Accountable Care Organizations and Public Health

Accountable care organizations (ACOs) are one model currently being tested throughout the country to improve quality of care and decrease cost. ACO success requires a population health management approach, which provides a tremendous opportunity for partnership with state and territorial health agencies health agencies (S/THAs), whose primary focus is population health. For ACOs to be successful, and for any health system to be truly integrated, public health must be at the table.

DEFINING AN ACO

An ACO is a network of doctors and hospitals in which the participating providers are collectively responsible for an enrolled population's care.[i] ACOs agree to manage all of the health care needs for their population, and in return may share in any savings associated with improvements in the quality and efficiency of the care they provide.[i] The ACO model addresses the widely held assumption that more medical care is equivalent to higher quality care by removing rewards for higher volume and greater intensity of services provided.[ii] ACOs instead reward the provision of higher quality services while managing costs and link payment directly to quality of care.

ACOs recognize variation in regional healthcare markets, but all include the following key elements:**Error! Bookmark not defined.**

- Provider organization as the base.
- Accountability for patient outcomes.
- Potential for shared savings.
- Use of quality metrics focused on patient-centered care, increased coordination of care, and incentives designed to reward performance.

Some examples of organizations that might participate in an ACO include large group practices, independent practice associations, physician-hospital organizations, integrated delivery systems,[iii] federally qualified health centers, and rural health clinics.[iv] ACOs may also involve nontraditional health providers such as public health and wellness programs with different payer participants.[v] Payment models vary depending on the amount of risk that providers are prepared to assume.[ii]

ACO INITIATIVES

The number of ACOs is growing rapidly across the country, with both public and private entities piloting ACOs in almost all states. As shown in **Figure 1**, a graphic from the ACO Learning Network, more than 250 organizations have self-identified as ACOs or are actively planning to become ACOs.[vi] Clearly, ACOs are on their way to having a significant presence in the U.S. healthcare system and it will be important for SHAs to not only understand what ACOs are, but also to be aware of the ACO initiatives in their state. A few examples of significant ACO initiatives include those supported by the Centers for Medicare and Medicaid Services (CMS) and several state Medicaid-based ACOs.

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CMS-Supported ACO Programs

3022 of the Patient Protection and Affordable Care Act (ACA) requires the Department of Health and Human Services Secretary to establish a shared savings program that helps Medicare fee-for-service program providers become ACOs. Working in concert with the shared savings program, Medicare supports two additional ACO models: the Pioneer ACO Model and the Advance Payment ACO Model. A total of 154 organizations are participating in Medicare Shared Savings Program initiatives.[viii]

Medicare Shared Savings Program (MSSP)
One of the largest ACO initiatives taking place in the country is MSSP. Under MSSP, ACO organizations are required to meet both quality performance standards and generate shareable savings to qualify for sharing in a percentage of the achieved savings with the Medicare program.[vii] As of September 2012, MSSP selected 116 organizations (through two different performance periods) to participate in the program. Applications for a third performance period were accepted through Sept. 6, 2012, and are slated to start in January 2013.[viii]

Pioneer ACO Model
The Pioneer Model was designed for organizations with previous experience operating in ACO-like arrangements with coordinated, patient-centered care. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program.[ix] Thirty-two ACOs are currently participating in the Pioneer ACO Model.[viii]

Advance Payment ACO Model
The Advance Payment ACO Model will provide additional support to physician-owned and rural providers participating in the Shared Savings Program who would benefit from additional start-up resources to build the necessary infrastructure, such as hiring new staff or implementing information technology systems.[x] Participants receive advance payments that will be recouped from the shared savings payments they earn.

State Medicaid-Based ACO Examples

Section 2706 of the ACA authorized a demonstration project for creating pediatric ACOs within Medicaid. Although still unfunded, states have begun to plan and implement Medicaid ACO initiatives themselves.[Error! Bookmark not defined.] The following are examples of state-based ACO initiatives in New Jersey, Colorado, and Oregon. Other states leading or participating in Medicaid-based ACO models include Arkansas, Illinois, Maine, Massachusetts, Minnesota, New York, Utah, and Texas.[xi]

New Jersey's Medicaid ACO Demonstration
In early 2011, the New Jersey Chamber of Commerce led a broad coalition of business, hospital, healthcare provider, and consumer group stakeholders to propose creating Medicaid ACOs in New Jersey.[xii] Legislation was passed to test the idea in a Medicaid ACO demonstration project, similar to the federal MSSP, which will create multi-stakeholder Medicaid ACOs. These ACOs will have a community-based structure, unlike MSSP ACOs. Applicants must have a geographic focus and will need 100 percent

of the acute care hospitals, 75 percent of the primary care providers, two behavioral health providers, and two community residents from that geographic area on the organization's board.[xii] The state is currently in the process of drafting regulations to implement its demonstration project and will soon be soliciting applications.[Error! Bookmark not defined.]

Colorado's Accountable Care Collaborative[xiii]
In 2011, Colorado began a pilot ACO model in response to failed attempts at capitated managed care in the state. The Colorado Department of Health Care Policy and Financing, which administers Medicaid in Colorado, divided the state into seven regions and selected a regional care collaborative organization (RCCO) for each of them. RCCOs are responsible for providing patient education and support services for Medicaid clients and also assist practices with care coordination. Initial results from the collaborative show cost, utilization, and client experience trending in the right direction, and plans for expansion of the program are in progress.

Oregon's Coordinated Care Organization Plan (CCO)
In early 2012, the Oregon legislature, with support from Gov. John Kitzhaber, created CCOs as part of his plan to generate savings, meet budget shortfalls, and improve care delivery and outcomes.[Error! Bookmark not defined.] CCOs, which focus on prevention and integrating physical, mental, and oral health under one umbrella, contract with the Oregon Health Authority to serve people on the Oregon Health Plan (Medicaid) in their local communities.[xiv] Beginning Sept. 1, 2012, thirteen CCOs began serving Oregon Health Plan members in 33 counties across the state,[xiv] with two more waves to be implemented Oct. 1, and Nov. 1. Commenting on the incorporation of public health into the CCOs, Director and State Health Officer for the Oregon Public Health Division Mel Kohn said that it is too early to know if public health considerations are playing a key role in the CCOs. He noted, however, that success will be more likely in counties with strong existing public health departments.[xv]

OPPORTUNITIES FOR ACOs AND PUBLIC HEALTH

Since providers only share in ACO savings when they decrease costs, it will be crucial for ACOs to switch from merely treating sickness to maintaining or improving health, to prevent costly avoidable illness and unnecessary care.[xix] Public health can have a significant role collaborating with ACOs in the areas of needs assessment, performance measurement and improvement, health promotion, and patient engagement—all central elements of ACOs.[xvi]

Benefits for SHAs

Financial incentives, improved health systems coordination, and improved population health are just a few of the ways SHAs can benefit from collaborating with ACOs. Many ACO requirements align with the 10 essential public health services and the ultimate mission of public health. **Figure 2** describes areas where selected essential public health services line up with requirements of the MSSP final program rules and National Committee for Quality Assurance (NCQA) ACO Core Measures.

***Figure 2**. Links Between State Health Agency Responsibilities and MSSP/NCQA Requirements*

State Health Agency Responsibilities (Essential Public Health Services)	Medicare Shared Savings Program Final Rules	NCQA Accountable Care Organization Core Measures
Monitor health status to identify and solve community health problems.	ACOs must have "a process for evaluating the health needs of the ACO's population, including consideration of diversity in its patient population, and a plan to address the needs of its population."[vii]	The ACO facilitates timely exchange of information between providers, patients, and caregivers to promote safe transitions.
Mobilize community partnerships and action to identify and solve health problems.	"In its plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders to improve the health of its population."[vii]	The ACO must have necessary stakeholder participation.[xvii]
Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.	"ACOs must have in place procedures and processes to promote coordination of care."[iv]	The organization has sufficient numbers and types of practitioners and provides timely access to culturally competent healthcare.[xviii]
Assure competent public and personal healthcare workforce.	An ACO must document how it will "implement the required processes and patient-centeredness criteria, including descriptions of the penalties that will apply if an ACO participant or ACO provider/supplier fails to comply with these processes."[vii]	The ACO has sufficient numbers and types of practitioners to provide timely and culturally competent care.[xvii]
Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	"The ACO must develop an infrastructure for participants and providers to internally report on quality and cost metrics … [to] evaluate performance and … improve care over time."[vii]	The ACO "measures and publically reports performance on clinical quality of care, patient experience and cost measures."[xvii]
Research for new insights and innovative solutions to health problems.	"ACOs must … promote evidence-based medicine."**Error! Bookmark not defined.**	"The organization identifies opportunities for improvement and brings together providers and stakeholders to collaborate on improvement initiatives."[xviii]

By working with ACOs, SHAs can help ensure better integration of health promotion and prevention into clinical heathcare delivery systems. Moreover, collaborating with ACOs will enable SHAs to more effectively and efficiently fulfill agency responsibilities, reduce costs, and improve the health of the population in their state.

With the current economic climate and ongoing budget pressures, states are looking for ways to improve quality of care while decreasing costs. Collaboration with ACOs can provide many financial benefits for states. SHAs can provide many services to ACOs and should pursue the opportunity to participate in the "shared savings" with ACO participants. Additionally, Medicaid ACOs have a tremendous ability to financially benefit SHAs. State governments pay up to 50 percent of the Medicaid budget for their state. If ACOs successfully decrease spending, Medicaid budgets will decrease, leaving additional funds to be allocated elsewhere, potentially for initiatives to improve population health.

Benefits for ACOs

SHAs provide a range of services to the population, including population-based primary prevention services, support for minority health initiatives, support for primary care providers, oral health, pharmacy, disease screening, and home healthcare services. SHAs working with ACOs will help prevent duplication of services, ensure the use of evidence-based practices, and address healthcare disparities. By collaborating with SHAs, ACOs could broaden the range of services available to patients and forge links to community programs to more effectively prevent illness and treat the whole person.[xvi]

To meet their quality and savings goals to keep a percentage of the savings, ACOs must track and monitor the health of their entire patient population (meaning any individual who has a relationship with an ACO physician).[xix] SHAs collect a vast amount of population health data related to risk factors and disease incidence, including chronic and infectious diseases, exposures, and access to care. SHAs also have experience conducting needs assessments and performance evaluations. Health departments could assist ACOs with monitoring population health status and provide technical assistance in reporting quality performance measures.

CONCLUSION

As more ACOs are formed and implemented across the nation, SHAs should be present during their development and a key partner during implementation. Successful collaboration among providers, payers, and public health can lead to higher quality, lower cost healthcare delivery, which will ultimately lead to improved population health.

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