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Analyzing Trends in Accountable Care Organizations: A Nationwide Survey

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ACCOUNTABLE CARE ORGANIZATIONS: A GROWING TREND

Fisher and colleagues at Dartmouth Medical School are generally credited with stimulating the development of accountable care organizations (ACOs). These organizations are comprised of health systems that offer incentives for performance and quality improvement. Through application of the principle of payment for performance, rather than payment for discrete services, ACOs seek to improve the quality of care for patients while reducing costs. Although the proliferation of ACOs represents an important shift, these systems bring together multiple existing mechanisms of performance improvement. In fact, in their 2007 paper, Fisher and colleagues acknowledged that, in their conception of ACOs, they were building on ideas explored by other investigators over a period of more than a decade prior to that time.[1]

ACOs help address the quality improvement goals of the Triple Aim, which were described by Berwick and colleagues from the Institute of Healthcare Improvement. In a seminal article, Berwick and colleagues argued that reform of the US healthcare system requires simultaneous pursuit of improving the overall care experience, improving population health, and reducing the cost of care for populations on a per-capita level. This is the so-called Triple Aim concept. These authors suggest that 3 inescapable design constraints underlie effective accomplishment of the Triple Aim: 1) recognition of the unit of concern as a patient population; 2) policy constraints in a given organization, such as budgetary limitations, or a requirement for equitable treatment of all patient subgroups; and 3) existence of a single authority, or integrator, that coordinates services, enabling implementation of all 3 aspects of the Triple Aim simultaneously. One method of implementation would be establishment of a registry to track patient subgroups longitudinally, over time.[2]

When ACOs were first envisioned, patient registries were rare, and the precursors of the ACO in the United States were largely limited to integrated delivery networks (IDNs), including large health systems with multiple specialties, such as Kaiser Permanente, Mayo Clinic, and Geisinger Health System, as well as public bodies such as the Veterans Health Administration. Additional efforts to reform healthcare led to implementation of the Patient Protection and Affordable Care Act in 2010, which mandated implementation of ACOs and IDNs within Medicare, through the Medicare Shared Savings Program. As defined by the US Congressional Research Service, ACOs have several key characteristics, including[3]:

- Integrating the activities of many different providers and provider types across a broad range of settings
- Emphasizing optimal use of primary care services
- Helping payers achieve savings through integration of care across providers
- Generating savings, which are shared with providers in the form of incentives
- Generating savings by the use of efficiencies, which do not reduce the quality of services provided
- Acceptance that improved quality and reduced costs are ultimately the responsibility of providers
- Measuring improvements in outcomes across defined populations

GROWTH OF ACOS

Organizations that were early adopters of the ACO model commonly operated under either the Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Program (MSSP) or the Pioneer ACO Program. More recently, the number of ACOs in the private market has grown substantially.[4]