Law and the Public's Health

This installment of *Law and the Public's Health* examines accountable care organizations (ACOs) and their role in Medicare and health system reform. In particular, it considers the potential impact of ACOs to achieve greater integration of health care and public health.

Sara Rosenbaum, JD

The George Washington University School of Public Health and Health Services,
Department of Health Policy, Washington, DC

ACCOUNTABLE CARE ORGANIZATIONS

TAYLOR BURKE, JD, LL.M.

This installment of *Law and the Public's Health* examines accountable care organizations (ACOs), a health-care delivery system centerpiece of the Affordable Care Act (ACA).¹ ACOs represent a new Medicare payment model, and the ACA contains provisions to expand the model to Medicaid and private payers. Health-care providers and insurers are closely watching implementation of the ACO reforms because of their potential impact on health-care organization, delivery, quality, and costs. Following a description of the legislative reforms, the broader implications of ACOs for public health policy and practice are discussed.

BACKGROUND

The term “ACO” originally was coined by researchers and policy experts to describe entities that consist of integrated providers that are jointly held accountable for achieving measured quality improvements in care and reductions in the rate of spending growth for a defined patient population. The health services research and policy literature generally describes ACOs as structures dedicated to quality and efficiency with the mission and the authority to impose practice, reporting, and compensation standards (including penalties and rewards) across a group of physicians on behalf of the patient population.^{2,3} These features have been identified as carrying certain advantages, including fostering quality through the greater clinical integration of care across health-care settings; greater financial efficiency; and increased transparency and information about the process, costs, and outcomes of health care.

In 2009, the Medicare Payment Advisory Commission (MedPAC), Congress's Medicare-policy advisory arm, identified ACOs as a potential tool for restructuring traditional Medicare coverage.⁴ MedPAC defined an ACO as a group of physicians (possibly including

a hospital) that assumes responsibility for annual Medicare spending for a defined patient population.⁵ Under MedPAC's recommendations, ACOs would be compensated through an arrangement that combines traditional fee-for-service payments with financial incentives to reduce costs, improve quality, and achieve greater information transparency. MedPAC indicated that the success of the model would depend on the adoption of clear quality standards combined with a payment methodology that rewards quality while reducing current financial incentives for uncontrolled practice and volume expansion.

Restructuring the clinical organization and integration of care among individual physicians, as well as among physicians, hospitals, and other health-care providers, has been identified as essential to improving health-care quality and efficiency at both the individual and population levels.^{2,3} Because most public programs and private insurance plans pay for care on a fee-for-service basis, hospitals, individual physicians, and other providers generate revenue based on the volume of services they provide to a patient. Furthermore, the current payment system does not either reward or require evidence of integration as a condition of payment. The absence of incentives to alter practice is associated with very high health costs (with health expenditures anticipated to rise to 20% of the gross domestic product by 2019)⁶ and evidence of inappropriate use of resources.^{7–10}

The legislation creating ACOs as part of the ACA is hardly the first time that Congress has engaged in delivery reform efforts aimed at holding a single entity financially responsible for its patients across the care continuum. The Health Maintenance Organization Act of 1973 (hereafter, HMO Act) and the rise of managed care entities participating in Medicare and Medicaid directly contributed to greater financial and clinical integration of health-care delivery in the early 1990s. But these efforts focused on the full integration of coverage and care, leading to new forms of insurance coverage. The ACO concept, by contrast, focuses