Are ACOs the Answer to High-Value Healthcare?

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**Background:** The Patient Protection and Affordable Care Act required the Secretary of the Department of Health and Human Services to establish the Medicare Shared Savings Program (MSSP) by January 1, 2012. The MSSP is intended to encourage physicians, hospitals, and other providers and suppliers to form accountable care organizations (ACOs) to provide cost-effective, coordinated care to Medicare beneficiaries. Under the MSSP, ACOs can qualify for additional payments by meeting specific savings benchmarks and quality measures.

**Objectives:** To review the anticipated changes in the role and responsibilities of ACOs and to evaluate the challenges and opportunities that various healthcare stakeholders, including patients, providers, and payers, will encounter with the launching of the new MSSP.

**Discussion:** ACOs assume responsibility for overall care, cost, and quality of patient care. The MSSP will provide ACOs additional payments for meeting cost-savings and quality benchmarks. The extra savings will be shared with participating providers based on different risk-sharing options. As the MSSP and new ACOs launch, stakeholders will be impacted differently. This article is based, in part, on responses of approximately 100 payers to a survey conducted in June 2011 by Xcenda. Each stakeholder group, including providers, payers, patients, and manufacturers, must monitor the reactions and relationships between all players in the care continuum. Providers will have to achieve a greater level of coordination and collaboration than typically exists today. Government and commercial payers will have a role in determining how quickly they will adopt accountable care models. Patients are expected to become more engaged and participatory in their care to achieve optimal outcomes, and manufacturers will be required to prove the value of their products given the clinical value proposition embedded in accountable care models.

**Conclusion:** Whether ACOs are the answer to providing higher-quality healthcare at lower costs remains unclear. All signs, however, point toward a systemic change in an effort to improve patient care and contain healthcare costs. It will be important for all healthcare stakeholders to understand the roles that ACOs will play in ensuring access to care and quality of care.

Section 3022 of the Patient Protection and Affordable Care Act of 2010 (ACA) calls for the Department of Health and Human Services to create the Medicare Shared Savings Program (MSSP) and other pilot programs to reduce healthcare costs while improving the quality of care. The ACA requires the Centers for Medicare & Medicaid Services (CMS) to launch the MSSP by January 1, 2012.

Accountable care organizations (ACOs)—an arrangement among healthcare providers “who collectively agree to accept accountability for the cost and quality of care delivered to a specific set of patients”—were envisioned by the ACA as a vehicle for physicians, hospitals, and other providers to provide cost-effective, coordinated care to Medicare beneficiaries. The MSSP will create for healthcare professionals a framework for sharing risk, which, in turn, will supply financial incentives for integrated care.

CMS released its proposed rule on ACOs and the MSSP on March 31, 2011, and subsequently, the Center for Medicare & Medicaid Innovation (CMMI) announced an alternative, non-MSSP-affiliated pathway to establishing ACOs called the Pioneer ACO Model. After the initial proposed rule received strong...

Stakeholder Perspective, page 450

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criticism across the healthcare community, CMS released its final ruling on ACOs and the MSSP on October 20, 2011, which included significant changes aimed at making participation in ACOs more attractive to providers. Under the MSSP and the Pioneer program, providers in ACOs will continue to receive fee-for-service (FFS) payments from Medicare, but will have opportunities to get additional payments if their ACO meets savings benchmarks.

Patients will be empowered with access to competitive networks of providers offering quality healthcare at relatively lower costs; this is likely to foster competition among ACOs and drive performance up.

Private payers are expected to test different methods of payments to ACOs and may also join independent, non–MSSP-affiliated ACOs.

The first-year costs for starting an ACO are estimated at $1.75 million.

Figure 1 Payers’ Plans to Contract with ACOs

ACOs indicates accountable care organizations.

NOTE: These data reflect responses to a June 2011 survey of nearly 100 payers responsible for >200 million covered members.

Even before CMS released its final MSSP-related ACO regulation, the move toward accountable and more integrated care—with the concept of shared savings between payers and providers—began gaining momentum. Hospitals, physicians, and health plans have already formed or are contracting with ACOs.

In June 2011, Xcenda’s payer market research platform, the Managed Care Network (MCN), conducted a survey of its panel members, consisting of nearly 100 payer decision makers representing more than 200 million covered members. They were asked to identify whether their organizations were contracting with ACOs, planning to contract, or not planning to contract ACOs within the next 12 months. Based on the MCN panel responses to this survey, 61% of payers are already contracting with ACOs or are planning to contract with them within the next year (Figure 1).

With the formation of ACOs, payers and providers are creating a new healthcare delivery model that will test value-based and quality-based reimbursement mechanisms. The growth of ACOs, along with a focus on the delivery of increased quality of care at lower costs, will require each sector of healthcare to understand how ACOs will affect all stakeholders, including patients, providers, payers, and manufacturers. This article focuses on the implications for these stakeholders of implementing ACOs and the imminent launch of the MSSP.

Payment to ACOs

Currently, Medicare reimburses covered services based on the FFS structure. This payment approach creates an incentive to provide a high volume of services to receive greater payments. To promote improved quality of care, CMS is introducing new financial incentives that reward the delivery of high-quality care and the management of patient costs. To achieve this, collaboration among providers will be necessary to leverage resources and reduce unnecessary and duplicative procedures.
Along with FFS payments, ACOs participating in the MSSP that meet savings benchmarks will receive a portion of the savings as an “added bonus.” Under CMS’s final ruling, the benchmark rate will be ACO-specific, calculated based on annual Medicare Part A and Part B FFS claims of beneficiaries who have been assigned to an ACO during the most recent 3-year period before the ACO’s agreement with CMS.²

The Pioneer ACO Model launched by the CMMI allows existing ACOs and integrated-care systems to partner with private payers in a shared-savings program.⁴ CMMI began accepting applications in June 2011 for Pioneer ACOs to start the first performance period by the end of 2011.⁶ Applicants are required to participate in the program for a minimum of 3 years. ACOs that meet program savings and/or performance standards will have the option to extend their agreements for as long as 5 years.⁶

The aim of the Pioneer ACO Model is to achieve greater savings by transferring ACOs to a population-based model in the third performance year, given satisfactory performance during the first 2 years of operation. Participating pioneers will be held financially accountable by CMS, and their performance results will be published.⁶

Distribution of Shared Savings to ACOs

CMS’s final ruling on the MSSP-based ACOs contains 2 models for distribution of shared savings: the one-sided and two-sided risk-sharing models.¹ The one-sided model would allow CMS to share savings (not losses) for an ACO’s first 3-year agreement period with CMS. In subsequent agreement periods, however, one-sided ACOs would automatically convert to the two-sided model as a way to encourage participation in the MSSP, without incurring a penalty in the early stages, but then move into a true risk-sharing arrangement.²

The two-sided model allows ACOs to share savings, but ACOs would also bear greater risk and responsibility for incurring any losses annually in the 3-year program if savings benchmarks are not met; however, participating ACOs would also be eligible to receive a higher amount of any shared savings. In both models, saving payments would be paid out to ACOs as a percentage of the difference between the average per-beneficiary expenditure and the expenditure benchmark. ACOs that implement one-sided and two-sided models could receive up to 50% or 60% of shared savings, respectively.²

Under the Pioneer ACO Model, participating ACOs enter an agreement with CMS that differs in its risk-sharing structure from that of their counterparts under the MSSP. Compared with ACOs participating in the MSSP, eligible Pioneer ACOs may earn a larger proportion of the shared savings with the Pioneer model’s core payment structure.⁶ At the same time, Pioneer ACOs are also liable for greater shared losses beginning in their first performance period.⁶ Table 1 summarizes the Pioneer ACO core payment structure and variant arrangements on the core structure.²

### Quality Performance and Shared-Savings Payment

ACOs under the MSSP will be required to report on 33 quality measures that cover 4 areas: patient–caregiver experience; care coordination/patient safety; preventive

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### Table 1: Pioneer ACO Core Payment Arrangement and Alternate Options

<table>
<thead>
<tr>
<th>Payment option</th>
<th>Performance period 1</th>
<th>Performance period 2</th>
<th>Performance periods 3, 4, 5</th>
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<tbody>
<tr>
<td>Core arrangement</td>
<td>Up to 60% shared savings and shared losses 10% maximum</td>
<td>Up to 70% shared savings and shared losses 15% maximum</td>
<td>Population-based payment, with up to 70% shared savings and shared losses 15% maximum</td>
</tr>
<tr>
<td>Option A</td>
<td>Up to 50% shared savings and shared losses 5% maximum</td>
<td>Up to 60% shared savings and shared losses 10% maximum</td>
<td>Population-based payments as in core arrangement</td>
</tr>
<tr>
<td>Option B</td>
<td>Up to 70% shared savings and shared losses 15% maximum</td>
<td>Up to 75% shared savings and shared losses 15% maximum</td>
<td>Population-based payment, with up to 75% shared savings and shared losses 15% maximum</td>
</tr>
</tbody>
</table>

ACO indicates accountable care organization.

Adapted from the Center for Medicare & Medicaid Innovation. Pioneer accountable care organization (ACO) model request for application. May 2011.
health; and at-risk populations. In the first year of the 3-year agreement period between ACOs and CMS, ACOs that fully capture and report on these quality measures would be eligible for 100% of potential bonuses.

CMS will set quality performance benchmarks and minimum attainment levels for each quality measure based on these data; the performance benchmarks and minimum attainment levels will be set before each annual cycle. For the following years, CMS will use ACO performance data to update benchmark levels, and the shared-savings payout will be based on these new benchmarks.

The final ruling by CMS requires providers to notify patients about any affiliation with an ACO. Patients must also be informed that they can seek care from other providers at any time.

As required by the final ruling on the MSSP-based ACOs, ACOs would be required to repay CMS within 90 days for any shared losses incurred. Any ACO that experiences a net loss during the first 3-year agreement period is allowed to reapply to the MSSP, but the ACO must identify in its application the causes for the net loss and must specify what safeguards are in place to enable the ACO to potentially achieve savings in its next agreement period.

**Shared-Savings Calculation**

Before the shared savings can be calculated, CMS would apply threshold percentages to the total savings. A payment cap would be applied before the ACO distributes payments to its participating providers. Table 2 presents an example of a calculation for a one-sided versus a two-sided model.

This reimbursement method under the MSSP imposes financial accountability and risk on participating provider organizations. The goal of this model is to avoid reducing costs at the expense of quality care; this will necessarily result in increased coordination among providers as collaboration will likely reduce waste and unnecessary services.

**Impact on Healthcare Stakeholders**

The implementation of ACOs in the near future will introduce broad challenges and opportunities for different healthcare stakeholders.

**Opportunities for Patients**

Because ACOs are patient-centered, the final ruling by CMS requires providers to notify patients about any affiliation with an ACO. Providers must tell patients that they are eligible for shared savings, because the ACO offers incentives to improve quality of care while reducing costs. Providers must alert patients that the ACO is financially bound to CMS requirements and may have to pay penalties if the ACO fails to provide high-quality and cost-effective care. Patients must also be informed that they can seek care from other providers at any time. Providers are required to notify patients that the ACO may use the patient’s claims data throughout the organization.

If they prove successful, ACOs should translate to

<table>
<thead>
<tr>
<th>Table 2</th>
<th>The One-Sided and Two-Sided ACO Models</th>
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<tbody>
<tr>
<td>Design element</td>
<td>One-sided model</td>
</tr>
<tr>
<td>Maximum sharing rate</td>
<td>50%</td>
</tr>
<tr>
<td>Minimum savings rate</td>
<td>2.0%-3.9%, depending on number of assigned beneficiaries</td>
</tr>
<tr>
<td>Minimum loss rate</td>
<td>None</td>
</tr>
<tr>
<td>Maximum sharing cap</td>
<td>Payments capped at 10% of ACO’s benchmark</td>
</tr>
<tr>
<td>Shared savings begin</td>
<td>Once minimum savings rate is exceeded</td>
</tr>
<tr>
<td>FQHC or RHC participation incentives</td>
<td>No additional incentives</td>
</tr>
</tbody>
</table>

ACO indicates accountable care organization; FQHC, federally qualified health center; RHC, rural health clinic. Source: Reference 2.
improved overall healthcare. Patients can choose to be seen by providers who are affiliated with high-performing ACOs. The individual's ability to select a provider will create competition among ACOs to provide quality care. Competition may drive the quality of care up and the cost of care down; some ACOs may also encourage patients' loyalty to their provider network by ensuring quality care, improving customer experiences, and charging lower copayments. Furthermore, patients are also capable of participating in ACOs' governance, which allows them to advocate for themselves.

ACOs may also focus on lifestyle modification programs and interventions that may produce a high return on the investment. Such interventions include:

- Tests focusing on prevention and early diagnosis
- Immunizations, weight management programs, and smoking cessation programs
- Regular screenings for serious diseases (eg, cancer)
- Evidence-based treatment guidelines and shared decision-making tools.

Many of these interventions exist, but a stronger focus on effectiveness and implementation can help reduce costs and hospitalizations. Studies have shown that patient education and access to primary care can reduce the frequency of emergency department visits and hospitalizations in patients with chronic diseases by 20% to 40%. Insured members should be aware of and engaged with the changes introduced by new ACO entities so that they can continue to drive competition.

**Challenges for Patients**

Patients will need to be educated to understand the potential benefits of ACO participation, including the ways by which ACOs can improve care and manage costs. They will also need access to the appropriate information that allows them to compare their ACOs' performance against the performance of other ACOs. Because ACOs can receive additional compensation for driving down healthcare costs, they may limit the use of new, more costly drugs and technologies; therefore, patients may need to take precautionary measures to allow themselves access to appropriate therapies as needed.

**Opportunities for Providers**

Providers will be impacted the most by the ACO implementation. The goal of ACOs is to coordinate high-quality care across different healthcare settings and reduce costs. The primary objectives of accountable care models is to ensure that patients receive care in the most appropriate and least intensive settings, and that the services delivered are not duplicated or conflicting. ACO proponents believe that coordinated and enhanced care will reduce the need for high-end procedures, specialist services, and duplicated care. By accepting greater responsibility, physicians may experience more opportunities to report quality-of-care achievements and receive financial benefits.

Providers in ACOs can meet most of the MSSP 33 quality measures set by CMS by establishing and following systems already in place, such as Medicare’s Physician Quality Reporting System, electronic health records (EHRs), and electronic prescribing. Satisfactory performance in these measures, and the delivery of care below the predetermined expenditure benchmark, will likely create opportunities for payers for sharing the ACO’s savings. CMS will continue to reimburse providers based on the FFS method, with the potential shared savings as a supplemental method. Figure 2 illustrates the payment flow from CMS for a physician group practice ACO.

**Shared savings.** Providers in ACOs who meet the quality measures and deliver care below the expenditure benchmark are eligible to receive a portion of the savings they helped earn. As previously mentioned, this expenditure benchmark is based on Medicare Part A and B FFS claims data of the ACO’s patient population, to anticipate the ACO’s performance. ACOs can receive

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**Figure 2** Physician Group Practice ACO Payment Flow

ACO indicates accountable care organization; CMS, Centers for Medicare & Medicaid Services; FFS, fee-for-service.

Reducing administrative burden, and shifting providers’ incentives to offer quality care, private payers recognize various benefits in working with ACOs, such as aligning providers’ incentives to offer quality care, reducing administrative burden, and shifting financial risks/ liabilities to providers.

Although Medicare has occupied the spotlight in the discussion and development of ACOs, private payers have also been implementing ACO pilot programs across the nation to expand services to commercially insured patients. Many believe that hospitals and physicians will lead the charge toward high-quality and low-cost care and that private payers will follow. However, this process could occur in the reverse. Private payers may be able to influence hospitals and physicians by interacting with ACOs and modifying their payment models to incentivize quality care.

### Challenges for Providers: Initial Investment

Projected first-year costs to start an ACO are $1.75 million. Providers must invest in health information technology to track patient outcomes. Implementation of compliance programs, production of marketing materials, fees for consulting attorneys, and restructuring of internal operations for CMS monitoring will also result in high costs for participating providers.

### Opportunities for Private Payers

Private payers inadvertently opened a loophole for providers by excluding Medicare Part D expenditures from the benchmark calculation. This exclusion may incentivize ACO providers to prescribe Part D drugs, because the expenditures will not count toward the ACO’s cost of care, thereby leaving more room for shared savings.

### Improvement of Patient Experience and Coordination of Care

Providers believe that the lack of patient information is a major barrier to improving coordination of care. The current FFS payment structure creates fragmented care, resulting in disconnected payments. To remedy this problem, CMS has agreed to provide claims data for patients across all providers participating in an ACO. Depending on the timeliness of these data, providers will be able to see the services that other providers in the ACO are delivering, which will allow primary care physicians to serve as more effective care coordinators. The ACO must notify patients and receive approval before requesting claims information, but the patients will not suffer any repercussions for declining.

**Physician Engagement.** Successful clinical care will require strong physician relationships within ACOs. Internal inclusivity and cross-functional synergies could lead to valuable input from providers. Hospitals can help providers by holding leadership roles in the ACO, offering quality incentives, and seeking provider input on health information technology initiatives. CMS requires providers and other ACO participants to control 75% of the organization’s governing body, meaning that providers carry a strong voice in every ACO.

**Changing Role of the Pharmacist.** Pharmacists can demonstrate great value to their ACOs. Given their medical expertise and experiences coordinating with physicians, nursing staff, and other staff members, pharmacists can support ACOs in determining appropriate and cost-effective therapies to include in their formulas. Collaboration within ACOs between pharmacists and provider staff may help prevent costly expenditures related to patient hospitalizations, comorbidities, adverse events, and more. Pharmacists will continue to play an important coordinator role with other providers in the ACO. Pharmacists’ close collaboration with other providers within the ACO will directly contribute to the organization’s quality and cost-saving goals.

### Table 3: ACO Payment Structure Options

<table>
<thead>
<tr>
<th>Payment Structure Options</th>
<th>Description</th>
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<tr>
<td><strong>Shared-savings bonuses</strong></td>
<td>ACO reserves a percentage of shared-savings payments for bonus payments to affiliated providers. Proposed by Medicare Payment Advisory Commission. Low risk for providers.</td>
</tr>
<tr>
<td><strong>Bundled payments</strong></td>
<td>Gives ACO authority to distribute per-episode payments to affiliated providers. Proposed by private payers. Medium risk level for providers.</td>
</tr>
<tr>
<td><strong>Capitated payments</strong></td>
<td>Allows ACO to allocate predetermined, per-patient annual payments among affiliated providers. Proposed by private payers and state of Massachusetts. High risk for providers.</td>
</tr>
</tbody>
</table>

ACO indicates accountable care organization. Source: Reference 14.
methodologies to better suit the needs of policyholders included in the ACO population.\textsuperscript{20}

Figure 3 outlines the benefits of ACO implementation from the payer perspective.\textsuperscript{5} Private payers recognize various benefits in working with ACOs, such as aligning providers’ incentives to offer quality care, reducing administrative burden (by making a single payment to a provider group for a patient’s care), and shifting financial risks/liabilities to providers.\textsuperscript{5}

However, Figure 3 also shows some barriers payers expect to encounter with ACO implementation, concerns that center mainly on provider incentive issues.\textsuperscript{5} Some payers are already considering new models that parallel ACO requirements. For example, UnitedHealthcare is testing a model designed to deliver better medical outcomes for cancer treatments by addressing the costs of patients’ cancer care and the portion of chemotherapy drug profits the provider receives.\textsuperscript{21} Office visits, chemotherapy administration, and lab fees will still be reimbursed on an FFS basis. UnitedHealthcare will discontinue provider income from drug sales revenue by paying the same fee, no matter which drugs are administered.\textsuperscript{21}

Collaboration with ACOs. Private payers will be able to consolidate resources and provider expertise by contracting with ACOs. The ACA has implemented mandates that expand benefits, implement minimum medical-loss ratio requirements, prohibit the preexisting conditions exclusion, and increase pressure to restrain premium increases. By contracting with ACOs that have larger patient populations, some of these added pressures could be shifted to the ACO.

In addition, in view of the emerging evidence of success, it is not surprising private payers are showing interest in contracting and encouraging the formation of ACOs. Blue Shield of California, Catholic Healthcare West, and Hill Physicians formed an ACO to cover 40,000 members of California’s Public Employees’ Retirement System.\textsuperscript{22} The goal was to keep healthcare costs flat in 2010 by merging the existing Blue Shield HMO benefit product with members affiliated with existing primary care physicians from Hill Physicians. As a result, millions of dollars were saved in the first year, and premiums did not increase in 2011.\textsuperscript{22}

Collaboration with providers. Private payers are expected to test different methods of payment to ACOs, leading the charge in this aspect. Private payers may also join independent, non-MSSP-affiliated ACOs by using their own networks of providers or by leveraging their staff-model HMO arrangements. Paul Markovich, Executive Vice President and Chief Operation Officer of Blue Shield of California, has stated that his organization would be “proud to support all of [Blue Shield’s] grantees as they work to materially improve care and succeed under federal health reform.”\textsuperscript{23}

Insurance exchange population. It has been suggested that providers are forming commercial ACOs to seek private payers whose number of members will increase once state-level insurance exchanges are established in 2014.\textsuperscript{24} Insurance exchanges are competitive marketplaces in which small businesses and individuals may purchase qualified health benefit plans with various coverage options. Providers can collaborate with private payers to assemble similar organizations to help providers gain additional business from the flood of health insurance exchange beneficiaries. The Congressional Budget Office predicts that 24 million people will purchase coverage through the exchanges by 2019.\textsuperscript{25}
**Challenges for Private Payers**

**Unintended consequences.** Financial incentives and enhanced collaboration between physicians and hospitals may increase the negotiation power of providers, resulting in higher costs for payers. ACOs may also indirectly dictate coverage policies and treatment guidelines of private payers, because they must strive to deliver care within quality parameters. ACOs and private payers may also find themselves in disagreement in instances where private payers do not cover a service, but ACOs may need to include that service in their quality-of-care report.

**No guarantee ACOs will succeed.** CMS can eventually terminate an ACO if it does not meet quality-of-care requirements. Therefore, this unknown element provides risk to private payers if they collaborate with ACOs, especially because private payers cannot participate in ACOs’ governance. Private payers could take a proactive approach and research the patient satisfaction data of an ACO’s providers before collaborating with it.

Transparency in one sector encourages transparency in affiliated sectors; therefore, manufacturers will likely maintain ongoing relationships with providers by conveying each product’s added value for patients.

**Opportunities for Pharmaceutical Manufacturers: Real-World Outcomes Data**

As purchasers of healthcare services shift from volume-based to quality-based reimbursement mechanisms, drug manufacturers will be expected to provide additional clinical and health economic data to support the use of their pharmaceuticals during interactions with risk-bearing providers.

As previously mentioned, ACOs can achieve numerous quality measures by implementing EHRs. EHRs will help demonstrate the real-world impact of healthcare services and pharmaceutical agents and provide an opportunity for manufacturers to distinguish their products from competitors. EHRs allow providers to see and evaluate a patient’s health risks, behaviors, and status before that patient is even physically seen by the provider. Transparency in one sector encourages transparency in affiliated sectors; therefore, manufacturers will likely maintain ongoing relationships with providers by conveying each product’s added value for patients.

Because many quality measures are based on the use of EHRs, providers are pressured to thoroughly use and adapt their technology during the ACOs’ first few years. EHRs will allow providers to track patient outcomes, and EHR-based outcome studies will undoubtedly result in changing treatment behaviors. Manufacturers’ use of these data, along with clinical trial data, will improve the effectiveness of physician details. Once the ACO program becomes fully implemented, manufacturers will be able to leverage a correlation between high-quality outcomes of drugs and provider behaviors.

These economic and outcomes-based data also support quality-measure goals and may improve a manufacturer’s access to formularies and inclusion in clinical guidelines. Impactful data are anticipated to include outcomes such as reduced comorbidities, hospital admissions, hospital length of stay, adverse effects, and number of physician administrations.

If ACO providers believe that a manufacturer’s products will support their quality-of-care and cost-saving goals, the organization may offer manufacturer representatives the opportunity to join the ACO in an advisory role. Manufacturers and providers may form strong professional relationships by joining services with a collaborative goal of quality improvement. Patients will likely experience the greatest benefits if cost-savings and high-quality care remain the primary focus of any stakeholder collaborative.

**Challenges for Manufacturers: Exclusion of Medicare Part D Expenditures**

Because Medicare Part D drug expenditures would be excluded from the ACO’s benchmark calculations, this would incentivize prescription of Part D products, such as oral drugs and other self-administered products. Manufacturers that only produce physician-administered, Medicare Part B drugs may be held hostage by this impending loophole.

Overall, ACOs will financially incentivize providers to prescribe cost-effective drugs, use formularies, and follow recommended treatment guidelines. With time, patient outcomes and product value are likely to become the predominant topics of conversations between manufacturers and providers.

**Conclusions**

Since the release of CMS’s final ruling on the MSSP and ACOs, the constructs regarding the implementation of the MSSP have become much more concrete. However, as the MSSP nears launch and newly created ACOs begin to enter the marketplace, their true impact on various stakeholders remains to be seen. Assuming smooth implementation and consistent uptake by healthcare stakeholders, ACOs should be able to meet their goals of streamlining services and reducing overall healthcare costs.
Within the ACO model, patients will be empowered with access to competitive networks of providers offering quality healthcare at relatively lower costs. As consumers, patients will need to be cognizant of the changes in the healthcare delivery system to better take advantage of competing services. Physician networks and hospitals will need to increase their collaboration to achieve high-quality care and to ensure profitability under the new payment model.

Simultaneously, payers will have to ensure buy-in from the provider community to sustain the shared-savings model and its goals to bring change to the healthcare delivery system. In view of the new stakeholder roles, manufacturers will also have to prove their products’ value to ACO decision makers to make certain that patient access to the most appropriate therapies will be preserved at all times. As a result, it will be advantageous for all stakeholders to understand the inner workings of the new ACO landscape and play a supportive role with other stakeholders along the care continuum to enhance appropriate access to their services.

Author Disclosure Statement
Ms Yeung, Mr Burns, and Mr Loiacono reported no conflicts of interest.

References
The ACO Payment Model a Potential “Game Changer,” but Will It Improve Outcomes?

The accountable care organization (ACO) payment concept is a game changer in terms of moving away from the current cottage-style care delivery system that is focused on a volume-driven business model. The ACO represents a move away from the model of incentives to earn more by doing more toward a more organized and centrally coordinated delivery system that provides incentives to do only what is needed for individual patients. Yeung and colleagues rightly pose the question whether ACOs can solve the issue of high-value healthcare concerns.

A change in payment structure through any program type will necessarily alter the roles and business models of providers in the care delivery system. Clearly, the trend is toward global payments for patient services, but because many options are still being tested (ACO, medical home, or other), the right payment model or models and quality parameters linked to reimbursement have yet to be determined.

PROVIDERS: Physicians will have a positive financial incentive in coordinated care along with achieving outcome goals, but these will be difficult to achieve in the real world. Such an approach is likely to work well in rural areas using a medical home, whereas urban areas are more likely to follow an ACO-style approach. But the ACO strategy changes the physicians’ relationship with their hospital and other clinical partners and could therefore create ill will.

Hospitals and health systems are in a position to coordinate care and provide the administrative structure to ensure quality as envisioned by the ACO concept. Under the global payment options, there is an opportunity to improve care coordination, but at a higher financial risk to hospitals, and with an increased likelihood of straining physician–hospital relationships.

PATIENTS: At first glance, this approach offers opportunity for better care coordination for the same or less amount of out-of-pocket cost. However, whether the promise will result in better care delivery and outcomes remains a concern. Can such an altered reimbursement system deliver the quality promised, while maintaining tight cost controls? And what would be the reality of out-of-pocket costs incurred by the patient?

PAYERS: Health plans would have the opportunity to share some of the financial risk or shift it down to providers while maintaining administrative and claim management functions that increase the ability to predict the business health of the plans. They can be a big winner in this new payment approach, as they work with providers or patients in managing financial risk. The payment structure change will challenge and force payers to alter their business model to focus more on information technology and on customer service, which they have developed slowly and promoted directly to the public over the past few years.

As the only stakeholders not taking financial risk, pharmacy benefit managers (PBMs) are at the greatest risk for establishing their future business value with their current model. This is likely to position PBM services, functions, or firms themselves to be subsumed under health plan or health system organizations as a lower-value commodity vendor. This same issue will be a challenge to third-party administrators, who have sought to expand their service lines without taking on financial risk.

For employers, unions, and municipalities looking to cut costs out of the system and improve integrated care delivery, global payment systems provide more fiscal certainty and predictability for plan sponsors contracting with third-party payers. A key question for purchasers of healthcare is whether such an approach can avoid disruptions or unintended consequences from drawbacks in the current models affecting delivery system stakeholders.

The continuing lack of leadership in healthcare reform implementation from Washington, DC, introduces another layer of confusion and concern from all perspectives as we consider payment system change, along with the impact of that change on stakeholders. The next 18 to 24 months will lead us to a new payment vista that is most likely to be global payment oriented, with some measure of patient quality outcome metrics built into the financial reimbursement equation.

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