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.

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. 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.
In Virginia there are currently 18 Medicare Shared Savings Program (MSSP) ACOs, when private entities are included, ACOs together cover 5-10% of Virginians. The MSSP ACOs receive financial rewards for controlling costs while improving care delivery. To determine an individual ACOs 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.

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.

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