.aspx>

CMS FAQ on ACOs: <https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf>

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