Accountable Care Organizations (ACOs) and the Pharmaceutical Industry

An ROI^2 White Paper

Background

Accountable Care Organizations (ACOs) are integrated health care systems capable of delivering comprehensive multispecialty inpatient and outpatient services. Their goal of seamless integration would be achieved through the electronic health record (EHR).[i] The rudiments of ACOs began to form organically in the last decade as large multispecialty physician groups began to form in certain geographic regions and hospitals started buying medical practices (both the physician- and hospital-centered systems used digitized patient records to varying degrees); however, the seven pages devoted to ACOs in the Affordable Care Act legislation stimulated increased formation and importantly, set up guidelines, goals and required architecture.

The Center for Medicare and Medicaid Services' (CMS) *Pioneer ACO* program approved 32 ACOs as beta sites for testing different economic models. This was done in order to explore how providers and other stakeholders might share in cost-savings that could be realized in the new system. Cost savings—through efficient health care delivery (achieved via lessening redundancies in testing, drug interactions, medical and prescribing errors and other means)—would follow the computerization of the patient's health record. Each provider in the ACO would also have access to each patient's imaging studies, blood work, consults, etc. which would provide practitioners with real-time data, all of which would lead to further increased efficiencies and assumed better outcomes. These Pioneer ACOs would use historical data as comparators for the calculation of putative savings.

Some observers have claimed that ACOs are just new wine in old bottles, i.e., repackaged HMOs. Although there are some similarities, there are also important differences. First, patients can choose to receive care out of network without penalties (it was this network restriction that caused the backlash against HMOs in the '90s and forced insurance companies to offer more options). Second, physicians can still receive fee-for-service payments, and capitation is not written into the regulations and guidelines—at this time.

Webinars

ROI^2 has produced two webinars (November, 2011 and February, 2012) on ACOs; both were hosted by one of their advisors, Barry Mennen, MD. The panelists for the first were Jim Smith, Director of Corporate Accounts at Shire Pharmaceuticals, and Matt Eyles, VP, Public Affairs and Policy, Coventry Health Care, representing the insurers. Some of the key points to emerge were:

- While most payment methodologies still incent volume rather than value or better care coordination, through the ACO model, insurers and CMS are seeking to align incentives towards the provision of better care, better patient experience and lower costs.

- How ACOs will approach formularies is not yet known since their architectures differ
- In addition to the years of Health Economics Outcomes Research (HEOR) that the pharma industry has done, additional data derived from the ACO model would be helpful

The second webinar concentrated on the Pioneer ACOs, and the panelists were Frank Messana, Affiliated Consultant, Arete Strategies, Advisors to Biopharma Companies. Frank specializes in managed markets and reimbursement. From the Innovation Center of CMS—the people who developed the Pioneer ACO program—we were also joined by Mai Pham, MD, an internist and the Director of ACO Programs. From this second seminar, the key takeaways were:

- The answers to best practices for efficiencies in the various ACO models are not yet in—this was one of the main reasons for the Pioneer program
- Some ACOs are hospital-centered, while others are practice-centered; the Pioneer program will hopefully tease out the key differences in cost-saving approaches
- The pharmaceutical industry may provide a resource for helping large multi-specialty groups transition to ACOs
- The industry may also help with value-added programs that would enhance efficiencies and/or improve patient outcomes, e.g., programs to increase adherence and persistence, or better communication vehicles for patients to learn about their illnesses, etc.
- Because the providers are incentivized toward efficiencies and cost-savings, pharma may be able to function with ACOs differently than they did with managed care
- This landscape is changing, and pharma should stay attuned to this evolution

The importance of ACOs for ROI^2 is a likely shift in the focus of our Influence Intelligence^{TM} reports—and in the construction of our Influence Vectors^{TM} . This would reflect the changes in decision-making and organizational architecture that each ACO would bring. We are therefore carefully monitoring the dynamics of ACO development and adjusting our modeling systems appropriately.

Further reading:

McCanne, D. How does the Affordable Care Act define ACOs? *PHNP health blog*, October, 2010

Gold , J. FAQ on ACOs: Accountable Care Organizations, Explained. *Kaiser Health News*, Oct. 21, 2011

Silverman, E. Accountable Care Orgs and Pharma: Ian Explains. *Pharmalot*, May 5, 2011

[i] This differs from the electronic medical record (EMR) in that the EHR is owned by the patient and flows across providers, institutions, laboratories, pharmacies, etc., while the EMR is kept by a single health provider's office and owned by that provider (i.e., a digital version of the classic "patient chart").