ACCOUNTABLE CARE ORGANIZATIONS: A GATEWAY TO A VALUE-BASED DELIVERY SYSTEM

Elements of ACO Models

The goal of ACO models is to improve health care quality while controlling costs. To accomplish this, ACO models typically address the following areas:

1. **Care Delivery Transformation:** Effective ACO models incorporate defined strategies for supporting team-based care, ensuring communication across providers for care coordination, improving patient access to care, and engaging patients in managing chronic conditions.
2. **Financial Model:** ACOs transition providers from fee-for-service to value-based payment arrangements. These arrangements typically increase a provider's financial risk over time. Common payment approaches include upside-only shared savings, two-sided shared savings/loss arrangements and capitation models. All financial models should clearly define the methodology for calculating financial benchmarks and attributing the patients for which an ACO is accountable.
3. **Quality Measurement:** ACO models should incorporate quality measures that allow for the monitoring of population level outcomes, guard against underutilization of necessary services, incentivize providers to focus on priority populations or conditions, and provide actionable care delivery information to all providers.
4. **Information/Data Sharing:** Data is essential for ACOs to effectively manage the health of their attributed patients. ACO models must have established processes for routine data sharing between payers and providers to promote effective care management.

Accountable Care Organizations (ACOs) are formal networks of health care providers that accept financial responsibility for the cost and quality of care delivered to a group of attributed patients. ACO models are grounded on providing effective care coordination, improving patient outcomes, focusing on wellness and health, and reducing unnecessary care.

Under the George W. Bush Administration, the Centers for Medicare and Medicaid Services (CMS) began testing core ACO concepts with the launch of the Physician Group Practice Demonstration (PGP) that operated from 2005 to 2010. The PGP model encouraged coordination across Medicare Part A and Part B services, promoted investment in care management and process improvement for clinical care teams, and created incentives for providers to improve health outcomes. PGP model providers received Medicare fee-for-service payments and could also earn shared savings payments based on their performance on quality and cost efficiency measures. The ten physician groups that participated in PGP all saw improvements in quality, especially on chronic condition measures, and roughly half qualified for shared savings payments each year.

The success of the PGP model led to widespread support for the inclusion of ACOs as a new care delivery model in the 2010 Affordable Care Act (ACA). The ACA established the Medicare Shared Savings Program (MSSP) - a voluntary, permanent program where Medicare providers and suppliers could create ACOs – and also chartered the Center for Medicare and Medicaid Innovation (CMMI) to design and test other health care reforms including new ACOs and other value-based payment models such as bundled payments.

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Under the Obama Administration, CMMI launched advanced ACO models through several demonstration projects. Two of the most important efforts to date are: (1) the Pioneer ACO Model (2012-2016) and (2) Next Generation ACO Model (2016 to present). These models offered enhanced shared savings opportunities while imposing greater financial risk requirements for experienced ACOs. Both models have been successful.

Value-based payment policies and models, including ACOs, have contributed greatly to bending the cost curve of national health expenditures over the last ten years. The Pioneer ACO demonstration's success resulted in its permanent inclusion in the Medicare program.

The Success of ACOs: Growth and Impact

- **ACOs have contributed to slowing the growth in health care costs:** Value-based payment policies and models (including ACOs) have contributed greatly to the enduring slowdown in national health expenditures over the last ten years. A report from the Office of the Inspector General found that MSSP ACOs generated $1 billion in savings during the first three years of the program and improved performance on 82 percent of quality measures.
- **ACOs have demonstrated improved care coordination and quality:** A 2019 study found that ACO-affiliated hospitals were more likely to implement care coordination strategies. Another study found that coordination efforts resulted in a 21 percent in inpatient admissions and a 22 percent reduction in total medical expenditures.
- **ACOs promote the shift to value-based care:** ACOs have become an increasingly common and important pathway for providers moving from FFS to value-based payments. A 2019 study found that ACOs cared for over 44 million Americans nationwide (60 percent under commercial, 30 percent under Medicare, and 10 percent under Medicaid contracts). Furthermore, the proportion of ACOs accepting downside risk grew from around 18 percent in 2015 to 30 percent in 2019. ACO adoption has had beneficial spillover effects across the health care system. As providers adapt their practices to deliver high-value care, they also raise the expected standard of care for the providers and patients outside ACOs.
- **ACOs increase the use of preventative care:** A study of Medicare beneficiaries found that the prevalence of breast and prostate cancer screening was 10 and 14 percent higher respectively among those enrolled in ACOs compared to those treated by FFS providers. Another study examining the rate of annual wellness visits found that 25.9 percent of patients in an ACO received a visit compared with 17.6 percent of those not in an ACO.
- **ACOs improve the health care systems ability to respond to emergencies:** Interviews with ACOs detail how investments in data infrastructure, care coordination, and training combined with financial flexibility afforded by value-based payment models allowed them more effectively respond to the needs of patients during the COVID-19 emergency.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for its members, the Task Force is also a leading national voice on value-based payment and care delivery transformation.

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