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Accountable Care Organizations: What Pharmacists Should Know

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Accountable Care Organizations are groups of physicians, hospitals and other health care providers that voluntarily form networks to improve the quality of health care services and reduce health care costs for a clearly defined patient population. [3,4]

National health care expenditures are continuously rising, accounting for 17.9 percent of the gross domestic product (GDP) in 2011 and expected to rise to 19.6 percent of GDP in 2021.[1] This demonstrates the growing need to find solutions to slow down spending on health care while maintaining and even improving quality of care. The Patient Protection and Affordable Care Act (generally known as the Affordable Care Act, or ACA) enacted in March 2010 authorized the Centers for Medicare and Medicaid Services (CMS) to contract with accountable care organizations (ACOs) to address these issues.[2] This article will define and provide characteristics of what an ACO is, how they will get reimbursed, challenges that exist to their implementation, and what role pharmacists have in these new and upcoming health care organizations to provide high quality of care while controlling costs.

Accountable care organizations are groups of physicians, hospitals and other health care providers that voluntarily form networks to improve the quality of health care services and reduce health care costs for a clearly defined patient population.[3,4] These providers are held jointly accountable for quality improvements of patient care and spending growth reductions.[5] Accountable care organizations emerged from the concept that physicians who are tied to a hospital already function as a network and take care of patients within that hospital system. Now, these once informal networks can become formal so that public and private payers can hold these systems accountable for the outcome of care.[4] The three goals of an ACO are to promote integration among health care professionals to provide better care for individuals, improve the health of the population and reduce the growth rate in health care expenditures. This promotion of continuity across the health care continuum ensures that patients are treated in a convenient and cost-effective manner, while the enhanced communication amongst health care professionals contributes to a reduction in unnecessary hospital admissions and readmissions, procedures and duplicate therapies.[2]

A group of health care providers can qualify as an ACO in one of five categories under the Medicare Shared Savings Program: 1) group practices, 2) independent practice associations (IPAs) or other networks of individual practitioners, 3) hospital and professional joint ventures or partnership, 4) hospitals that employ ACO professionals or 5) any other group approved by the Department of Health and Human Services secretary.[4] Regardless of the variations of health care providers comprising the group, each ACO must promote evidenced-based medicine, patient engagement, coordination of care and report quality and cost metrics.[2] One of the most prominent characteristics of an ACO is the shift of accountability from insurers to providers, giving providers financial incentives to cooperate and save money by avoiding unnecessary tests and procedures.[6] An ACO will work to bring the different components of health care delivery together, such as primary care, specialists and hospitals, to ensure that all the parts work and fit together effectively. In order to encourage patients and payers to buy into the idea of ACOs, this model will need to prove that the overall health care product they are creating actually does improve quality and lowers cost.[6]

In an effort to ensure a large enough sample size and sufficient time to gather meaningful performance measurements, there are required elements that must be met to become an ACO. All ACOs must agree to a three-year contract and must serve an assigned population of at least 5,000 patients.[4] This may mean that rural or smaller-scale hospitals must form partnerships amongst themselves in order to jointly reach the required 5,000 patients. Each ACO must also have a formal legal structure allowing it to receive and distribute shared payment. An additional requirement is having a governing body responsible for the oversight and strategic direction of an ACO, which is composed of at least one ACO beneficiary without conflict of interest, an executive/officer who manages operations and a medical director who is the physician in charge of clinical management.[2]

Since the concept of ACOs is fairly new, many organizations creating ACOs do not yet have sufficient data to produce valid quality measures or benchmarks of success to evaluate the performance standards of an ACO. Until enough meaningful data is obtained to provide a systematic evaluation, certain core elements of ACOs can be used to give a rough assessment of ACO success: improving patient care, providing better health for the population and reducing overall spending growth.[7] For current ACO models, payers collect data over a given period of time on their ACO's costs for their patient population, as well as quality of care and population health measures. The ACOs are held accountable by whether or not they provide high quality care while reducing unnecessary costs. Some ACOs may require their providers to meet minimum quality standards in order to continue to participate in the network.[4] An ACO will be deemed successful in cost reductions based on a spending benchmark set for each ACO based on its beneficiaries' previous expenditures. If the ACO keeps its spending growth below the average per capita spending growth for all beneficiaries, it will have been deemed to have achieved savings.[4]

Though many details of ACO programs have yet to be established, it has been suggested that a three-tiered reimbursement program be implemented. In this approach, there are three levels of ACOs with increasing degree of responsibility and risk. Simply put, the greater financial risk invested, the more potential reward the ACO receives of shared savings. Those ACOs operating under the higher risk tiers would be permitted to keep a larger portion of the savings it provides its payer.[2] Tier 1 is a low financial risk tier, with fee-for-service payment. Tier 2 displays moderate financial risk, with fee-for-service, partial capitation and some bundled payment methods. Tier 3 is the highest level of financial risk, with full or partial capitation and extensive bundled payments. This third tier provides the highest amount of shared savings and bonuses.[4]

The driving force behind the ACOs' patient-centric approach is an emphasis on quality of care instead of quantity.[2] In this new pay

for performance model, health care providers are rewarded for efficient use of health care and coordination of care.[4] If an ACO improves patient care and reduces the cost of that care, it will share in the savings it achieves for its payer.[3] To provide stronger incentives, there are no negative risks to participation (at least in the beginning of implementation) an ACO will not share in any losses if treatment of patients costs more than expected.[4] This is implemented by the first performance year's quality reporting standard being merely pay for reporting. This means that ACOs will receive full credit for quality reporting as long as they accurately submit the measures. However, in the second performance year, pay-for-performance for these measures will be phased in. If an ACO fails to report quality measure data accurately, completely and on a timely basis, they may be subject to termination or other sanctions.[8]

Therefore, the obstacle for pharmacists is not only to find emerging ACOs, but to reach out and convince the health care professionals in the ACO that pharmacy is essential for overall cost reduction in the ACOs.

The CMS finalized new rules under the ACA establishing the Shared Savings Program under which doctors, hospitals and other health care providers may work together to better coordinate care for Medicare patients through an ACO. The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting the quality performance standard. If quality measures are met and savings are achieved, a percentage of that savings is shared back with the ACO. How savings will be divided amongst the providers is to be determined by each ACO.[4] Before an ACO can share in any savings generated, it must meet the quality performance standard. To do so, CMS will measure and report quality of care using 33 measures in four key domains: 1) patient and caregiver experience, 2) care coordination and patient safety, 3) preventive health and 4) at-risk populations. By improving this quality of care for individuals, better overall health for the population is expected.[8, 9]

There are several challenges that pharmacists must overcome in order to be incorporated into the ACO health care structure. The first obstacle to pharmacists' incorporation into ACOs is defining and establishing an appropriate path forward.[7] As ACOs are still new, the path for pharmacists to join these organizations is not yet established. ACOs are still struggling to discover an ideal system for patient care, which includes determining which health care providers should be included in order to have the best outcomes. Therefore, the obstacle for pharmacists is not only to find emerging ACOs, but to reach out and convince the health care professionals in the ACO that pharmacy is essential for overall cost reduction in ACOs. Pharmacists are already utilizing and being reimbursed for medication therapy management (MTM) services, including comprehensive medication reviews and preventative counseling, which have been shown to significantly reduce health care costs and improve patient outcomes.[2] Since these are the goals for ACOs, it seems obvious that pharmacists should be included in the organization, but pharmacists need to convince emerging ACOs of their value. It is essential that pharmacists are recognized for the benefits that arise from providing MTM services in order to guarantee a position for pharmacists in the future of health care.[2]

The second challenge is the need for useful performance measures, including measures from a quantitative and qualitative perspective.[7] Once pharmacists have overcome the first challenge and are included in ACOs, they need a reliable method by which performance can be evaluated. Quantitatively, this could include studies that determine the number of hospital stays for patients that receive pharmacist counseling regularly through their ACOs versus those patients who do not. These studies would demonstrate the pharmacists' value to ACOs, as well as reveal areas of patient care in which pharmacists could be utilized to improve patient outcomes and reduce health care costs.

Qualitative measures of pharmacists' performances are also important to determine improvement of patient outcomes and patient -reported satisfaction with the ACO. Methods for these studies could include patient surveys or rates of membership in an ACO. Receiving patient feedback is vital to ensure that patient goals and ACO goals are both being met for overall health care. As versatile members of the health care team, pharmacists can help to improve patient satisfaction and ACO effectiveness if there is a way to measure how patients view their health care experiences. ACOs as a whole will be evaluated and reimbursed based on effectiveness, making measures of pharmacists' performance important in order to fully employ their expertise to improve the ACO's success.

The final challenge for pharmacists' incorporation into ACOs is to form a reimbursement plan for pharmacy services.[7] Pharmacists and all other health care providers will share in this challenge as the whole health care structure undergoes massive changes to move toward coordinated care. The CMS has several programs in place to help ACOs get started and function through the first year before significant profits are made, and many ACOs contract with an outside payer to receive quality payments or direct financial support. However, the system needs to be set up so that when the ACO receives payment, each health care professional, including pharmacists, receives their portion of the payment as well.[7]

Options for pharmacists' reimbursement include fee-for-service plans, capitation payment plans, and bundled payment systems.[10] In fee-for-service plans, pharmacists would receive reimbursement for individual services provided to each patient. The specific fee for each service could vary depending on the type of intervention, but would be a fixed amount that was previously decided upon by the ACO. Examples include a relatively large fixed amount paid to pharmacists for each comprehensive medication review (CMR) done with a patient, but a smaller amount paid for every patient a pharmacist counsels on a medication. In the fee-for-service plan, pharmacists would document and bill every intervention made directly to the ACO. In capitation payment plans, pharmacists would receive a fixed amount per patient they serve covering a predetermined time period; that is, pharmacists would receive a certain amount of money based on the number of patients enrolled in the ACO. Lastly, in bundled payment plans, a comprehensive payment for patient care from multiple health care providers is bundled together in one sum to the ACO and is then distributed to the providers.[10] In all three models, pharmacists are paid by their ACOs, but the major difference is the time at which the pharmacist receives payment. With a fee-for-service or capitation payment plan, pharmacists would receive payment up front for anticipated service to patients, while pharmacists in a bundled system would receive payment once the ACO is reimbursed after patient care has already occurred.

The obstacle with these payment plans is that pharmacists need to demonstrate their value of lowering patient health care costs and improving patient outcomes in order to receive enough compensation for their services and their fair portion from the ACO's profits. It is important to remember that as pharmacists optimize medication therapy regimens, short-term prescription costs may increase, but long-term health care costs will decrease with improved disease state management. In order to be compensated for their part in reducing overall costs, pharmacists need to be informed on payment systems to reimburse the ACO as a whole, as well as the system by which the ACO plans to reimburse providers.

The two main goals of ACOs are to improve the quality and reduce the costs of health care. In order to achieve these goals, ACOs will need to improve medication and chronic disease state management, as well as reduce hospital readmissions.[5] In the United States, chronic diseases account for approximately 75 percent of health care expenditures.[2] Furthermore, 32 percent of adverse events leading to hospitalizations are due to medications.[8] Pharmacists have the capabilities to help ACOs meet their objectives and have the potential to play a huge role within ACOs. Pharmacists also have the clinical expertise to help patients optimize appropriate medication use, reduce medical related problems, and improve health outcomes through the delivery of patient care services, such as MTM, health promotion and education, and disease prevention and mitigation.[5]

An ACO must demonstrate that it delivers high quality of care by meeting the quality performance standards set by CMS before they can share in any savings. There are many specific ways that pharmacists can help ACOs meet the four domains of performance standards outlined previously. In the first domain, patient and caregiver experience of care, pharmacists can have an impact on providing timely care, appointments and information to patients. They can also positively affect health promotion and education, augment decision making between clinicians and patients and improve health and functional status of individuals. Within the sec-

ond domain, care coordination and patient safety, pharmacists can play a role in decreasing admissions due to ambulatory conditions, such as chronic obstructive pulmonary disease and congestive heart failure, reducing hospital readmissions and providing medication reconciliation after discharge from an inpatient facility. Pharmacists' roles in the preventative health domain include influenza and pneumococcal vaccination, tobacco use assessment and cessation intervention and blood pressure checks. Additional pharmacist responsibilities in this domain include lifestyle and disease state management. The fourth domain's at risk population consists of patients with diabetes, hypertension, ischemic vascular disease, heart failure and coronary artery disease. Pharmacists can provide these patients with disease state management and MTM. As health care professionals, pharmacists have the knowledge and skills to assist ACOs in meeting their performance standards and will be a key component within this new model of health care.[8]

Pharmacists will be a very valuable member to the health care team within ACOs. There are many different ways that they can improve medication therapy outcomes, while also reducing health care costs in the inpatient and outpatient setting. When a patient is admitted to the hospital, a pharmacist can review the patient's medications and recommend to the physician initial drug regimens or medication changes that need to be made.[5] This will ensure that the patient is receiving the appropriate drug therapy due to their medical conditions. Additionally, it will reduce medication related adverse events, which can be expensive and cause many hospital admissions. Before the patient leaves the hospital, the pharmacist should be actively involved in the patient's discharge planning. Pharmacists can counsel patients on their new medication regimens and answer any questions patients have before being discharged. Ultimately, this would help prevent hospital readmissions which are very costly to the health care system.[2]

By evaluating medication therapies for drug interactions, allergies, dose adjustments, adverse events, therapeutic duplications, cost-effective medications and adherence trends, pharmacists can be extremely beneficial to ACOs within outpatient facilities.[11] They are often recognized as medication experts and can effectively perform MTM. Pharmacists can be involved in drug therapy management clinics, such as anticoagulation or HIV clinics. They can provide comprehensive medication reviews and medication reconciliations to patients with chronic disease states, which can be difficult for patients to manage on their own. During MTM sessions, pharmacists can counsel nonadherent patients in order to increase their compliance.[8] Overall, MTM encounters would increase patients' knowledge about their medical conditions and drug therapy, decrease costly adverse events and hospital admissions and improve the quality of patient care. Additionally, just as pharmacists in the inpatient setting have access to a patient's medical records, it is very important that outpatient pharmacists have similar access to obtain a complete medical understanding of the patient. Developing an integrated electronic medical record (EMR) that can be accessed in whatever setting the patient receives care is a major component of ACOs. Generating an accurate and comprehensive medication profile for patients would be a way that pharmacists could contribute to EMRs.[5] Pharmacists in the outpatient setting are a key component to ACOs because of their accessibility to the public. They are one of the most accessible health care professionals and directly impact patient care.

It is essential that pharmacists collaborate with all health care professionals to improve the quality of health care and reduce costs within ACOs. A pharmacist is just one type of clinician across the health care continuum who can contribute to the success of ACOs. It is important that pharmacists become knowledgeable about their role within ACOs so that they can educate physicians, insurance companies, patients and legislators about the value of pharmacy services within ACOs.

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