

ACCOUNTABLE CARE ORGANIZATIONS

WHAT ARE ACOS?

ACOs are organizations of physicians and other health care providers who work together to improve the quality of care and reduce costs for a defined patient population. ACOs can include health systems, hospitals, physicians and physician groups, other health care providers, and insurers.

WHAT ARE ACOs TRYING TO IMPROVE?

ACOs are intended to address three main issues:

- Decrease the fragmentation of care delivery and improve accountability for the quality and cost of care of a defined patient population.
- Move provider payment methods away from a system—fee for service—that rewards volume, growth and intensity of services regardless of quality, toward value-based methods providers are rewarded for delivering high quality care efficiently.
- The presumption that more care means better care.

The Affordable Care Act (ACA) authorized Medicare to implement accountable care organizations (ACOs) to help achieve the triple aim of improving the experience of care, the health of populations, and reducing per capita costs. Along with Medicare, private payers and state Medicaid programs are embracing ACO models that typically set cost and quality targets and reward providers that meet those goals.

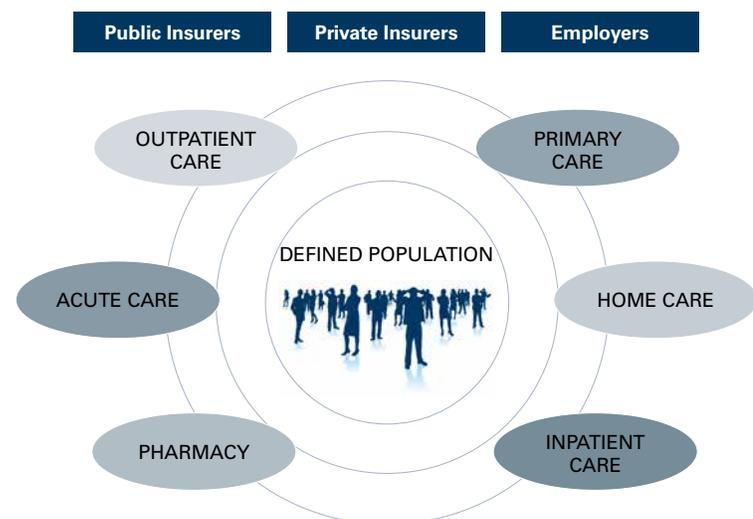
ACOs are widely seen as a key ACA component to control health care spending, which historically has grown at a faster rate than wages and the overall economy, making health care increasingly unaffordable for more Americans. This brief provides a general overview of ACOs in the U.S. and parallel developments in Virginia.

ACO MODEL

Improve the Quality and Experience of Care, Improve the Health of Populations and Reduce Per Capita Costs

LEADERSHIP

DATA MANAGEMENT, CARE COORDINATION



CURRENT STATE OF ACOs IN THE U.S. AND VIRGINIA

Since 2010, the number of ACOs has been growing steadily in the U.S. In 2014, the total number of private and Medicare ACOs exceeded 600, covering approximately more than 20 million Americans.¹ The majority of ACOs are located in large metropolitan areas, with the most populous states – California, Florida and Texas – having 30 or more ACOs each.²

CURRENT STATE OF ACOs IN THE U.S. AND VIRGINIA (CONT.)



KEY IMPLICATION

As providers commit to new ways of reimbursement and delivery of care for private and public payers, both Medicare and private ACO models will influence costs, experiences with care, and health outcomes.

For example, while federally-backed ACOs drive ACO formation, private ACOs have the flexibility to experiment with different models of delivery and payment. As no dominant ACO model exists, we can expect further innovations in Virginia's health care delivery system.

In Virginia there are currently 18 Medicare Shared Savings Program (MSSP) ACOs, when private entities are included, ACOs together cover 5-10% of Virginians.³ The MSSP ACOs receive financial rewards for controlling costs while improving care delivery. To determine an individual ACO's share of savings, the MSSP calculates initial benchmark costs based on per capita Medicare inpatient and outpatient expenditures on beneficiaries assigned to the ACO averaged over 3 years prior to the ACOs formation.⁴

Preliminary data from 7 of the Virginia MSSP ACOs indicate costs have been reduced by 2% below their benchmark, earning shared savings payments of nearly \$16 million. These data also show ACOs operating in Virginia are, on average, in the 80th percentile or above in performance on several measures related to patient experience (i.e., getting timely care, appointments, and information, how well doctors communicate, and patient's ratings of their doctor), preventive health (i.e. tobacco use assessment and cessation intervention), and controlling the blood sugar levels of diabetics. However, these ACOs, on average, perform at or below the 50th percentile in, among other areas, vaccinating for influenza and pneumonia and screening for depression.⁵

OUTLOOK

Due to the rapid development of ACOs, research on ACOs has been conducted piecemeal, relying mainly on narrow studies of individual, non-hospital ACO pilots and pre-ACO data. Nevertheless, early evidence suggests that payment innovations may improve quality of care and contain costs.⁶ For hospital-led organizations, health systems with centralized leadership may serve as effective platforms for ACO development.⁷ Better quality outcomes and lower spending may be associated with physician-led organizations, due to larger physician groups' size, greater proportions of affiliated primary care physicians (PCPs), and location in areas with high Health Maintenance Organization (HMO) penetration.⁸

While coordinated care delivery among ACOs is necessary to achieve the triple aim, shifts toward more highly integrated systems may have unintended consequences. Consolidation of providers could lead to a higher degree of market power, and with that, the ability to extract higher prices from some purchasers.

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¹Petersen M, Gardner P, Tu T, Muhlestein D, Growth and Dispersion of Accountable Care Organizations: June 2014 Update. ²Muhlestein D, Continued Growth of Public and Private Accountable Care Organizations, Health Affairs Blog February 19, 2013. Available at <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/> ³Medicare Shared Savings Program Accountable Care Organizations. Available from: <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-0/ay8x-m5k6> ⁴Centers for Medicare and Medicaid Services; 2013. Available from: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/FAQ.html> ⁵Medicare Shared Savings Program Accountable Care Organizations Performance Year 1. Available from: <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-0/yuq5-65xt> ⁶Song Z, Safran DG, Landon BE, He Y, Ellis RP, Mechanic RE, Day MP, Chernew ME. Health care spending and quality in year 1 of the alternative quality contract. N Engl J Med. 2011 Sep 8;365(10):909-18. ⁷Chukmaitov A., David W. Harless, Gloria J. Bazzoli, Henry Carretta, Siangphoe U. (2014) "Delivery System Characteristics and their Association with Quality and Costs of Care: Implications for Accountable Care Organizations" Health Care Management Review. 2014 Feb 21. [Epub ahead of print] PubMed PMID: 24566250. ⁸McWilliams JM, Chernew ME, Zaslavsky AM, Hamed P, Landon BE. Delivery system integration and health care spending and quality for Medicare beneficiaries [published online June 17, 2013]. JAMA Intern Med. doi:10.1001/jamainternmed.2013.6886.