Accountable Care Organizations: Evolution of Care Delivery and Provider Compensation in the U.S.

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"How can the best medical care in the world cost twice as much as the best medical care in the world?"[1]

Dartmouth Professor Elliot Fisher asked this question at a 2006 meeting of the Medicare Payment Advisory Commission on regional variation in spending and outcomes. Fisher pointed out higher spending regions fail to deliver higher quality care. As redress for a fee-for-service system that rewards volume without regard to quality or cost, Fisher suggested the formation of what he called "accountable care organizations (ACOs)." He envisioned ACOs as groups of providers charged with population health management, compensated according to the value of care (defined as Quality/Cost) rather than its volume.

Four years ago, the Affordable Care Act put money behind the ACO movement, offering ACOs a share of any savings they could generate among Medicare beneficiaries. Since then, roughly 500 ACOs have emerged.[2] The movement has expanded well beyond Medicare ACOs to include commercial and Medicaid ACOs. ACOs serve 1–10% of the population in a majority of states, up to a maximum of 25% in Oregon.[3] By one estimate, ACOs currently serve between 37 million and 43 million patients.[4]

As with any organizational evolution, ACOs have changed beyond the "extended hospital medical staff" envisioned by Fisher. ACOs today may be comprised of medical groups and may not always include hospitals. Moreover, ACO sub-types have emerged and include Totally Accountable Care Organizations (TACOs), which are Medicaid ACOs that provide medical care but also mental healthcare, substance abuse treatment, and social supports addressing problems like homelessness.[5]

Amidst all the media attention, pharmaceutical and device manufacturers are asking three questions about ACOs.

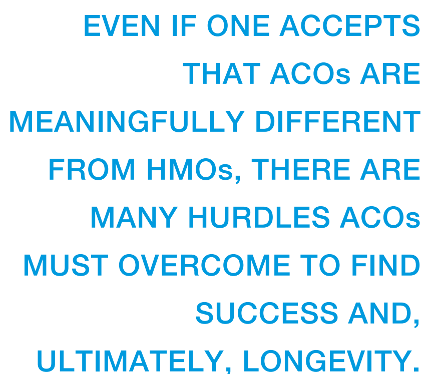
1. Are ACOs here to stay?
2. What impact should I expect for my products?
3. What can I do to successfully navigate the ACO environment?

1. ARE ACOs HERE TO STAY?

Probably the best approach to this question is to ask a slightly different one: are ACOs just thinly disguised versions of their HMO cousins, doomed to the same failures of the early 1990s? Detractors have made this case, yet if ACOs fail, it won't be for the same reasons as HMOs.

First, ACOs are compensated differently from HMOs. HMOs were paid via capitation without any meaningful quality-based metrics tied to the capitated rate. Just as fee-for-service promotes overutilization, capitation promoted underutilization. If ACOs are too frugal with care, it may impact the quality measures. Furthermore, as ACOs are geography-based, rather than employer-based, the patient population is not expected to change rapidly, so ACOs will likely retain populations for longer than traditional insurance plans.

Second, computer technology and the ability to monitor metrics have far outpaced that used by HMOs of the early 1990s. An efficient Electronic Health Record (EHR) system is a *sine qua non* for a successful ACO. EHRs allow the real-time data sharing and access to sophisticated clinical decision support tools ACOs need in order to fulfill their promise of better care coordination. Having pathway models and these tools at providers' fingertips can help keep them "on pathway" and allow sophisticated analyses, such as risk stratification, to identify high utilizers for focused intervention.



Third, patients do not join ACOs as they did HMOs, and many are not aware that they are in ACOs. Rather, their providers join ACOs. Without the affirmative requirement to join, patient awareness that they are managed by providers in an ACO will likely remain low. This lack of awareness reduces the odds of patients resisting the structure.

Fourth, a key source of patient complaints during the HMO revolution was payers' authority to restrict patients to particular providers. Unlike HMOs, ACOs are not empowered to restrict patient choice in this way. For example, a patient served by a Medicare ACO may see any provider who accepts Medicare — regardless of whether the provider participates in the ACO.

Even if one accepts that ACOs are meaningfully different from HMOs, there are many hurdles ACOs must overcome to find success and, ultimately, longevity.

Technology

One challenge concerns the same technology that will drive ACOs' success. EHR systems are produced by different manufacturers who do not necessarily make their systems compatible with one another. Providers within an ACO may not be using the same EHR system. Just as problematic, the ACO's EHR may not communicate with systems used by all of the ACOs' third-party payers. If the ACO cannot use its system to effectively coordinate care, that part of the ACO value proposition collapses. The Office of Standards and Interoperability at the Department of Health and Human Services recognizes this challenge and is working to ensure that EHR systems can communicate with one another.[6]

Incentives

Incentives pose the second major challenge for ACOs. The expectation is that ACOs will be paid via risk sharing. The Medicare Shared Savings Program was set up to phase in risk sharing during later years; however, it began with shared savings or the positive incentive for risk sharing. Most initial commercial ACO contracts are also limited to the upside potential only. Payers and ACO executives have indicated there is a simple reason for this: providers are loath to adopt downside risk before proving the risk is minimal. Related to this is the financial potential. Will physicians change the way they practice for a bonus that may represent 2% or 3% of income? What about 5%? How much is enough to change providers' behavior?

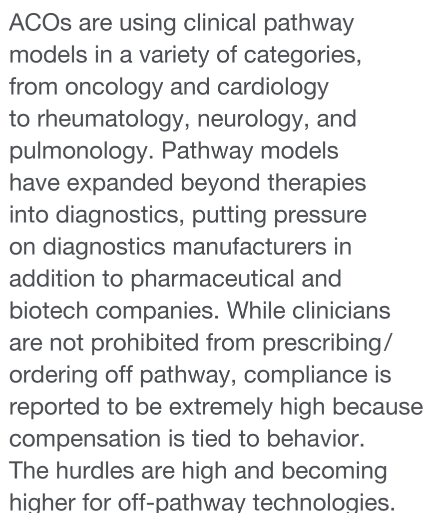
Tracking Utilization

Patients have the right to decline sharing of their personal health information among ACO's providers. ACO executives are concerned about this, increasingly so after data breaches among the recently launched healthcare exchanges. It is conceivable that the public will decline to grant ACOs permission to share their data in sufficient numbers to allow ACOs to reach their potential in oversight of a population to determine interventions that will improve health.

Even when patients consent to have their data shared within an ACO, the ACO may not be able to track patients as thoroughly as necessary. The best example to date concerns ACOs that lack hospitals and thereby have difficulty tracking hospital admissions. Inability to accurately track utilization will make calculation of performance, and ultimately payment, difficult, if not impossible.

2. WHAT IMPACT SHOULD I EXPECT FOR MY PRODUCTS?

As their time horizons lengthen, ACO executives will be focused on the prevention of use of more intensive services and early intervention, as well as evidence-based medicine. ACOs are investing heavily in case managers and hospital discharge planners to keep patients healthier and ensure care transitions are smooth. In addition, there is growth in the use of clinical pathways.



ACOs are using clinical pathway models in a variety of categories, from oncology and cardiology to rheumatology, neurology, and pulmonology. Pathway models have expanded beyond therapies into diagnostics, putting pressure on diagnostics manufacturers in addition to pharmaceutical and biotech companies. While clinicians are not prohibited from prescribing/ordering off pathway, compliance is reported to be extremely high because compensation is tied to behavior. The hurdles are high and becoming higher for off-pathway technologies.

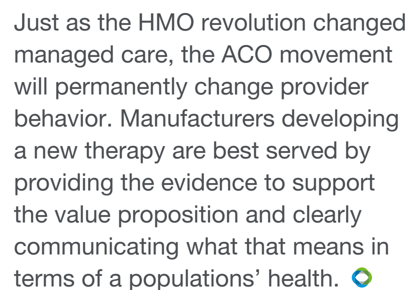
Bundled/episodic payment in some categories is putting price pressure on a variety of products and services and further supports the use of pathways. This type of compensation previously was limited to transplants and labor and delivery. There is, however, increased focus on areas where variation in quality and cost are high, particularly orthopedic procedures such as knee and hip replacements.

Overall drug use is expected to rise as ACOs seek to shift appropriate cases from the surgical theater to the office setting to reduce costs. The mix of drugs is likely to shift as pressure to prescribe generics and biosimilars, which is already strong, gets even stronger. Use of clinical pathway models supported by clinical decision support tools, with compensation tied to prescribing decisions, is expected to facilitate this shift.

3. WHAT CAN I DO TO SUCCESSFULLY NAVIGATE THE ACO ENVIRONMENT?

To successfully access the ACO market, manufacturers need to invest heavily in clinical, economic, and humanistic **evidence generation**. ACOs demand evidence that drugs, devices, and diagnostics have positive impact on the value equation. This means boosting the quality of care, reducing the cost of care, or both. Less than budget impact, ACOs are looking at **value impact**.

Communication regarding a new therapy's value proposition will be key as ACOs seek to invest in technology that helps them shift care out of the hospital and into the home or office, and prevent rather than acutely treat. Manufacturers of home healthcare and tele-health technologies, as well as evidence-based screening and diagnostic tools, have a clear message to which ACOs should be receptive, while manufacturers of chronic care therapies will need to emphasize the impact of disease management and adherence programs for the ACO's population over time.



Just as the HMO revolution changed managed care, the ACO movement will permanently change provider behavior. Manufacturers developing a new therapy are best served by providing the evidence to support the value proposition and clearly communicating what that means in terms of a populations' health.

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