



# Achieving Accountable and Affordable Care

Key Health Policy Choices to Move the Health Care System Forward

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Judy Feder and David Cutler December 2010

Center for American Progress



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# Introduction and summary

Reforming our nation's health care system so that it no longer delivers too much low-benefit care at too high a cost will require our new health reform law to spark a system-wide revolution. Disorganized care based solely on fee-for-service payments to a variety of unconnected physicians, hospitals, and clinics will have to give way to coordinated, integrated courses of treatment that deliver high-quality care at lower costs. Prevention and primary care will need to be stressed as much as treatment of the sick. And duplication and medical errors will have to be systematically found and eliminated.

We know medical care can be better organized and delivered. Virtually every industry in our economy over the past 15 years drove down costs, increased quality, and experienced a surge in productivity. The result: An increase in our national income at a rate not experienced since the 1960s. And the outlier in our economy? Our health care industry, which missed out on the productivity boom even as it incorporated all kinds of new and expensive life-saving equipment and services. The impact of this failure to innovate based on costs and quality in health care is enormous. Absent any savings from the recently enacted health reform law, federal spending on medical care is expected to hit 25 percent of gross domestic product (the total output of our economy) by 2035, up from 15 percent of GDP today.<sup>1</sup>

In contrast, increasing health care productivity growth to the average of other industries could cut medical spending by over \$2 trillion and reduce federal government spending by almost \$600 billion over 10 years.<sup>2</sup> Family, employer, and state and local government budgets would benefit in the same way. The possibility of a more efficient, less costly health care system is universally shared. Every analyst who studies health care believes it is possible to simultaneously lower costs and improve quality. The major question is how to realize it.

Reflecting the bulk of studies, the idea underlying the new health reform law, the Affordable Care Act, is to promote efficiency through three interlocking steps. First, we need to gather the right data on what patients need and how best to pro-

vide that, and then feed that information to patients, purchasers, and providers. The American Recovery and Reinvestment Act of 2009 launched the health IT revolution, allocating \$30 billion to wire the medical system. The terms for accessing the money are set, and all observers look for a substantial increase in health IT investment as a result.

Second, we need to move health care payment systems away from rewarding the provision of more care to a system of rewarding better care. It is natural (indeed beneficial) that health care providers such as doctors, hospitals, and clinics respond to the economic incentives they face, which sends them looking for ever more sophisticated kinds of care to deliver to their patients. The problem is, performing coronary artery bypass surgery brings in thousands of dollars to hospitals and surgeons, while keeping diabetic patients healthy so they do not need surgery, in contrast, lowers profits. That's why payment incentives have to change.

Third, we need to encourage providers to reform their operations so that they can take advantage of the information resources and payment incentives. This third step is the subject of this paper, though the concept of the accountable care organization, or ACO, is clearly and directly related to the first two steps. Why? An accountable care organization is a group of medical care providers who accept responsibility for providing or arranging all care for a group of patients under a payment arrangement that allows them to profit from reducing costs and improving quality. Because patients need so many different types of medical care—primary care providers, specialists, hospitals, labs, pharmacies, and more—an ACO must necessarily coordinate care across different providers.

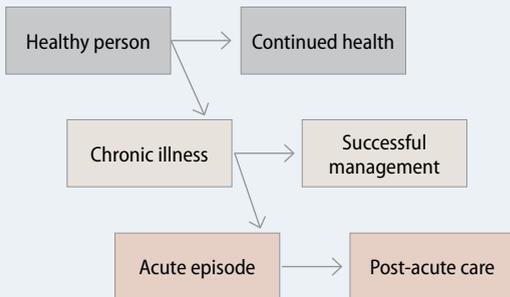
That's how an ACO works, good primary care to regularly assess and manage patients' care needs, information technology that facilitates efficient and effective care management, specialist care when needed, and bundled payment systems that reward quality care. An ACO can coordinate health care needs to boost quality and lower costs. (See box on page 3)

## Where are the savings?

Thinking about people who start off healthy, develop one or more chronic illnesses, and ultimately need acute or post-acute care helps clarify three sources of savings:

- More efficient care in acute and post-acute settings
- Preventing acute illness
- Reducing administrative costs

Bearing in mind our health care flow chart below, let's see how coordination through accountable care organizations can best deliver these three types of savings:



### More efficient care in the acute and post-acute setting

Patients who need acute or post-acute care often receive care that is not beneficial, or experience setbacks because of lack of coordination. The widely cited studies of the Dartmouth Atlas researchers show that care in acute settings varies greatly across the country, with little impact on patient survival or satisfaction.<sup>3</sup>

### Preventing acute illness

The best way to minimize the cost of acute episodes of care is to prevent them from occurring. The problem is that prevention is very haphazard in the United States today. Only 43 percent of patients with diabetes in our country receive all recommended screenings. The share is over 60 percent in the United Kingdom and near that in the Netherlands.<sup>4</sup> If our payment system were to promote better primary care to manage diabetes, as much as \$2.5 billion could be saved from avoiding hospital care.<sup>5</sup>

### Reducing administrative costs

Coordinating among the many different providers in the United States involves significant administrative expense. Because records are not electronic, an enormous amount of time is spent on documentation, obtaining appropriate permissions, and ensuring appropriate reimbursement. A recent study estimated that administrative costs account for 39 percent of the difference in hospital and physician care between the United States and Canada.<sup>6</sup>

### Accounting for accountable care

The total amount that could be saved through more efficient operations is enormous. The studies noted above suggest that about 30 percent of medical care spending is not associated with the improved health of patients, or improved “outcomes” in health policy parlance, and another 10 percent is wasted in administrative costs. The amount to be saved may be as high as 40 percent of total medical spending, or over \$2 trillion annually in the next decade.<sup>7</sup>

The Affordable Care Act requires the Centers for Medicare and Medicaid Services, or CMS, to start an accountable care organization program by January, 2012, inviting all organizations who qualify to participate for their Medicare patients. Learning from experience and building on success, the goal is to expand more effective payment and service delivery not only throughout Medicare but to all the institutions that pay for health care and the patients they cover over time.

The law is intentionally evolutionary, not revolutionary, because past experience—most notably the backlash against health maintenance organizations in the 1990s—demonstrates that forcing consumers and providers to become more efficient is neither welcome, effective, nor sustainable. Instead, the law aims to entice both consumers and providers into sharing in and delivering demonstrably better care at lower cost.

CMS is now in the process of writing the rules for the accountable care organizations. Equally important, the agency is creating a Center for Medicare and Medicaid Innovation, which will be broadly responsible for piloting complementary initiatives that promote better care along the spectrum of innovation. ACOs, the Innovation Center, and other pilot programs specified in the law represent companion pieces of an overall strategy to maximize the potential for sustainable and significant payment reform.

The success of health care reform will depend heavily on the way the tools that the law provides are actually put into effect. Certain features of an ACO program are generally agreed upon. Having good information and performance measures is key. To enable quality improvement at lower costs, CMS must collect outcome-and-cost information in real time and assure its availability to providers and consumers. Providers should readily understand how to form and sustain an ACO, and be held accountable for results, not each operational detail. And the opportunity to do well by doing good—that is, to benefit financially from efficiency—must be strong enough to entice participation and achieve intended results.

Less clear is how best to design policy to achieve both the goal of broad participation and the commitment to better, lower-cost care. New payment arrangements must not only be attractive but also have real potential to change behavior among health care providers and patients alike in order to improve quality and reduce costs. The choices that CMS makes in defining ACOs and related innovations will be critical to a successful launch of payment and delivery reform in the coming decade. Three aspects of design are particularly important:

- Whether payment reforms are designed around hospital systems or encourage new forms of integration among physicians and other health care providers
- How much payment incentives should limit payment for costs above expectations in addition to rewarding costs that are below expectations
- What rights and responsibilities consumers have in a system where providers are paid on a bundled-care basis and rewarded for more efficient care

Based on analysis of each of these three issues, this paper proposes answers to each question. Specifically:

- On payment reform, we encourage the development of physician-led accountable care groups alongside hospital-led organizations. CMS can encourage these organizations by tying financial rewards to reduction of preventable inpatient and emergency care, as well as providing organizational and technical support to physician-led organizations.
- On payment incentives, we suggest a payment system that first optionally and then as a requirement leads providers to share in the financial risks of overspending as well as in the savings from underspending, relative to spending targets.
- On rights and responsibilities, we believe that consumers should be active partners in improving the quality of their care. That means consumers should decide whether to join an ACO, and if they do, they should be able to count on rules for consumer protection and creative ways to benefit financially from seeking quality care at lower costs.

See our table on page 6 for a quick snapshot of our recommendations.

In the pages that follow, we will detail how accountable care organizations are designed to attract the participation of health care providers and their patients. Then we turn to how to ensure that these new arrangements actually deliver better quality at lower costs—avoiding the concentration of pricing power by promoting alternatives to hospital-led accountable care organizations, and assuring that payment incentives promote real change in the delivery of care. We close our paper with a discussion about how patients can partner with their health care providers in delivery reform and, together, build the confidence and commitment we'll need if innovations in health care provider practices and payment reform are to take hold.

## Accountable care organizations

### Quality care at lower costs

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#### Summary of payment reform recommendations

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##### Base requirements for setting up an accountable care organization

- Clear standards for becoming an ACO, such as having a minimum number of primary care physicians and the capacity to report basic performance measures
- Emphasis on primary and patient-centered care as the focus for care management
- Investment in data systems to measure and disseminate cost and quality information in real time to guide patient care
- Strong performance measures to assure that financial benefits reflect “better” not “cheaper” care

##### Participating providers

- Encourage physician-led organizations by stressing reduced hospital use in measures of quality, such as avoidance of ambulatory-care-sensitive admissions or emergency room visits
- Enable physician-led ACOs through CMS arrangements with organizations that have the technology and management capacity to support care coordination

##### Financial rewards and restraints

- Offer providers an initial choice between a payment arrangement that enables them only to share savings or a payment arrangement that offers health care providers a greater share of savings if they also agree to share some risk
- After three years, require providers to share in risk as well as savings

##### Consumer involvement

- Inform consumers about an ACO’s payment system and enable them to choose to participate
  - Provide consumer protection against poor quality ACO-provider choices and consumer benefits to using high-quality, low-cost care
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# What are accountable care organizations?

The concept of an ACO, now defined in law by the Affordable Care Act, first emerged in recent years to characterize arrangements among health care providers who collectively agree to accept accountability for the cost and quality of care delivered to a specific set of patients.<sup>8</sup> The essence of an ACO lies less in its organizational form than in elements of its delivery and operation that enable “accountable” care, specifically its:

- Capacity to deliver the continuum of care, grounded in strong primary care
- Payment that rewards specified improvements in quality as well as slower cost growth
- Reliable measures of patients’ health to assure that savings are achieved through improvements in care

These three elements reflect a health care delivery reform strategy—a combination of effective primary care and active coordination of care—to promote better care at lower costs by reducing the unnecessary use of high cost services, such as hospital inpatient and emergency room care.

Equally important, these three elements reflect a payment-reform strategy that ties payments to the effective measurement of actual quality performance, which in turn assures any savings come from improving care not skimping on care. Both strategies are further distinguished from past reform efforts by holding health care providers, rather than insurers, “accountable.”

Consistent with the concept as developed in the field, the law specifies that ACO participation—a choice open to all health care providers who satisfy specified criteria—can accommodate a broad range of organizational arrangements, including:

- Physician group practices or networks of individual practices
- Physician-hospital partnerships
- Hospitals employing physicians

How many and what kinds of providers actually participate in ACOs and the probable consequences on cost and quality will have less to do with specifications of organizational form than with the qualifying “criteria,” broadly defined, and payment arrangements, which the Center for Medicare and Medicaid Services has yet to fully specify.

Still, we know the broad outlines of what’s to come. The new health care law says that to qualify as ACOs health care provider organizations must have leadership, management and legal structures, and defined processes to ensure the delivery of evidence-based, coordinated care as well as patient engagement. Further, health care provider participants must demonstrate the capacity to implement quality, cost, and other reporting requirements essential to assess the performance of an ACO against quality improvement and payment objectives.

More substantively, the law requires that providers have primary care capacity sufficient to serve a minimum of 5,000 Medicare beneficiaries, demonstrate the capacity for patient-centered care, and agree to specified terms of payment. Consistent with health researchers’ early development of the ACO concept, the statutory language gives prominence to “shared savings” as the mechanism for setting these terms.

The shared savings model establishes a benchmark for per capita spending, based on historical experience for a given population projected forward by the projected national average dollar increase in per beneficiary spending. Health care providers in an ACO are paid on a traditional fee-for-service basis, but if their spending is below the benchmark and their performance passes the threshold for patient service and quality of care then they share the resultant savings with the Medicare program.

Reflecting discussion, debate, and evolution of the ACO concept, the final statute also explicitly authorizes the secretary of the Department of Health and Human Services to adopt alternative payment mechanisms. Specifically, the law allows for so-called partial capitation, a health-payment term that means some portion of the payment is made on a per person basis rather than a per service basis. Partial capitation would enable Medicare not only to share savings but also risk with providers.

More broadly, the new health reform law allows for other payment models that “will improve the quality and efficiency of items and services.”<sup>9</sup> These models could include a shared savings and shared risk approach, where the ACO bears all of the costs and reaps all of the savings that occur within a “corridor” around a predetermined spending amount.

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## Balancing inclusiveness with incentives for change

A fundamental challenge facing the implementation of our new health care reform law is the need to balance inclusiveness (the number of providers participating in new delivery arrangements) and impact (the ability of new arrangements, like accountable care organizations, to actually promote efficient delivery of care).

To engage as many providers as possible to enter into new arrangements means accommodating the varied composition of health care delivery systems across the country as well as the varied relationships within these health delivery systems. And it means the new law must deal head on with the enormous challenge of facilitating collaboration among the substantial proportion of physicians who operate independently in very small practices.<sup>10</sup>

To promote inclusiveness, the law's specification of organizational arrangements "eligible" to participate as ACOs is quite varied, including fully integrated health delivery systems such as Geisinger Health System in Pennsylvania, as well as networks of individual physician practices such as the Hill Physician Medical Group in California. ACO proponents recommend that this variation in organizational capacity be further accommodated by using a "tiered" or "staged" approach in setting organizational and performance requirements and payment systems.<sup>11</sup>

At the lower end of the organizational spectrum, smaller and less formally integrated groups of providers can form organizations that have only modest care management potential. This helps to engage as many providers as possible "where they are"—running small, independent practices—while actively assisting them in moving where they want to be, participants in an integrated delivery system. At the more organized end of the spectrum, more aggressive performance standards (outcome measures for managing particular diagnoses) and payment incentives (partial capitation) can be used, in order to increase the potential for cost and quality results.

Establishing these different "tiers," however, does not eliminate the need for specific decisions about what kind of health care providers are encouraged to participate in an ACO, how they get paid, and how much patients will know about, and be protected in, new payment arrangements—the decisions we turn to now.

# Encouraging physician-led alongside hospital-led ACOs

A number of ACO management structures are possible. The Affordable Care Act recognizes five types of potential qualifying arrangements. Three of these organizations include hospitals:

- Integrated health delivery systems in which hospitals and physician practices share common ownership
- Multispecialty group practices in which physicians own or have strong affiliations with hospitals
- Physician-hospital organizations in which physicians are a subset of hospitals' medical staff

The remaining two organizational types—independent practice organizations and even less-organized networks of physician practices—are physician-only organizations.<sup>12</sup>

Of these five types, the promotion of hospital-led organizations is the least surprising. Given the limited presence of organized systems of care around the country, the original ACO concept aimed to capitalize on existing informal networks—notably hospitals and the physicians who practice there. These physicians are often referred to as the “extended hospital medical staff.”<sup>13</sup> Proponents of ACOs believed that using payment practices to make these hospital-physician networks both visible and accountable would give both hospital management and physicians the incentive to cooperate in order to achieve continuity, coordination, and efficiency in the delivery of care.<sup>14</sup>

Clinically, the value of an integrated system that includes the full spectrum of health care providers is obvious—bringing everyone on board to improve the quality and efficiency of care. Economically, hospitals are seen as both the most likely source of resources to build electronic and other infrastructure needed for care integration, and most likely to cooperate in efforts to reduce admissions if they can offset revenue losses from fewer admissions with a share of the savings that result.

Indeed, there has been a recent trend toward hospitals' employment of physicians. In 2009, 49 percent of residents and fellows receiving new jobs and 65 percent of established physicians in new employment relationships were hired in hospital-owned practices.<sup>15</sup> And there is widely-reported hospital interest in creating ACOs.

But whether hospital-led organizations will transform health care delivery remains an open question. To be sure, some hospitals have led transformation efforts that favor patient-centered, integrated care over maximizing inpatient stays and revenues.<sup>16</sup> But history demonstrates that health care provider "integration" can also be used to fend off health delivery reform, protect hospitals' ability to secure referrals, and enhance provider clout in negotiating higher reimbursement rates with private insurers. All of these possible consequences of health care integration can increase rather than decrease overall costs.

In fact, hospitals' current interest in buying physicians' practices and creating ACOs is markedly similar to their behavior in the early 1990s as the health maintenance organization movement took off. HMOs are generally not seen to have led to much clinical integration or efficiency.<sup>17</sup> Indeed, there were cases of significant conflicts between hospitals and physicians, including contention, rather than collaboration, over the distribution of resources. The efforts in the 1990s for hospitals to employ physicians was generally seen as a failure because employed physicians were less productive than independent physicians.<sup>18</sup> Thus, hospital interest in tight economic affiliations with physicians waned for a time.

But it then reemerged in ways that promoted cost increases, not efficiency. In the Community Tracking Study's 2005 visits to 12 communities, analysts found that hospitals were actively hiring specialists to brand and promote heart, cancer, orthopedic/spine, and other specialized services in order to capture this lucrative business. At the same time, physicians were creating specialty hospitals, ambulatory surgical centers, and imaging centers to compete for the same patients.<sup>19</sup> As this trend continued in 2007, analysts described displacement of longstanding informal relationships between hospitals and physicians by a two-track system, with physicians either employed by, or separating from and possibly competing with the hospitals. In either case, the driving force behind the arrangement was the effort to secure market power (relative to competitors and to payers), not to enhance efficiency in the delivery of care.<sup>20</sup>

California's experience with collaboration demonstrates these problems. Hospital prices in California rose substantially—by an average annual rate of 10.6 percent from 1999 to 2005—as alliances between hospitals and organizations of physi-

cians improved “negotiating clout for both.”<sup>21</sup> While Medicare’s administered pricing system protects the program (taxpayers and beneficiaries) from enhanced market pressure, private payers are hard-pressed to resist payment demands from dominant hospital systems.

Avoiding this outcome in ACO implementation will require not only strong financial incentives to change hospital behavior in hospital-led ACOs (as we detail below) but also the encouragement of ACO models in which hospitals are less central to managing the delivery of care. Physicians can gain substantially from forming organizations to reap the rewards of reducing unnecessary hospital use. Indeed, some experience with physician organizations shows the promise of physician-led arrangements in achieving desired efficiencies.

Over a decade ago, analysts studying California found that so-called capitated medical groups—physician groups that accept payments on a per enrollee basis rather than on a per service basis—performed as well or better than integrated systems in controlling use of hospitals.<sup>22</sup> They avoided expenses for excess capacity that hospitals would not or could not eliminate, and found ways to move their patients smoothly through the system “even without the hospital’s cooperation.”<sup>23</sup>

More recent analysis of experience testing a shared-savings payment model in 10 provider organizations in Medicare’s newly completed five-year Physician Group Practice demonstration, the forerunner to ACOs, found more evidence of savings in physician-led organizations than in integrated systems or organizations with community hospital ownership.<sup>24</sup> Evaluators posited that potential revenue loss impeded hospitals’ ability to reduce avoidable admissions.

Developers of episode-based care similarly call attention to the “internal tensions” that arise between collaborating hospitals and physicians in the face of the substantial profits physicians can earn from preventing hospital use. As a result, they “question the proposition that hospital-centric organizations will deliver the best results for the country.”<sup>25</sup>

The Affordable Care Act highlights the potential role that physician-led organizations can play in reducing the unnecessary and costly use of the hospital through better primary care and care management. By mobilizing their skills and taking charge, physicians can call the shots in distributing the substantial savings that can result. Physicians can also encourage hospitals to compete for, rather than count on, their referrals, and thereby promote better quality at lower costs.

In markets with a single dominant hospital, however, it may be difficult to foster this competition. But forming ACOs should not become an excuse for promoting hospital consolidation by encouraging hospitals to capture physicians and foreclose rival hospitals. If physicians are able to take the lead in establishing care management organizations, then they will be far better positioned to capture savings than if hospitals are in control.

To encourage physicians to actually take the lead, ACO quality performance benchmarks and rewards for good care should emphasize health care delivery changes that depend on physician engagement in better care. Reducing preventable hospital admissions or readmissions should be a key quality metric, emphasizing the avoidance of ambulatory-care-sensitive use of hospitals in emergency settings or as an inpatient.

In addition, the Department of Health and Human Services can help physicians form ACOs by providing or facilitating technical support. Connecting interested physicians with certified care management companies could replicate successful experience that has enabled independent physicians to better manage and coordinate care.<sup>26</sup> So-called quality improvement organizations in Medicare—private, typically nonprofit organizations with which CMS contracts (one in each state) to improve the efficiency and quality of Medicare services—could be enlisted in helping physician groups make the appropriate arrangements.

Finally, the Department of Health and Human Services can aid the development of physician organizations by stressing other aspects of the reform effort that concentrate on physicians, alongside the accountable care organizations. For instance, the new law allows significant innovation in patient-centered “medical homes,” or physician practices providing care that is “accessible, continuous, comprehensive and coordinated and delivered in the context of family and community.”<sup>27</sup> Encouraging better primary care through the Center for Medicare and Medicaid Innovation provides a natural complement to the promotion of physician-led ACOs.

## Promoting an alternative to shared savings

The impact of accountable care organizations on spending and performance will be significantly affected by the terms on which ACOs get paid. The shared savings model continues fee-for-service payments, which health care providers are familiar with, but gives them a bonus if cost increases are below cost trends as calculated by CMS. The maintenance of current payment systems and the potential for upside gains but no downside losses are a key element in the ACO concept's grounding in evolutionary, rather than revolutionary, change.<sup>28</sup> Proponents see rewards as more likely than risks to achieve the desired balance between encouraging broad provider participation and securing cost savings.

The shared savings approach has been recently tested in the Physician Group Practice demonstration—a model of quality improvement combined with rewards for savings on which ACOs are based. Preliminary experience from that demonstration alongside statistical analysis showing that even modest changes in performance could generate substantial savings relative to fee-for-service projections provided a foundation for successfully integrating ACOs into the Affordable Care Act.<sup>29</sup> But in a three-year evaluation although some participating organizations spent below targets and earned bonuses, evaluators attributed variations in savings more to measurement error and pre-existing organizational capacity than to behavioral changes or the prospect of financial rewards.<sup>30</sup>

Concerns about the shared savings approach focus in part on the weakness of its incentives. Its reliance on modest rewards does not eliminate continuing, and potentially greater, rewards to providers from maintaining current costly styles of practice. While shared savings may entice some providers into new arrangements, it provides a relatively weak impetus to real change.<sup>31</sup>

Skepticism about the limited effectiveness of shared savings now fuels interest in alternative payment strategies. An alternative with greater potential to balance the goal of participation with the goals of delivery reform is to offer prospective ACOs a time-limited choice between the shared savings model and alternatives that not only share savings but also some risk. Under this alternative approach, ACOs could keep a larger share of the savings from better management, but in exchange share some of

the losses for costs above target spending levels. Payments could continue to be made through fee-for-service or limited payments could be paid out as a lump sum, and new ACO entrants would be given a choice of model, but after three years of participation in “shared savings” all ACOs would be expected to shift away from that approach.(see box)

## Payment models for accountable care organizations

There are several ways that payments to ACOs could be structured, reflecting different degrees of risk and incentives—the shared savings approach, the shared savings and risk approach, and the so-called partial capitation approach. Let’s look at each in turn.

### Shared savings only

This model is specifically called for in the Medicare Shared Savings Program section of the Accountable Care Act. In this model, a target amount is set for each ACO, generally as past spending projected forward by the expected growth in per person medical costs. Actual payments are then made on a fee-for-service basis.

Periodically, providers receive additional savings if actual costs fall below the target by a sufficient amount. For instance, in the Physician Group Practice demonstration, shared savings was triggered when costs were at least 2 percent below target. The threshold was set to assure savings were “real” and not a statistical artifact. So for every dollar saved greater than 2 percent, the provider received 80 percent of the savings and the government received 20 percent.<sup>32</sup>

### Shared savings and risk

This model would set a target spending amount, as in the shared savings-only model, and fee-for-service payments would continue to be judged against the target. But in place of the threshold and a share of savings above that level, the ACO would have a “corridor” around the target amount, within which the ACO would retain all savings or bear all costs.

In the model discussed by the Medicare Payment Advisory Commission, or MedPAC, the corridor would allow for maximum profits or losses of 4 or 5 percent.<sup>33</sup> A similar approach could use a sliding scale

for “sharing,” with the government keeping a greater share of savings and bearing more of the expense as costs diverge from the target.

### Partial capitation

The shared-savings-and-risk approach could move further away from fee-for-service payment by using capitation payments, or lump-sum payments made regardless of utilization levels, to replace fee-for-service payment in the corridors. This approach would use the same target spending level as the other two—but would make regular payments for a portion of that level without regard to “fees” or volume of service.

For example, ACOs would receive a monthly lump-sum payment equal to the targeted amount of spending. ACOs would face the same maximum profits or losses as in the previous approach. But Medicare’s payments would be adjusted retroactively to share savings and risks, based on actual service costs.

### Which model to choose?

Analyses of how best to encourage more efficient care come to different conclusions about the best model to use. What is clear, however, is that a shared-savings model by itself is not ideal.

We thus recommend that CMS offer clearly defined alternatives to the shared-savings model, and require ACOs to transition away from shared savings after three years. For most providers, the closest alternative to current payment structures is the shared-savings-and-risk model with an underlying base of fee-for-service payments. At the option of providers, however, CMS should be able to convert the fee-for-service payment to a capitation amount.

A strategy that puts providers at risk for cost increases as well as rewarding them for cost reduction limits the current incentive to just do more and puts pressure on the largest sources of preventable costs, especially inpatient and emergency department care. But those risks are “bounded,” which means potential losses and savings are capped at a level specified by CMS, and for those not ready to take those risks are imposed only after a three-year period.

Positive incentives could be further increased by having the Innovation Center offer loans to health care providers willing to take risk. These loans could be used to invest in redesigning the practice, for example by investing in nurse coordinators and electronic records in order to make greater responsibility possible. Such loans would address another major critique of “shared savings”—its continued reliance on fee-for-service payment leaves investments in improved care delivery “unpaid for.”<sup>34</sup>

The proposals above are not the only feasible alternatives that could be offered alongside shared savings.<sup>35</sup> Others recommend that the Center for Medicare and Medicaid Innovation test several models of risk-sharing, partial capitation or “mixed” payments.<sup>36</sup> Testing certainly makes sense, and learning and adapting are at the heart of the new health law’s strategy for payment and delivery reform. But unless a robust alternative is available simultaneously and on the same scale as a shared-savings model, its appeal and adoption will likely be hampered. Offering that alternative from the get-go, as we recommend, creates a better balance between participation and impact than does reliance on a single model alone.<sup>37</sup>

## Engaging and protecting consumers

Payment reform can only succeed if consumers see it as improving and not undermining their care and if those patients are active participants in their care process. As providers regularly note, they will face difficulties in assuming “accountability” for both the quality and cost of care if consumers are not involved. Consumer organizations are now actively espousing payment reform and are engaged in promoting consumer-oriented terms of accountability.<sup>38</sup>

Responding to their concerns—and sensitive to avoiding a repeat of the HMO backlash—the Affordable Care Act’s qualifying criteria for ACOs include requirements directly aimed at patient engagement. Alongside the other organizational requirements noted above, ACOs must “define processes to promote evidence-based medicine and patient engagement ... and coordinate care” and demonstrate their use of “patient-centeredness criteria,” specifically defined to include patient and caregiver assessments or the use of individualized care plans.<sup>39</sup>

Further, the law requires that measures of quality used to assess ACO performance include patient, and “where possible” caregiver, experience, broadly understood as the patient’s assessment of how much the provider listens, explains, respects their statements, and spends time with them.<sup>40</sup> Consumer organizations are appropriately promoting aggressive implementation of these provisions, along with requirements for adequate provider networks, risk adjustment, and other elements of ACOs to achieve delivery reform that provides quality care.<sup>41</sup>

Equally important to these efforts are decisions in areas where the law is virtually silent. In the initial ACO concept and its application in the Physician Group Practice demonstration, providers choose to participate in an ACO but patients do not. Providers are held accountable for the costs and quality of care for patients who rely on them for most (“a preponderance”) of their care—determined after the year’s end. Identification of those patients, and—for quality and payment purposes—assessment of their experience against cost and quality benchmarks occurs after the fact, and is referred to as “retrospective assignment.” Patients are not aware they are in an ACO and they retain the freedom to choose any provider at any time.

Retaining patients' choice of providers—or in health care parlance not requiring a “lock-in”—is a key element in engaging rather than forcing consumers into health care delivery reform. But uninformed consumers and retrospective assignment run counter to effective consumer engagement. It does nothing to encourage patients to alter their use of specific services or their preventive care to improve the cost and quality of care. And it leaves consumers unaware of financial incentives—rewards as well as risks—that may lead providers to discourage appropriate as well as inappropriate services, to avoid referrals for expensive services, or to be reluctant to serve some patients.

More active consumer participation and consumer protection is therefore required. To assure both consumer participation and protection, ACOs should employ informed, prospective assignment—letting both providers and patients know in advance who is participating in the new health delivery arrangements—rather than retrospective assignment, which happens when beneficiaries are assigned to an ACO at the end of the time period over which the ACO's spending levels are compared to CMS's expenditure target. The uncertainty of retrospective assignment for both providers and patients undermines the investment each of them has in shared decision-making to achieve better care at lower cost. Prospective assignment, perhaps accompanied by allowing consumers to “opt out” by retaining access to their physician under traditional payment rules, can strengthen that investment.<sup>42</sup>

Further, informing patients in advance of the ACO arrangement facilitates what some have called a “good faith social contract” or “soft lock-in” that specifies a commitment to work together but not a restriction on choice.<sup>43</sup> For example, the Geisinger health system has adopted what they call the ProvenCare model to pay for hospital services. It includes a “patient contract” that describes the commitment of the system, patients, and families in adhering to the program's best practices. Use of the contract dramatically increased consumer adherence to provider recommendations—raising the share of patients receiving all 40 elements of the ProvenCare process from 59 percent to 100 percent within 6 months.<sup>44</sup>

Such contracts would be strengthened if ACO providers are allowed to reward consumers for living up to the contract terms. Reductions in Medicare cost-sharing for consumers who agree to participate in ACOs is one proposed mechanism for providing financial rewards.<sup>45</sup> But Medigap insurance, or private insurance used to supplement traditional Medicare coverage, eliminates cost-sharing for many Medicare beneficiaries, limiting the effectiveness of this approach.

Mechanisms to reduce Medicare Part B premiums for beneficiaries who adhere to contracts are possible, but complicated. The simplest arrangement for sharing savings with consumers might be to allow providers to offer them a rebate—an explicit share of the “shared savings” or other bonus the ACO actually earns—as a reward for adherence to ACO recommendations.

But no matter how “gently” ACOs are implemented, changing providers’ financial incentives raises real questions, and fears, among some patients. Rigorous adherence to the quality measurement and performance requirements that are fundamental to ACOs are essential to effective reform—and to preventing the backlash that accompanied HMO implementation. Given new financial incentives for providers, consumers also deserve active protection—recourse in case of “bad” behavior on the part of ACO providers.

To that end, CMS should assure beneficiaries’ access to some kind of ombudsman—someplace to go for help arranging a second opinion or recommendation of alternative provider if they question a provider’s recommendation. In the event that all appropriate physicians, including specialists, participate in an ACO, establishment of external appeals—as applies in Medicare Advantage plans—might also be necessary.

# Conclusion

Debate surrounding the enactment of the Affordable Care Act frequently included critique of its measures to contain costs. But the new law is designed to enable, not force, cost containment by allowing Medicare to experiment with alternative payment designs. The accountable care organization regulation, alongside related efforts in the Center for Medicare and Medicaid Innovation, is key to making Medicare the engine for system-wide reform.

This evolutionary, rather than revolutionary, approach to reform embedded in the Affordable Care Act reflects appropriate concern with moving reform briskly, but not too far and too fast, in order to instill patient and provider confidence. Among the many choices the Center for Medicare and Medicaid Services will make in striking the balance between impact and acceptance, evidence and experience underscore the importance of the three areas of reform we have focused on:

- Encouraging accountable care organizations where physicians, not just hospitals, dominate
- Moving to payment models that penalize losses as well as reward cost savings
- Engaging consumers in the choice of ACOs and the steps they can take to contribute to higher-quality, lower-cost care.

With the adoption of these recommendations, Medicare's launch of ACOs in 2012 alongside related payment changes will signal its commitment to the transformation of our medical system that the Affordable Care Act aims to achieve.

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## About the authors

**David M. Cutler** is a Senior Fellow at the Center for American Progress and the Otto Eckstein Professor of Applied Economics at Harvard University, where he recently completed a five-year term as associate dean of the faculty of Arts and Sciences for Social Sciences.

**Judy Feder** is a Senior Fellow at the Center for American Progress and a professor of public policy at the Georgetown Public Policy Institute, where from 1999 to 2008 she served as dean of the institute.

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