Future considerations for clinical dermatology in the setting of 21st century American policy reform: Accountable Care Organizations

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An Accountable Care Organization (ACO) is a network of providers that collaborates to manage care and is financially incentivized to realize cost savings while also optimizing standards of care. Since its introduction as part of the 2010 Patient Protection and Affordable Care Act, ACOs have grown to include 16% of Medicare beneficiaries and currently represent Medicare's largest payment initiative. Although ACOs are still in the pilot phase with multiple structural models being assessed, incentives are being introduced to encourage specialist participation, and dermatologists will have the opportunity to influence both the cost savings and quality standard aspects of these organizations. In this article, part of a health care policy series targeted to dermatologists, we review what an ACO is, its relevance to dermatologists, and essential factors to consider when joining and negotiating with an ACO. (J Am Acad Dermatol 2017;76:170-6.)

Key words: Accountable Care Organizations; Affordable Care Act; health care reform; health policy; management.

INTRODUCTION

In this article (the first in the *Health Policy & Practice* section), we describe the structure of Accountable Care Organizations (ACOs) and present a framework to help dermatologists decide whether ACO participation is right for their practice setting. Of note, although many private insurance companies and state Medicaid programs now use integrative ACO structures, this article will focus on the more standardized Medicare ACOs.

Abbreviations used:

AAD:	American Academy of Dermatology
ACO:	Accountable Care Organization
CMS:	Centers for Medicare and Medicaid Services
MSSP:	Medicare Shared Savings Program
MACRA:	Medicare Access and Children's Health Insurance Program Reauthorization Act

What is an ACO, and why was it created?

In 2014, US national health care expenditure was approximately $9403 per capita (third highest worldwide) and accounted for 17.1% of the nation's gross domestic product, nearly double the metric for the European Union.[1] One commonly cited origin of the high expenditure is the lack of patient care coordination that has frequently resulted in duplicative or fragmented care. Studies have demonstrated that more coordinated care often costs less, for instance, by preventing 2 providers from ordering the same test.[2] Conceived as a mechanism for unifying care and subsequently included as part of the 2010 Patient Protection and Affordable Care Act, an ACO is a network of providers that collaborates to manage care and is financially incentivized to realize cost savings while optimizing standards of care. ACOs that meet or

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Funding sources: None.
Conflicts of interest: None declared.
Accepted for publication July 29, 2016.

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Published online October 1, 2016.
0190-9622/$36.00

http://dx.doi.org/10.1016/j.jaad.2016.07.063

exceed a prescribed minimum savings rate *and* satisfy minimum quality standards receive a portion of the savings that the organization generated ("shared savings"). On a fundamental level, ACOs are simply an umbrella concept that refers to the linking of health delivery organizations with payment and performance measurements.

Quality measures must be met for an ACO to qualify for shared savings from the Centers for Medicare and Medicaid Services (CMS). These 34 measures span 4 quality domains—Patient Experience of Care, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population—and align with quality measures used in other CMS programs.[3] Providers must meet minimum performance standards to simply qualify for shared savings, if existent. Of the maximum amount of shared savings that an ACO is eligible to receive (discussed below), the actual amount awarded to the ACO is based on a performance score that CMS determines using data from the ACO quality measures. Thus, providers are incentivized not just to meet standards of care but to exceed them.

Under the CMS agreement, Medicare continues to pay individual ACO providers for services as it currently does under the Medicare fee-for-service payment system. In addition to fee-for-service payments, ACOs are rewarded or penalized based on their total annual spending for a population of beneficiaries as compared with a historical benchmark. The CMS develops this unique financial benchmark for each ACO based on the organization's per-beneficiary expenditures over the previous 3 years for Medicare fee-for-service Parts A and B. This benchmark is also updated for each contract year on the basis of national Medicare spending growth.

Two major characteristics differentiate contemporary ACOs from the managed care (eg, Medicare Advantage programs) or capitated care systems that were prevalent in the 1990s: ACO reimbursement remains fee-for-service and beneficiaries are still able to see any Medicare-enrolled provider they choose, including providers outside of the ACO. This design is intended to provide the benefits of managed care while maintaining patient choice in selecting a provider.

Why should dermatologists care?

Since the introduction of ACOs as part of the Affordable Care Act, the number of Medicare ACOs has grown to 442 and, as of May 2016, included 8.9 million beneficiaries, or approximately 16% of all Medicare beneficiaries.[4,5] Although the ACO model is still in the pilot phase, ACOs represent Medicare's largest payment initiative, and it is likely that ACOs will be integrated into future Medicare-associated practice models in some capacity.[6] In fact, participating ACOs helped CMS achieve its goal of tying 30% of all Medicare payments to alternative payment models by 2016, a threshold that CMS hopes to increase to 50% by 2018.[7]

Incentives are being introduced to encourage specialist participation, which has been demonstrated to improve organizational efficiency.[6] Specifically, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) has delineated Track 2 and Track 3 ACOs as qualified advanced alternative payment models, exempting all providers who bill through a Track 2 or Track 3 ACO participant taxpayer identification number from the reporting requirements of the Merit-Based Incentive Payment System.[8] (Other alternative payment models and the impact of MACRA and Merit-Based Incentive Payment System will be discussed in a forthcoming piece of this series.)

Currently, participation in an ACO remains completely voluntary. Based on an American Academy of Dermatology (AAD) Member Practice Profile Survey conducted in December 2014 to January 2015 (distributed to a representative sample of 7031 members with a response rate of 28.5%), 19.5% of dermatologists either already belong to or will soon belong to an ACO, with an additional 8.6% reporting interest in joining an ACO in the immediate future.

Of the current ACO quality domains (Patient Experience of Care, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population), the domain that dermatologists can directly influence is Patient Experience of Care, which is predominantly a measure of patient satisfaction. (The other domains specifically target primary care—related services, such as colorectal cancer screening, readmission rates, and management of diabetes.[9]) Financially, dermatologists can help an ACO with cost savings, for example, by reducing unnecessary hospitalizations and inappropriate antibiotic use for cellulitis/pseudocellulitis or by more accurately diagnosing pigmented skin lesions and cutaneous fungal infections, thereby lowering biopsy rates of benign lesions and prescriptions for inappropriate topical medications, respectively.[10-12] Thus, when considering the 2 ACO aims of meeting quality standards and realizing cost savings, both realms represent salient opportunities for dermatologists to impact the ACO in a positive manner.