de la Torre JI, Varacallo M. Accountable Care Organization (ACO). 2018 Nov 13. StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2018 Jan-. [PubMed: 28846320]

Accountable Care Organization (ACO)

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Last Update: November 13, 2018.

Introduction

The Affordable Care Act (ACA) has as its primary goal, the creation of value for the patients of our healthcare system. One of the main ways it accomplishes value-based outcomes is driven by incentivizing doctors, hospitals, and healthcare providers to coordinate clinically efficient patient care. The healthcare providers become eligible for various (financial and/or other occupationally-based) bonuses when clinical care is delivered effectively with quality outcomes. [0] Strategies such as the Bundled Payment Care Initiative (BPCI) and Affordable Care Organizations (ACOs) will emphasize reducing expensive and unnecessary services becoming more cost-effective for patients. [0] Hospitals and physicians must meet specific quality benchmarks, which focus on disease prevention, carefully managing patients with chronic diseases and keeping patients healthy.

The term ACO was originally coined by researchers and policy experts to describe entities that consist of responsibly integrated healthcare providers that all are working toward achieving a common clinical goal and outcome: efficient, high quality, patient care while utilizing a common clinical pathway that incoporates principles of treament and therapeutic modalities in a multifaceted provider setting. [3]

There are three core Affordable Care Organizations principles: [0]

1. Provider-led organizations with a strong base of primary care that is accountable for quality and per capita costs
2. Payments linked to improvement in quality and reduced costs
3. Reliable and increasingly sophisticated measurement of performance, to support improvement and provide confidence care is improved, and cost savings occur.

Function

To achieve these goals, the Affordable Care Act significantly changed the way healthcare is offered and how healthcare providers are reimbursed. While the primary purpose of the Affordable Care Act is to provide all Americans with access to affordable health insurance, various components will potentially have a significant

being replaced by a variety of managed care initiatives. The Affordable Care Act proposes to further reform of the health care service-delivery system through the establishment of Accountable Care Organization and the Bundled Care Payment Initiative through the Medicare program. The implementation of both the Affordable Care Organization and Bundled Care Payment Initiative seeks to incentivize and facilitate integrated, coordinated medical care. Affordable Care Organization initiatives try to achieve this through organizational structure reforms, while the bundled payment initiative looks to do so with payment reforms.

Affordable Care Organizations place financial responsibility on providers in hopes of improving patient management and decreasing unnecessary expenditures, while providing patients with the freedom to select medical service providers. The Affordable Care Organizations model promotes clinical excellence while simultaneously controlling costs. This cost-control depends on the Affordable Care Organization's ability to incentivize hospitals, physicians, post-acute care facilities, and other providers to form partnerships and promote better coordination of care delivery. By increasing care coordination, Affordable Care Organizations hope to reduce unnecessary medical care and improve health outcomes. According to the Centers for Medicare and Medicaid Services (CMS) estimates, Affordable Care Organizations implementation is estimated to result in a median savings of $470 million from 2012 through 2015.

Issues of Concern

Affordable Care Organizations (ACOs) were a significant component of the Affordable Care Act as they proposed a method for cost containment within the healthcare system. As the healthcare field shifts from the traditional fee-for-service (FFS) model, alternative payment schemes have focused ACOS and BPCIs.

Bundled Payment Care Initiatives (BPCIs)

BPCIs have become increasingly popular in various, selective fields of predictable surgeries (i.e. elective procedures) such as total joint replacements.[5][6] Furthermore, in future fields and evolving areas across subspecialties like orthopedic surgery, BPCI models are potentially being implemented and/or becoming experimental in diagnostic related groups such as hip fracture patients, elective cervical spine procedures (ACDFs), and isolated surgical extremity trauma. [7]

Accountable Care Organizations (ACOs)

Instead of bundling all the cost for a single episode of care as in the Bundled Payment Care Initiative, ACOs measure the specific quality outcomes over a 3-year period and requires demonstrated improved outcomes.

For the Affordable Care Organization, “this emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that [Affordable Care Organizations] should have at least limited accountability for achieving these improvements while caring for a defined population of patients". [8]

Stakeholders in Affordable Care Organizations Include:

Healthcare providers

Affordable Care Organizations are composed mostly of hospitals and healthcare professionals. Depending on the Affordable Care Organization level of integration, providers may include health departments, social security departments, safety net clinics, and home care services. The providers within an Affordable Care Organization work coordinate care, align incentives, and lower costs. Affordable Care Organization are different from Health Maintenance Organizations (HMO) in that providers have more freedom in developing the infrastructure. Any provider or provider organization may assume the leadership role.

Payors (insurance companies, third-party organizations)

Medicare is the Affordable Care Organization principal payer. Other payers include private insurances and employer-purchased insurance. Payers play several roles in Affordable Care Organization to help achieve higher quality care and lower expenditures. Payers may collaborate to align incentives for Affordable Care Organization and create financial incentives for providers to improve healthcare quality.

Patients

more integrated Affordable Care Organization, the patient population includes uninsured patients. Patients may play a role in the healthcare they receive by participating in the decision-making processes.

The Medicare Shared Savings Program allows a variety of providers, including post-acute care provider, who voluntarily agrees to coordinate care for patients. They must, however, meet certain quality metrics to share in any savings they achieve. Those Affordable Care Organizations that elect to share losses have the opportunity to also share in greater savings. The success of each Affordable Care Organization is determined by approximately 30 quality measures organized into four domains. These domains include patient experience, care coordination, safety, and preventive health in at-risk populations. The higher the quality of care providers deliver, the more shared savings their Affordable Care Organization can earn, as long as they also lower growth in health care expenditures.

Clinical Significance

Although the Centers for Medicare and Medicaid Services (CMS) proposed the Affordable Care Organization model, currently there are several different varieties of an Affordable Care Organization available for patients. Typically, Affordable Care Organizations consist of a large payer, like an insurance company, coupled with a large group of healthcare providers. In addition, there are large employers that are taking advantage of the shared savings, partnering with healthcare systems, and removing the insurers altogether. The design of an Affordable Care Organization is based on the principle that each provider will be held accountable for the cost and quality of the care provided, prevention of disease, and avoidance of waste.

Other Issues

There are challenges with Affordable Care Organizations which include the lack of how Affordable Care Organization should be implemented. The American Hospital Association estimated that Affordable Care Organization formation incurs high startup costs and enormous annual expenses. Affordable Care Organization risk violating antitrust laws if they drive up costs through reducing competition. To address the antitrust violation concern, the US Department of Justice offered a voluntary antitrust review process for Affordable Care Organization.

Significant challenges face primary-care physicians who join an Affordable Care Organization via a group practice, hospital-medical practice alignment, or another joint venture such as an independent practice association. Physician groups need a robust Electronic Health Record system with advanced reporting, disease registries, and patient population care management. Organizations that achieve Patient-Centered Medical Home accreditation have mastered these functions and are further along the road to meeting Affordable Care Organization metrics.

Questions

To access free multiple choice questions on this topic, click here.

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Bookshelf ID: NBK448136PMID: 28846320