Special Article

Accountable Care Organizations and the Allergist: Challenges and Opportunities

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For decades, health care policy experts have wrestled with ways to solve problems of access, cost, and quality in US health care. The current consensus is that the solution to all three lies in changing financial incentives for providers and delivering care through integrated systems. The currently favored vehicle for this, both in the public and private sectors, is through Accountable Care Organizations (ACOs). Medicare has several models and has fostered rapid growth in the number of operative ACOs. At least an equal number of private ACOs are in operation. Whether or not these organizations will fulfill their promise is unknown but there is reason for cautious optimism. Allergists can and should be part of the process of this transformation in our health care system. They can be integral to helping these organizations save money by reducing hospitalizations and improving the quality of allergy and asthma care in the populations served. In order to accomplish this, allergists must become more involved in their medical communities and hospitals. © 2014 American Academy of Allergy, Asthma & Immunology (J Allergy Clin Immunol Pract 2014;2:34-9)

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The American health care system has been the subject of concern by policy makers for nearly a century because it is imperfect in 3 major realms: access, cost, and quality. Calls for reform date back to the presidency of Theodore Roosevelt (through that of his cousin Franklin), and Franklin D. Roosevelt's successor Harry Truman, who advocated for a national health system. Medicare and Medicaid under President Lyndon Johnson set about helping seniors and low-income people get care that had eluded them and President Richard Nixon led the efforts to rein in spending for health care by establishing health maintenance organizations and managed care. President and Mrs Clinton attempted and failed to get comprehensive reform in the 1990s, and the factors that motivated all these leaders to achieve some measure of change only continued to become more acute over the next decade. It was only with the passage of the Patient Protection and Affordable Care Act in 2010 and the upholding of its central provision, the individual mandate, by the Supreme Court in 2012, that real change became possible.

The realities that health policy makers confronted in 2008 when President Obama was elected included millions of Americans who lacked insurance coverage for medical expenses. As of 2010, nearly 50 million Americans lacked health insurance. Many Americans were being deprived of essential health care, often with disastrous results for them or their families.[1] This is the problem of access.

Comparison of the costs of medical care between the United States and the rest of the developed world showed that the United States was spending nearly twice as much on medical care as the next highest-cost country, Switzerland.[2] This is the problem of cost. Unfortunately, there is no evidence that spending more was getting Americans better outcomes. In fact, by many measures, Americans live shorter and unhealthier lives than most Western Europeans. Outcomes are not commensurate with cost. We pay a lot for care that may not be cost effective and for new methods of diagnosis and treatment that are expensive without demonstrable improvement in results.

Finally, too many errors are made in our system. This problem was highlighted by the landmark Institute of Medicine report of 1999, which estimated there are 100,000 unnecessary deaths a year in US hospitals because of errors, many of which are avoidable.[3] These usually are systems errors, not mistakes made by individuals, which implies that the systems need repair, not that health care providers need remediation. These are the problems of quality.

The outcry for change comes, not just from policy makers and analyst but also from employers, for whom medical insurance is one of their major costs and for whom suboptimal employee health is a significant cause of lost productivity. Thus, calls for reform and initiatives for change come from both public and private sectors, and both of which are key to explosive growth in interest in forming accountable care organizations (ACO). It is postulated (and hoped) that costs can be reduced by improving quality through better coordination of care in integrated health care organizational structures in which payment incentives encourage efficient and quality-driven care, or, as is popular to

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Abbreviations used
ACO- Accountable care organizations
CMS- Centers for Medicare and Medicaid Services
FFS- Fee-for-service
IT- Information technology
PCMH- Patient-centered medical home
PCP- Primary care physician
TIN- Tax identification number

say among health policy gurus, the system becomes value, not quantity, driven.

So, what is an ACO? ACO refers to a legal entity composed of a group of providers that assume responsibility (are accountable) to manage and coordinate care for a defined group of patients in an effective (high quality) and efficient (low cost) manner. Any of the following entities can form ACOs:

- Group practices
- Integrated delivery systems (eg, Geisinger Health System)
- Networks of individual practices (eg, independent practice associations)
- Partnerships or joint venture arrangements between hospitals and other providers (eg, Physician Hospital Organization)
- Hospitals employing other providers
- Regional collaborations of health providers (North Carolina Community Connections 646 Project) (S. Erickson, personal communication, August 2012)

ACOs have 2 major sets of functions, clinical and administrative. Clinical functions include coordination of clinical efforts among all participating providers (eg, primary care, specialists, and inpatient facilities), facilitating the delivery of more effective and efficient care through increased care access, population management, care management and care self-management education, and facilitating the ability to translate patient clinical and service use data to promote more effective care and establish clinical guidelines to more effectively care for these patients.

Administrative functions consist of establishing infrastructure for administration and governance, providing information technology, developing budgets, contracting with providers and establishing provider payment procedures, contracting with payers, and managing risk when necessary. The composition of ACOs includes primary care physicians, specialists, and, often but not necessarily, hospitals. Primary care physicians (PCPs) are considered to be the essential foundations of ACOs. There is considerable data that PCPs improve care access, provide preventative care, coordinate care, and can limit unnecessary emergency department and in-patient care.[4] Specialists may or may not be included in ACOs, either as participants or as contracted providers. Specialists could also form their own ACOs but not under Medicare. Hospitals often form their own ACOs because they have the access to capital and the infrastructure required to operate such systems. Their formation of ACOs accounts for their purchasing physician practices to "capture" them for the organization. Other organizational arrangements also exist in which entrepreneurs are founding ACOs in the private market. Even insurance companies are involved as partners with hospital systems or, in some instances, purchasing hospital systems to develop their own ACOs.

Various payment models have been used to pay ACOs and, within ACOs, to pay physicians. The shared savings model payment is based on the savings in health care costs achieved in a defined population over a specific time (usually 1 year) compared with previous risk-adjusted benchmark for the population with quality measures included. The savings are split between providers and payers. In this model, providers are typically paid on a fee-for-service (FFS) basis. That payment may include a monthly bundled severity-adjusted care coordination fee and a performance-related bonus based on meeting quality measures. Another model is a partially capitated, bundled payment. This model is often linked to care for specific disease states, such as diabetes or congestive heart failure or to episodes of care, for example, pneumonia. A third popular model, in private but not federally funded ACOs, is full capitation in which there is a per patient per month payment. These payments are typically risk adjusted and include a quality component. This is used for ACOs set up by large health care organizations that have considerable experience in managing complex health care systems and are sufficiently capitalized to take on risk.

In theory, it is believed that ACOs hold considerable promise in improving the quality of care by putting PCPs at the center of a patient's care. The patient-centered medical home (PCMH) is seen as the cornerstone of a successful ACO and encourages a team approach, with close coordination of efforts among members of the patient's health care team, the patients, their families, and, if appropriate, the community. It is believed that changing incentives through movement away from FFS and inclusion of quality measures in reimbursement will change the behavior of providers.

The current status of ACOs is that, as of February 2013, there were 429 ACOs in 49 states,[5] of which 250 were Medicare sponsored. Currently, there are as many physician-led groups as hospital-based ACOs, and physician-led groups are the faster-growing segment.[6] More are being formed all the time. Medicare expects to approve new ACOs annually. The Affordable Care Act mandated the formation of ACOs under Medicare in an effort to encourage this major transformation of how health care is delivered in this country. There are 2 major models of Medicare health maintenance organizations, the Shared Savings and Pioneer models.

There are more than 250 Medicare Shared Savings model ACOs currently operating or approved. The ACO and Medicare share any savings above 2% (lower savings might be due to statistical noise variations). One variation on this method is a 2-sided sharing in which the ACO also shares in losses, but they can then get a higher percentage of any savings. The savings are determined retrospectively by comparing the costs of care in that year with a comparable group of Medicare patients not participating in the ACO.

Another variant on this model is the Advance Payment model in which Medicare will subsidize the ACO formation and Medicare will recoup those costs through the savings generated. This is for smaller, typically rural, groups of providers that do not have the resources needed to set up an ACO. Finally, there currently are 32 Pioneer model ACOs operating under Medicare. But, in July 2013, 9 announced that they were dropping out of the Pioneer program. Seven wanted to go to the Shared Savings plan because the quality measure achievements for the next year were too burdensome. Two groups are dropping out entirely.[7] Those organizations staying with the Pioneer model will have to accept global payments, within 3 years, from Medicare, and 50% of their private contracts will have to be risk based by then. They will take on risk for the total care of the patient. This is only for larger, experienced integrated delivery systems such as Partners Healthcare in Boston.