Accountable Care Organizations

This Issue Brief is the first in a series that the American Pharmacists Association (APhA) is producing to help inform members of the evolving health care delivery system, in particular a predominant new delivery model—the accountable care organization (ACO). ACOs provide the profession of pharmacy the opportunity to optimize patient medication therapies as a core element of our future health care system. For more information go to APhA’s MTM Central at www.pharmacist.com.

THE ACCOUNTABLE CARE MOVEMENT
ECONOMIC FORCES ARE DRIVING NEW MODELS
Economic pressures are forcing government and commercial payers to look for new ways to curb the growth in health care costs. Many providers, recognizing the unsustainability of the current system, are enthusiastic yet cautious partners in a growing number of public and private initiatives that seek to improve health care by testing new delivery and payment models, including episodic bundled payments, patient-centered medical homes (PCMH), and most prominently ACOs.

ACCOUNTABLE CARE DIFFERS SIGNIFICANTLY FROM THE HMO MOVEMENT
The shared characteristics of the episodic bundled payment, PCMH, and ACO models are (1) risk-based payment, (2) care coordination, and (3) outcomes measurement. The combination of these facets has been heralded as a potentially transformative strategy to improve quality and lower costs. Much of the managed care movement (HMOs, PPOs, etc.) of the 1980s and 1990s was focused more on payer-driven cost controls that led to the use of gatekeeping and utilization review to lower costs, with less of an emphasis on quality. In contrast, ACOs are designed to incentivize provider-based strategies such as the development and implementation of best practices and clinically integrated decision making to eliminate waste and improve quality outcomes; cost, quality, and population health improvement are of equal importance. Another major difference is the recent focus on distributing risk to the level of the practitioner to affect behavior rather than receiving a capitated payment at the institution level, which historically tended to shield the individual physician from both the risk and rewards of improved care. Additionally, since the 1990s, there have been significant advances in health information technology enabling groups of providers to build more advanced systems of care that enhance the care management of patient populations.

ACO STRUCTURES VARY WIDELY
The archetype for the ACO model, as envisioned by academics, was the collaboration between disparate hospital and physician groups, whereby the outpatient and inpatient services could be coordinated and financially aligned through some type of joint payment (capitation, shared savings, etc.). In reality, ACO configurations have been much more diverse, ranging from merging health systems
to merging physician groups. One reason for this diversity is the proliferation of accountable care initiatives outside the official Centers for Medicare and Medicaid Services (CMS) programs (Figure 1). Among the variety of combinations, four main partnerships have begun to emerge:

**Insurer ACO:** A regional or national insurer takes the lead in organizing providers and bears the burden of ensuring accountable care (e.g., employs care coordinators in addition to providing data analytic technologies). Example: Blue Cross Blue Shield of Massachusetts ACO, MA

**Insurer-Provider ACO:** An insurer and a provider group are equal partners in providing accountable care. Both entities furnish services that are above and beyond industry expectations. Example: Carolina Advanced Health, NC

**Single Provider ACO:** An integrated delivery system receives payment for a population and takes on the responsibility of providing accountable care. The payer’s involvement is generally limited to the provision of a risk-based payment such as capitation or shared savings. Example: Billings Clinic, MT

**Multiple Provider ACO:** Two or more providers (usually a hospital and a physician organization) partner (i.e., do not own each other) to provide accountable care for a population. The insurer involvement, like the single provider ACO, is limited to the provision of a risk-based payment. Example: Optimus Health Care, CT

**ACCOUNTABLE CARE AND THE PATIENT-CENTERED MEDICAL HOME**

While the PCMH has gained much more widespread traction than the ACO model, most view the PCMH model—with its focus on primary care and preventive medicine—as merely a starting point for a more robust system of care (think of the medical home as part of the larger medical neighborhood). Some anticipate that the diffusion of the PCMH model and its focus on primary care will establish the foundation for larger systems that have the ability (and the incentives) to cover more of the care spectrum. Currently, some larger systems are looking to PCMH-accredited physician groups as prime partners for collaboration. However, some physician groups are using the PCMH model as a way of building their own ACO capabilities while taking on lower-risk contracts.

**GOVERNMENT AND COMMERCIAL INITIATIVES**

The Affordable Care Act authorized CMS to establish two ACO initiatives—the Pioneer ACO demonstration and the Medicare Shared Savings Program—which have prompted a significant response in ACO activity from the private sector in numerous markets. Well-capitalized health systems with control over much of the care spectrum were early adopters of the ACO model. However, the growth rate and total number of physician-sponsored initiatives have recently surpassed hospital-sponsored ACOs as insurers increasingly reach out to physician groups willing to assume more risk (Figure 2).
Despite similar aims, the approaches taken by public (federal and state) and private sector ACOs vary considerably (Table 1). Commercial partnerships are reassessing on a yearly basis while government contracts will be, generally speaking, evaluated every three years. The result will be faster evolution and greater flexibility outside the government programs. There is also wide variability among commercial insurers in their use of quality metrics, whereas the federal programs have done much more to standardize these measures. Therefore, providers engaging in ACO arrangements are encountering greater flexibility in the private sector but greater uniformity in public programs.

OUTLOOK

With the continued growth and dispersion of ACOs all over the country, 2014 will likely bring with it an emphasis on results. If the Medicare Shared Savings Programs yield financial savings and improved outcomes, the likelihood of the program being rolled out more broadly would naturally increase. If savings are minimal to nonexistent—but there is a measureable increase in quality—the program could see similar acceptance based on those merits.

While growth in the Medicare Shared Savings Program has been steady, CMS has signaled that there will be only one new group of ACOs announced in 2013 (three groups were announced in 2012). This reduction may be due to limited bandwidth within CMS, specifically in regard to the data-sharing requirements of the program, but perhaps also due to a potential plateau in interest from organizations with populations sufficiently large for forming an ACO. Recent developments in the Pioneer ACO program may signal broader challenges within the ACO movement, such as low tolerance for risk among providers and geographic disparities relative to historical cost trends. Initial results from the program reflect modestly positive results in year one, with only thirteen of the thirty-two participants achieving a sufficient cost reduction to receive shared savings payments from CMS. As a result, seven Pioneer ACOs have chosen to pursue accountable care through the lower-risk Medicare Shared Savings Program and two have chosen to leave the program completely. These departures indicate an emphasis on savings rather than quality. Regardless of the growth within public programs, we expect to see more providers partnering with commercial payers to continue seeking new ways to achieve the goals of accountable care.

1 Provider (or provider groups), when used in reference to ACO initiatives, tends to refer more often to groups of physicians (whether primary care or specialists) and hospitals. Most ACO initiatives focus on the primary care physicians but also involve specialists to some degree, especially when contracts are based on total cost of care.

2 The medical home is a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. (Source: Patient-Centered Primary Care Collaborative. www.pcpcc.org/about/medical-home)

ACCOUNTABLE CARE ORGANIZATIONS 101 WAS PREPARED BY THOMAS MERRILL, SENIOR ANALYST OF LEAVITT PARTNERS