**Experience with Accountable Care Organizations**

**Introduction**

Health care systems across the world are mandated to improve population health, promote patient experience and enhance cost efficiency to guarantee sustainability of care. However, a number of issues in the contemporary health care systems arouse controversies related to quality and costs. Ideally, due to demographic changes across the world, social and economic burden related to healthcare continue to rise. Particularly, in the United States of America, the cost in health care system does not match the quality of care it offers since the government-backed systems are too costly for the national budget. For instance, in 2012, the national budget on health care in America was approximately $2.8 trillion, which only accounted for about 17.2% of the U.S gross domestic product (GDP) (Pimperl et al., 2017). With this, there is irrefutable evidence that the current payment system in healthcare in America is the highest all over the world but the quality of care remains among some of the lowest and unevenly distributed. The fragmented payment system in which doctors and hospitals are paid on the basis of unrestricted fee-for-service terms account for this massive expenditure on healthcare in the country (Kocot et al., 2013). Hence, it is imperative for healthcare systems to embrace a shift in payment models that guarantees cost efficiency and quality of care delivery.

One approach that addresses the continued growth in healthcare spending together with uneven quality delivery inclines to the policy of Accountable Care Organizations (ACOs) (Berwick, 2011). Hence, the present study unravels the concept of ACO, in the aspect of meaning, how it works and its benefits to the healthcare systems.

**Accountable Care Organizations**

Accountable Care Organizations is a healthcare program whereby groups of physicians, health facilities together with other care providers voluntarily come together to provide coordinated high-quality care to specified Medicare patients (Bennett, 2012). ACOs work on the principles of coordinated care which ensures that patients get the right quality care within the right time. Moreover, ACOs purpose to prevent medical errors and to avoid unnecessary duplication of care services that would result in a high cost of service delivery. The establishment of ACOs under the umbrella of Affordable Care Act (ACA), aims at ensuring better care for patients, better health for populations, together with reduced cost of care through improvement in health services deliveries. Essentially, those tasked with the ACO program ensure that the integrated delivery system is supported by evidence, assess performance measurements and reduce the overall rate of healthcare cost as they guarantee quality.

The Centers for Medicare and Medicaid Services (CMS) which defines the activities of ACO requires the latter to care for a minimum of 5000 patients within 3 years. Within this framework, the ACO model needs to provide assurance for the accountability of both cost savings and improved quality outcomes for a specified group of patients. Ideally, payment reduction is the main purpose that underlies the model of ACOs (Berwick, 2011). Under the ACOs program, payment for health services is fixed based on the average patient population. With the program, the ACO providers will keep payments made by patients after subtracting the total cost of care but are not liable to risks if costs of care exceed the revenue collected. However, these terms stipulated by the ACOs are subject to changes. Under the ACOs program, CMS anticipates that cost of Medicare would be reduced to $960 million just in three years of its implementation.

Since its establishment in March of 2011, ACOs has provided bundles of evidence on improved quality of care and reduction in health care costs. In six years of introduction, ACOs have proliferated in over 800 public and private health establishments (Kim et al., 2017). Besides, more than 28 million patients have benefited from the program with anticipation that over 100 million patients are more likely to be covered in the future years. Moreover, other countries within the umbrella of Organization for Economic Co-operation and Development (OECD) such as the United Kingdom (UK), Australia, Germany, and France have embraced the ACOs policy context into their healthcare systems (Pimperl et al., 2017).

**How ACOs Work**

Evidence suggests that the health care system in America faces criticism due to its fragmented nature of payment and care delivery systems. In other words, lack of integration among care providers has led to waste and duplication of services which culminates in unnecessarily high costs of care especially for patients with chronic diseases. However, through the ACOs, a potential solution to fragmentation is enhanced (Kim et al., 2017). ACOs program works on the concept of integration based on the primacy of primary care. In this program, primary care physicians (PCPs), specialized nurses, general practice nurses and other allied care providers work together to deliver efficient, successful and affordable cost of care to their patients. The concept that underlies the ACOs is predicated on the presumption that professionals and health facilities will work in unison to deliver the quality care to patients. Essentially, ACOs works under the law established by Section 3022 of the ACA and assume all the responsibility for the care of patient population under the Medicare beneficiaries (Bennett, 2012). Besides, the law requires the ACO practitioners to consolidate electronic medical records, integrate inpatient and outpatient information and implement information technology that guarantees efficient and quality healthcare. Moreover, ACOs practitioners and facilities are expected to report their saving to the federal government to ensure accountability on cost of care.

ACOs ensures that patients are engaged in shared decision making regarding diagnostic tests and therapeutic options within a care facility. Moreover, the ACO works on the concept that care providers and patients have the right information related to the given care (Kocot et al., 2013). In other words, ACO works with established standards of care by adhering to the stipulated competency defined by medical ethical codes (Berwick, 2011). However, the ACOs ascertains quality of care especially for patients with chronic conditions by allowing them to seek care free of charge to Medicare provider of their wish as long as they are beneficiaries of fee-for-service Medicare.

However, the financial opportunity for shared saving in the ACOs program varies depending on its tolerance for risks to patients. As such, Medicare offers three ACO programs, which include Pioneer ACO Model, the Medicare Shared Savings Program (MSSP) and the Advance Payment ACO Model. These three subprograms under the initiative of ACO provide guidelines on to payments of Medicare based on varied saving plans (Pimperl et al., 2017).

**Pioneer ACO Model**

The model as managed under the CMS Innovation Center (CMMI) is a complementary together with an advanced model for Medicare Shared Savings Program. Under the model, practitioners are required to bear with the downside risk associated with per-beneficiary spending that exceeds the targeted financial spending on medical care (Kim et al., 2017). Besides, with the model, the practitioners tasked with the implementation of the ACOs are conditioned by the terms of the medical care to abide by the substantial risks of healthcare for a 3-year contract for patients under their coverage. The model works under the hospice of experienced health care providers who can deliver quality care at most affordable costs. The Pioneer model envision healthcare organizations to provide the best quality care despite experiencing financial risks. However, since the program was tested in over 32 organizations, it has provided bundles of evidence in its five-year experiment that high-quality care can be delivered even when signatory health facilities are experiencing financial turmoil (Pimperl et al., 2017).

**Medicare Shared Savings Program (MSSP)**

The MSSP sub-program is a lucrative initiative that allows PCPs and the health care facilities to share savings with the CMS after considering their previously expected spending on healthcare. Essentially, the model allows physicians under the ACOs program to receive portions of achieved cost savings as they provide advanced care to patients. The excess savings are then returned back to Medicare in anticipation for future use. Apparently, the MSSP is a sub-program aimed at providing care to fee-for-service beneficiaries. With this model, CMS develops a 2-sided payment arrangement (Fisher et al., 2012). In the first approach, if it is discovered that the ACOs practitioners and healthcare organizations are spending lower than the projected target while quality measurements are improving, then ACOs will be entitled to reimbursement bonus called the “sharing cap.” The latter is a portion of savings that reflect the target spending relative to the actual expenditure during the entire process of healthcare delivery (Bennett, 2012). However, in the second approach, CMS requires the ACOs to pay an amount known as the “loss cap” if the actual costs of care exceed the spending targets. Ideally, the benefits of the MSSP sub-program has seen its implementation across 48 states in over 221 ACOs programs (Pimperl et al., 2017).

**Advance Payment ACO Model**

The model is a subset of MSSP and a pilot project controlled by the CMMI. The sub-program provides up-front federal funding to health facilities in the formation and implementation of the ACOs. In addition, it provides capital to assist 35 smaller ACOs and less well-capitalized PCPs for them to provide quality care (Kocot et al., 2013). Moreover, the sub-program targets the rural health facilities implementing the ACOs and provides the requisite technologies and management systems for these institutions to provide efficient and quality care to patients.

**Have the ACOs made Healthcare Provisions Better?**

According to Fisher et al. (2012), the pressure around the implementation of accountable care organizations continues to rise with anticipation that both government-funded programs and commercial insurance will likely embrace the payment model. Besides, health systems not already enrolled on the MSSP of the ACOs are currently encouraged to consider this Medicare transition so as to provide evidence-based care. Conversely, hospitals are expected to use decision-making frameworks to assess the feasibility and effectiveness of the ACO initiatives together with organizational capabilities to implement the programs.

However, even though ACOs have attained rapid growth, implementation of the models in the American health care systems is far from certain. Further, while the performance of ACOs has improved the quality of care delivery and guarantees cost-effective clinical care, the programs are not yet overwhelming. Besides, some ACOs find the programs yielding marginal returns on investment while others have experienced losses. Hence, implementations of the ACOs come with advantages and disadvantages.

**Advantages of ACOs**

Formation of the ACOs may qualify from the arrangements made by professionals in a group practice, hospitals employing professionals and partnerships or joint ventures. Moreover, networks developed by PCPs from individual practices and other allied healthcare providers qualify as ACOs to advance care to patients. Regardless of this arrangements, it is apparent that formation of ACOs comes with cost advantages. It may be less costly to form and maintain these arrangements in addition to the aspect that the forum provides a framework for professionals to work better.

The other advantage of the ACOs points at the benefit reflected from the implementation of the MSSP sub-program. The MSSP provides additional reimbursement in the form of “sharing cap” which motivate organizations that adopt the ACOs to continue in the implementation of the model program (Kim et al., 2017). As such, health facilities implementing the ACOs under the sub-program of MSSP are likely to face less financial risk compared to organizations that depend on fixed capitation payments.

The overall advantage of ACOs models is that it improves quality of care to patients and reduced cost. Based on this context, sustainability of care is guaranteed and health facilities need to embrace the ACOs program to position their organization for future growth in the marketplace.

**Drawbacks of implementing ACOs**

In order to assess the effectiveness of the ACOs, hospitals will be required to continually evaluate the implemented ACOs models and sub-programs. Equally, the mandatory collection of quality metrics to affirm the effectiveness of ACOs model prompts hospital to incur additional costs. In other words, not all data related to quality will be provided which will require the hospital to conduct surveys to validate the effectiveness of the program.

The ACOs program requires that a large proportion of patients are covered by the Medicare services including those privately insured. Failure to cover more patients will mean that payment incentives required for managing complex medical conditions may not be achieved. In other words, ACOs works on the basis of pooling of cost together which can only be achieved when volumes of services are increased (Fisher et al., 2012). When this is not achieved PCPs find themselves in precarious situations which may comprise quality of services delivered due to limited financial incentives.

**Conclusion**

Traditionally, health systems have made payments to doctors and hospitals based on the considerations of volumes of services provided to patients. However, this approach does not address the appropriateness and quality of services for patient population. Besides, when care is not integrated, payment and delivery systems become fragmented leading to wastes, duplication of services in addition to high cost of care. Apparently, with the introduction of the ACOs, attempts have been made towards improving the quality of patient’s health care at a relatively reduced cost to ensure sustainability of medical services delivery. However, while the transition to ACOs as a form of Medicaid payment affirms cost-effective clinical care, hospital implementing the program are expected to assess their performance goals and capabilities of the models.

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