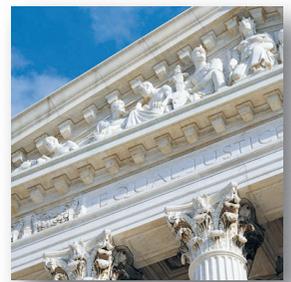


Accountable Care Organizations

An Improvement Over HMOs?

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Key words: Accountable Care Organization, health care reform, Affordable Care Act, Medicare, Medicaid, public health insurance

INTRODUCTION

Efforts to improve quality and access to health care in the U.S. while managing costs have been at the forefront of the nation's political debate for decades. Passage of the 2010 Patient Protection and Affordable Care Act (ACA) promoted innovations toward a health care system that addresses these three concepts (albeit skewed toward access). The introduction of Accountable Care Organizations (ACOs), whereby providers create comprehensive integrated networks to care for patients, was one of the touted achievements of health care reform legislation. This article focuses on the underpinnings of the ACO concept in relation to health care policy, the evolution of ACOs in relation to public and private health insurance, and opportunities for new models of efficient and effective care.

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THE CONCEPT OF ACCOUNTABLE CARE

Although the ACO concept is not new, the term ACO itself is. Introduced in various forums in 2006, the paradigm for ACOs emphasizes that they are responsible for the care provided. This care must be comprehensive, high in quality, and reasonable in cost. In today's electronic environment, an ACO might be a physical organization, such as a hospital or clinic, or a virtual entity consisting of collaborating providers and health care companies.¹⁻³

In developing a national strategy to implement accountable care, Dr. Mark McClellan, former head of the FDA and the Centers for Medicare & Medicaid Services (CMS), suggested three core principles for all ACOs:⁴

- provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients
- payments linked to quality improvement that affect costs
- reliable and progressively advanced performance measurement to support improvement and to provide confidence that savings are achieved through better care.

Currently, four types of organizations are envisioned to be designated as ACOs: integrated health systems, multispecialty provider groups, physician-hospital organizations, and independent provider associations. Additional structural models may emerge as commercial payers and organizations integrate to provide new ways of delivering preventive and chronic care.^{5,6}

Through the ACA, the federal government created a 2012 demonstration project, overseen by the CMS, to validate the ACO concept. This Medicare-only program limits participation to organizations with an enrollment of at least 5,000 beneficiaries for a minimum of 3 years.

The program has the capability of coordinating and reporting on costs and quality of care and includes a core group of specialists to ensure the provision of a full spectrum of health care. The CMS has the ability to provide incentives for organizations achieving certain benchmarks through the Medicare Shared Savings Program. By placing a measure of financial responsibility on providers, the CMS hopes to motivate stakeholders to form linkages and collaborations that promote high-quality, efficient care. Rewards in the form of payment incentives may accrue or be distributed to the organization, shareholders, and providers or to patients.⁶⁻⁸

PAYMENT METHODS AND RISK-SHARING

In October 2011, the CMS released final regulations pertaining to ACOs and began the process of enrolling qualified entities. In a radical departure from the strict fee-for-service payment model, ACOs are expected to share the financial risk of treating every health problem of every enrolled patient.

ACOs may choose a one-sided or a two-sided payment model for sharing any savings. In the one-sided risk model, ACOs share any savings above 2% that might accrue but are not liable for losses. With the two-sided model, ACOs assume the risk of both savings and losses but are not bound by the 2% savings goal before savings can accrue. In return for assuming a level of risk, ACOs are given greater latitude in organizing and delivering care if certain quality levels are maintained. After a 3-year demonstration period, this risk-sharing arrangement may switch to an alternative system based on evaluation of the program.^{6,9}

The CMS will continue to test various ACO models through the Center for Medicare and Medicaid Innovation (CMMI). For example, 32 organizations with significant integrated care experience have been selected as "Pioneer ACOs" and will be testing various options that seek to align financial incentives and share risk.¹⁰ Physician-based and rural

providers are currently being selected to participate in the “Advanced Payment ACO Model,” in which providers receive monthly payments in advance in order to make investments in their coordinated care infrastructure.¹¹ A survey by Leavitt Partners counted as many as 221 ACO entities in 45 states that were using varied models for risk-sharing.¹² The private sector’s experimentation with various models may lead to or may affect the final Medicare approach to ACOs and funding.

The ACA authorized a demonstration project to create pediatric ACOs within Medicaid programs. Although the project is not funded, the states are examining these models as a way to assist with their budget-constrained Medicaid programs. In the financial arena, Medicaid has paved the way for an ACO approach to health care, as nearly two-thirds of state Medicaid programs have some form of “managed” Medicaid.

Risk-based managed care is the predominant type of contractual arrangement states have with their Managed Care Organization (MCO) partners.¹³ However, these integrated networks must work locally to provide a wide range of benefits that include social services, as well as health care, to some of the poorest and most chronically ill patients in the country. Medicaid agencies will need to ensure that their partners are capable of building high-performing, quality-based teams that incorporate nontraditional clinical expertise (e.g., nutrition counseling, social services, and community outreach).

Currently, ACO Medicaid initiatives are moving toward setting up operations in five states. Decision-making at the state level may affect the implementation of these programs as the Medicaid programs work with state legislatures on beneficiary services and costs.¹³ In addition, states may choose to incorporate other types of reforms, such as adding subpopulations to their managed Medicaid populations, although this might entail delays as the states apply for federal waivers from the CMS.

DUAL-ELIGIBLE BENEFICIARIES

A subpopulation that is gaining increasing attention by the CMS and Medicaid agencies consists of the dually eligible beneficiaries (“duals”) covered by Medicare and Medicaid. This subset represents roughly 9 million of the

97 million (21%) Medicare beneficiaries but accounts for 36% of the Medicare program’s costs. Duals represent only 15% of the Medicaid population yet account for 39% of Medicare costs.¹⁴

Duals are insured by Medicare, and Medicaid is responsible for noncovered, excluded, or cost-sharing portions of the Medicare benefit. Traditionally, these programs have run parallel to, rather than in concert with, each other in order to manage health care costs. The ACA authorized the Medicare–Medicaid Coordination Office within the CMS to develop new treatment models to improve quality of care for duals. The CMS and 26 states are starting to participate in the demonstration project and are adopting various approaches, including ACOs, to address gaps in the care of high-cost patients. With limited experience in managing a population with chronic health and social needs, these demonstration projects face enormous challenges—yet it is possible that the rewards, through quality improvement and reduced costs, could be equally large.^{15,16}

POTENTIAL OBSTACLES

Despite the potential improvements that may be achieved with ACOs, it is still unclear just how much money can be saved. In a study of patients who had type-2 diabetes, published in October, Eddy and Shah, using the Archimedes model, noted that savings with ACOs were only modest.^{17,18} Their simulation found that a 10% improvement in performance in diabetes quality measures would create only 1.22% in savings for Medicare Parts A and B, which is below the level needed to trigger savings sharing. In addition, start-up costs would be about \$1.7 million for each ACO. The authors concluded that to achieve greater savings, ACOs would have to reduce costs, for instance, by improving information technology and coordination of care.¹⁷

Other impediments remain too. According to a Commonwealth Fund report, only 13% of hospitals surveyed responded that they were participating or planning to participate in ACOs.¹⁸ About 75% of the hospitals reported that they were not thinking of participating at all.¹⁸

MEASURING PERFORMANCE

In private and public insurance sectors, the performance of ACOs is expected to

be made transparent. For example, consumers would be able to learn about the quality of providers so that they can make informed choices about their health care. Five domains of performance would be measured: the patient–caregiver experience; coordination of care; patient safety; preventive health care; and care of the at-risk, frail elderly population.^{3,19}

CMS regulations provide ACOs with the freedom to organize and utilize a variety of providers in expanded roles. ACOs will be required to coordinate care for Medicare beneficiaries, offer incentives to providers when appropriate, and allow for innovations in the delivery of care. It will be the responsibility of the ACOs to develop, and reimburse for, enhancements to their health care system that might not have been encouraged previously.^{4,6} Pharmacists are beginning to play a key role in advancing medication therapy management at the time of patient discharge from the hospital as well as in monitoring patients 30 days after discharge. The models for payment and staffing are being developed as ACOs begin to expand their network of providers to deliver comprehensive care that embraces nontraditional covered areas.

Finally, patients will have a greater role and responsibility with the arrival of ACOs. In addition to participating in innovative programs designed to improve or maintain health, patients will be able to participate in some ACO decision-making processes.²⁰

CONCLUSION

Health systems around the world are struggling to balance the key components of care (cost, access, and quality) with policy changes that have taken place in the U.S. They need to find a way to improve the health care landscape that takes into account changes in social policy. Through health care reform legislation and new regulations, various ACO strategies are being tested across the nation.

Other reviews of similar approaches have reported mixed results to date; it is still uncertain, therefore, whether these novel, experimental delivery models will succeed or evolve into yet another system of care.

Unlike the case with a medical experiment or a clinical study, it is difficult to control all confounding factors associated with ACOs. The complexity of the health care reform legislation itself might burden the ACO model in unintended ways,

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resulting in failure to deliver on its promises. Other factors that could threaten the success of the ACO model include sequestration of the federal budget, which would remove millions of dollars from multiple areas of the health care delivery system, and a continuing, weakened recovery from the last economic recession.

It is clear, however, that health care policy will not be returning to the pre-ACA model. P&T committees, certainly, will have to adjust to changes in the law, pay attention to emerging rules in health reform legislation in order to remain in legal compliance, and become more aware of how their recommendations for and against medications will affect the economic outlook as well as the clinical performance of their institutions.

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