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In the Spotlight: Accountable Care Organizations – Coming into Focus

When it comes to health care reform, there are few things that have been talked about more than how to control the rapidly growing health care costs. Accountable Care Organizations (ACOs) have been one of the more popularly discussed ideas to potentially do just that. (In fact, this is our second paper on ACOs in our Spotlight series.) Whether people love them or hate them, the bottom line is that questions surround the Medicare ACO program. Originally sold as one of the few ways that the Affordable Care Act (ACA) attempts to address the growing health care costs problem, there is much disagreement about whether or not ACOs will actually accomplish this goal. Qualifying providers, including hospitals, physician group practices, networks of individual practices, and partnerships between hospitals and other health care professionals are eligible to form ACOs. ACOs must be willing to be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to them, and are expected to meet specific organizational and quality performance standards in order to receive payments for shared savings as part of the program.

The Medicare Shared Savings program is scheduled to begin January 1, 2012, but delays in the rule-making process may result in a delayed start to the program. ACOs will have to commit to participating in the program for at least three years. By coordinating care and offering shared savings, ACOs have potential to improve health outcomes while eliminating unnecessary services.

In June of 2011, the US Department of Health and Human Services answered several of these questions with a proposed rule outlining how ACOs, as defined by ACA will work. But does the rule incentivize providers to control costs? Or does it discourage participation in the ACO program altogether?

The Proposed Rule

Perhaps the most important thing to note about the proposed rule is the likeliness to change. For many provisions, the Center for Medicare and Medicaid Services is eager to incorporate comments from stakeholders, which may alleviate some of the concerns. In a September 2011 press conference, a CMS official reiterated this by saying comments, including those from health insurers, would be incorporated. ACOs must have at least 5,000 beneficiaries who are assigned to Medicare fee-for-service (FFS) in order to be eligible. HHS has already said they may give preference to ACOs who are participating in a similar arrangement with other private or third party payers. The participants in ACOs must maintain 75% control over the governing body. ACOs will also have to provide aggregate and individually-identifiable data quarterly, although beneficiaries may opt out of sharing their individual data.

There are several categories of eligible providers: those in group practice arrangements; networks of individual practices; provider/hospital partnerships or joint ventures; hospitals employing providers. Medicare-enrolled providers and suppliers that directly provide health care services to beneficiaries must have at least 75% control of the ACO's governing body in order to qualify. There are over 60 different quality measures in the proposed rule that ACOs must track and report in five key areas (patient experience, care coordination, patient safety, preventive health, and at-risk population). Providers may choose one of two program tracks based on ACO readiness. The first is a "one-sided model" in which providers share in the savings only for the first two years of the contract, but begin sharing in the liability for excess expenditures only in the third year. The second is referred to as a "two-sided model," which means the provider accepts downside risk immediately in exchange for a higher percentage of possible shared savings. These details offer important insight into the opportunities and concerns of implementing ACOs in 2014.

Opportunities for BCBSNC

There are several areas where BCBSNC can help overcome challenges to the ACO model. ACO success will depend on having a solid data infrastructure to provide data on care assessment, coordination, management, and measurements of outcomes and costs. We can offer assistance with administrative support as well as data infrastructure. ACOs will need to administer payments, set benchmarks, measure performance, and distribute the shared savings. We have an established care management program and can assist with process design and improvement as well as risk management. BCBSNC can use our long-time experience to help design a benefit structure to incentivize the patient to choose based on cost and quality. We can also shed light on information about the costs and outcomes of certain health care services.

Concerns

Some providers, including some in North Carolina, have been very outspoken about their concerns with the proposed rule for ACOs. Leading health care systems like the Mayo Clinic and Geisinger Health System have told CMS that they will not participate in the ACO program unless the rule is changed. Such providers find the rule too stringent and are concerned that it carries too much risk of losses. They also point out a disincentive to take care of patients with lots of health care needs and feel that the quality measures go into effect too quickly.

Since the ACO program is only an extension of the Shared Savings Program to Medicare Parts A and B, even those beneficiaries who participate in ACOs may choose to seek care from any qualified provider, whether in or out of the ACO, which will make it difficult to control costs outside the ACO.

Additionally, there are concerns that there may be legal issues. The payment methodologies for ACOs like shared savings, global risk, and bundled payments will likely not be compatible with the standard FFS payment model. There is also potential that federal laws geared toward preventing fraud and abuse will conflict with the ACO model. For example, it is illegal for a physician to refer a patient to himself and prohibit payments that reward additional referrals.

Despite these concerns, several provider groups have expressed interest in applying to become ACOs and many have already applied for the Pioneer Accountable Care Organization Model program. While at present there are no official ACOs in North Carolina that have applied to participate in the Medicare ACO models, there are nonetheless organizations who could qualify for such classification.

BCBSNC Views

BCBSNC supports a move toward quality, patient-centered care. We see a need for flexibility so that insurers and providers may implement innovative payment schedules to promote quality-based care. We recognize there is not yet a clear “best practice” to reimburse providers to get the outcomes a patient needs at a cost that society can afford. We believe that ACOs should represent a mix of providers, not only large hospital and health systems. There is concern that ACOs create unnecessary legal and administrative obstacles. We have some concerns about the potential for ACOs to have undue market power that would force out competitors and could raise the cost of medical care for everyone.

BCBSNC has encouraged patient centered medical homes launching our Blue Quality Physician Program (BQPP) in October of 2009. BQPP rewards practices that receive medical home recognition (as well as other quality and efficiency metrics). BCBSNC has also partnered with several primary care practices for an integrated, medical home model of care management collaboration that was piloted in 2010. Now in the program stage, this collaboration model integrates services of BCBSNC and providers so that a member’s health care needs can be

managed more efficiently and effectively. In 2011, BCBSNC partnered with CaroMont Health for a bundled payment agreement on knee replacements. This model is designed to help contain costs by paying for the entire episode of replacing a knee, including the pre-surgical and post-surgical care, instead of each individual service associated with the surgery. BCBSNC will save, on average, 6-10% per knee replacement, lowering costs for our members. Finally, we are participating in the Multipayer Advanced Primary Care Practice Demonstration program with Medicare, Medicaid, and the State Health Plan. As part of that project, we are developing models for data sharing with practices and care managers in the community to achieve many of the same goals that ACO's are trying to achieve.

We are not sure what the future of ACOs will be, but are expecting changes to the rules as HHS tries to incorporate comments from experienced and knowledgeable players. However, we continue to explore value-based payment models with providers throughout the state.

For More Information

HealthCare.gov: Accountable Care Organizations: http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html

Health Reform GPS: http://www.healthreformgps.org/resources/medicare-accountable-care-organizations/

The Commonwealth Fund: Shared Savings Models: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Aug/1539_Bailit_key_design_elements_sharedsavings_ib.pdf