

Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?

Timely Analysis of Immediate Health Policy Issues

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Introduction

In the current health reform discussions, accountable care organizations (ACOs) have been proposed as a novel way to slow rising health care costs and to improve quality in the traditional Medicare program and perhaps other public and private insurance programs. However, for many, it is not clear what ACOs are and whether and how they differ from other past reform approaches intended to achieve the same goals. The ACO concept is confusing partly because it is a concept with a history, one that is rapidly evolving and for which the terminology seems to keep changing. In fact, as the Issue Brief will show, different reform ideas have now been joined under the rubric of ACO.

The primary purposes of this Issue Brief are to provide insight into what ACOs seem to represent and whether they potentially offer a new and improved way to reform U.S. provider payment and delivery systems, with an emphasis on their application in Medicare. First, we clarify what ACOs generally are, including the current concept's genesis and important dimensions on which ACOs might vary. Second, we discuss what is new about the current ACO concept compared to previous reform concepts, such as "accountable health plans" or Health Maintenance Organizations (HMOs) and provider-sponsored organizations (PSOs) that were established for Medicare in the Balanced Budget Amendment (BBA) of 1997.

Third, we identify key ACO program features and issues policymakers are grappling with and about which there are different and even divergent viewpoints. These include: (1) the ACO definition and qualifying criteria, such as what kinds of providers must be included and whether an ACO is different from a patient-centered medical home (PCMH); (2) whether an ACO program should be voluntary or mandatory for providers; (3) similarly, whether beneficiaries should be assigned to ACOs or should elect to participate in one; (4) alternative ACO payment methods and their respective strengths and weaknesses; and, (5) quality measurement and monitoring. Decisions about these program features and issues will strongly influence providers and patients' reactions to the ACO concept.

Finally, we discuss several major implementation challenges, specifically, participation of and possible untoward impact on other payers and the new roles, responsibilities, and capabilities for providers and government. We also summarize some of the pointed skepticism that some have leveled at the ACO concept and consider whether this is another example of a concept advanced more by wishful thinking than by empirically based policy analysis.

We conclude that ACOs are no game changer in the short run because they require resolution of some challenging and complex issues as well as significant provider and policymaker learning, but nonetheless, they are important to try.

If done well, an ACO program could build on lessons learned from and since the managed care era of the 1990s, get critical provider payments and delivery system changes underway, and perhaps in the long run move us beyond reliance on what many consider a dysfunctional fee-for-service (FFS) payment system.

What is an ACO?

Fundamentally, the ACO concept couples provider payment and delivery system reforms in an attempt to solve the "chicken and egg" problem.¹ Many believe that to bend the cost curve while improving quality, we must reform the provider payment system first, because it pays for volume rather than value. Others hold that it is impossible to change the payment system to achieve the desired objectives unless delivery system reform first produces organizations capable of handling an altered payment system. They point to the need for health care professionals, now usually working in separate institutional settings, to work collaboratively and to demonstrate their capacity for handling new payment approaches. To avoid the quandary of where to start first—provider payment or delivery system reform—the ACO concept attempts to combine them.

More specifically, ACOs can generally be defined as a local entity and a related set of providers, including at least primary care physicians, specialists, and hospitals, that can be held accountable for the cost and quality of care delivered to a defined subset of traditional



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Medicare program beneficiaries or other defined populations, such as commercial health plan subscribers.² The primary ways the entity would be held accountable for its performance are through changes in traditional Medicare provider payment featuring financial rewards for good performance based on comprehensive quality and spending measurement and monitoring. Public reporting of cost and quality information to affect public perception of an ACO's worth is another way of holding the ACO accountable for its performance.

Proponents generally view three ACO characteristics as essential. These characteristics include: (1) the ability to provide, and manage with patients, the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post acute care; (2) the capability of prospectively planning budgets and resource needs; and, (3) sufficient size to support comprehensive, valid, and reliable performance measurement.³ Table 1 summarizes the diverse entities that could serve as an ACO, solely or in combination, including their capacity on the first two criteria.

Diverse entities could serve as an ACO, alone or in combination with each other, the collective serving as a local provider umbrella organization, system, or network (see figure 1). Shortell and Casalino⁴ identify five different types of

existing organizations that could either exclusively serve as an ACO in a local geographic area, or more likely lead or be part of an ACO led by another provider organization in the area. These existing provider organizations include (1) various types of physician groups or physician-centered organizations, namely multispecialty group practices (MSGs) and interdependent physician organizations (IPOs)—what most people refer to as an independent practice association (IPA); (2) hospital-centered organizations, namely hospital medical staff organizations (MSOs) and physician-hospital organizations (PHOs); and (3) Health Plan-Provider Organization or Networks (HPPNs). The latter is similar to a particular type of HMO, specifically one that contracts with one or more IPAs or with independent physician practices. However, rather than discussing HPPNs which can already participate in Medicare as a Medicare Advantage (PA) plan, we discuss organized or integrated delivery systems (ODSs or IDSs) more narrowly.⁵

Fisher and his team⁶ also acknowledge that this range of existing provider organizations could surely serve as ACOs, but they also introduce the idea that a new type of organization,⁷ fostered by analysis of Medicare claims data and comprised of local hospitals and the physicians who work in and around them, could also form ACOs. It is this “virtual” organization concept

that spurred the recent ACO interest based on the view that these less formal organizations could develop relatively quickly and throughout the heterogeneous forms of U.S. health care delivery.

Together, the Medicare Payment Advisory Commission (MedPAC), the organization that advises Congress on payment and related policies for Medicare, and Fisher provided the impetus for the current concept and interest in ACOs, building on two developments—an early, positive evaluation of the Medicare Physician Group Practice (PGP) Demonstration that relied on an FFS-based payment model⁸ and analysis by Fisher that patients cared for by particular physician groups flowed to or clustered at particular hospitals.⁹ The latter analysis suggested to some that a virtual, extended hospital medical staff could be held accountable for total spending and the quality of care for patients who obtain their care from this set of physicians, similar to the way that the MSGs in the PGP demonstration were being held accountable in determining their eligibility for financial bonuses for performance.¹⁰

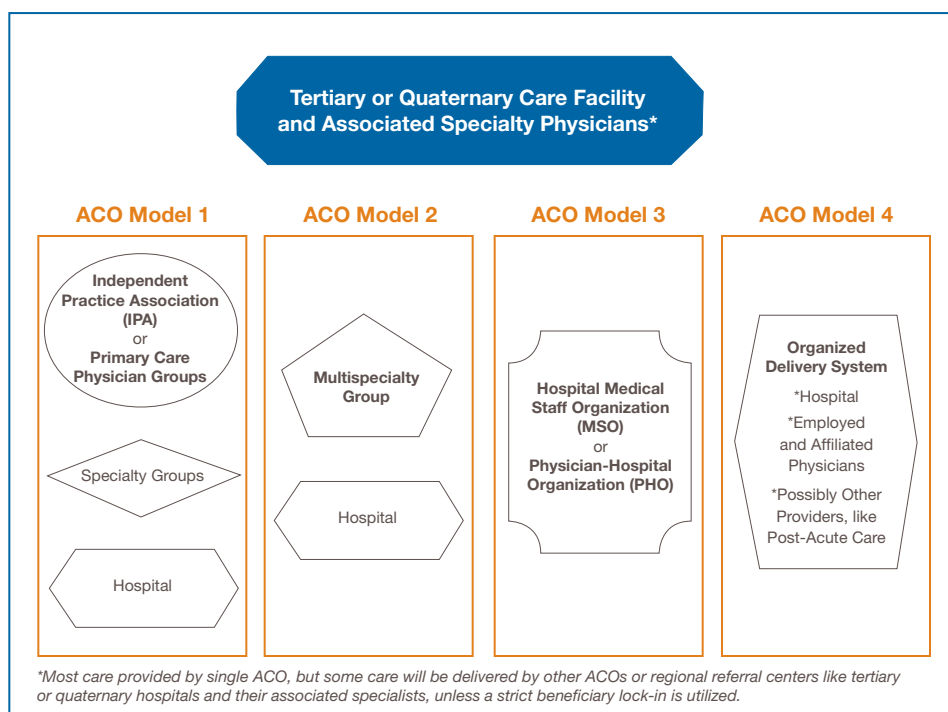
Others have followed with their own versions of ACOs, sometimes using different terminology and offering somewhat different prescriptions for their design features. For example, in the House of Representatives

Table 1. Potential ACO Models and Their Characteristics

Provider Type	Ability to Provide or Manage Care Across Continuum	Ability to Plan Budgets and Resource Needs (Accept and manage non-FFS payment)	Provider Inclusiveness	Level of Performance Accountability
IPA	Low/Medium	Medium	High	Medium
Multispecialty Group	Medium/High	Medium	Low/Medium	Medium/High
Hospital Medical Staff Organization	Medium	Low/Medium	Medium	Low/Medium
Physician-Hospital Organization (PHO)	Medium/High	Medium/High	Low/Medium	Medium/High
Organized or Integrated Delivery Systems	Medium/High	Medium/High	Medium	Medium/ High
Virtual approach-Extended Hospital Medical Staff	Medium	Low/Medium	High	Low

**Based on the literature about these types of organizations.*

Figure 1. Possible ACO Configurations, Comprised of Different Provider Organizations in Local and Regional Geographic Areas



Tri-Committee on Health Reform draft legislation that set up ACO demonstrations,¹¹ the definition of an ACO is quite broad, and the Secretary of the Department of Health and Human Services would delineate a more specific definition and qualifying criteria when proceeding to solicit demonstration participants. Qualifying criteria would have to delineate, for example, what legal structure would be acceptable for permitting the ACO entity and its constituent providers to receive and distribute payments and the minimum number and types of physicians needed in an ACO. The Senate Finance Committee Chairman's Mark also uses a quite broad ACO definition, but articulates more specific qualifying criteria, leaving less discretion for the Secretary in designing the demonstrations.¹²

What is new about the ACO concept and proposals?

While the notion of accountability is not new, the locus of accountability has changed. "Accountability" became

a key word and critical part of the managed competition approach adopted in President Clinton's Health Security Act, in which health maintenance organizations (HMOs) were dubbed "accountable health plans."¹³ Developers of the ACO concept also emphasize accountability, but focus directly on health care providers and the delivery system instead of insurers and HMOs. The focus on local providers and delivery systems stems from a desire to address a number of continuing, frequent problems, including absence of financial incentives to reduce cost and improve quality and resultant problems, such as uncoordinated care and unwarranted geographic variation in practice patterns and health spending. The new approach, then, emphasizes accountability at the level of actual care delivery.

Second, the ACO concept envisions direct contracting with provider organizations without the reliance on a health plan intermediary and thus is distinct and separate from the contracting that occurs in the Medicare

Advantage program, which presumably would continue in parallel. Actually, in the BBA of 1997, PSOs were created to facilitate Medicare engaging in financial risk contracting directly with provider organizations. However, only a few PSOs have developed and participated in the program in the decade that this option has been available. As discussed later, current ACO proposals do not envision the degree of provider risk assumption that subjected PSOs to state insurance regulation or the BBA-enabled alternative. Nevertheless, to the extent that some ACO proposals would involve providers taking financial risk, thereby raising concerns about solvency, and would employ even mild limitations or incentives to channel beneficiaries to ACO providers, the program might again have to address complex insurance regulation issues that affected the PSO effort.¹⁴

Third, the ACO concept and current proposals potentially allow great flexibility in both the types of organizations that would qualify to serve as an ACO and the available provider payment methods. Some think this degree of flexibility differs from previous reform approaches that emphasized particular types of insurance or provider organization—HMOs or IDs—or one approach to provider payment—full capitation, as in the PSO program. The degree of flexibility in the ACO concept and in some proposals is recognition of the substantial variation in local health care markets, as well as in provider organizations and their willingness and ability to accept nonstandard, FFS payments. The increased flexibility presumably would provide opportunities for virtually all physicians and hospitals to participate and would "let the market work," in the sense that local market conditions and dynamics would ultimately determine which ACO organizational model and supportive payment approach prevailed in any particular area.

Key ACO program features

Although various authors and legislative proposals have described the broad outlines of the ACO concept,¹⁵ there are many program options and design features that are being actively discussed and debated. Decisions about these ACO program options and features would substantially affect the nature and contours of the ACO program; its implementation, including its scale, pace, challenges, and potentially necessary supports; and short and long-term outcomes with respect to cost reduction and quality improvement. Here we discuss five key issues to watch as ACO program proposals unfold.

Specific ACO definition and qualifying criteria

Legislative proposals in the House and Senate¹⁶ both define ACOs quite broadly, but seem to leave important aspects of the ACO concept somewhat unclear or reflect different perspectives on some key issues, including how much of the decisions should be left to the Secretary of HHS. Program design decision issues include which type of provider organization can lead an ACO, in particular whether it must be physician led; what other types of provider organizations may or must be included; what specific ACO qualifying criteria should govern participation; and whether PCMHs can lead or be part of an ACO.

Some believe that physician-centered organizations should lead ACOs because the resources that flow from the decisions physicians make with patients account for a major portion of overall health care costs, regardless of where the care actually takes place. Most existing physician practices, which are solo or small, single specialty groups would not possess the three essential ACO characteristics described above.¹⁷ MedPAC and others have suggested that IPAs are an organizational model that would permit even small physician practices to come together to form organizations fulfilling these criteria. Some hold that if a MSG- or IPA-based ACO did not include a hospital, these

physician-based organizations could still be held accountable for the quality and costs associated with hospitalization.

Consistent with the call for flexibility, hospitals or hospital systems (ODSs or IDSSs) might also be allowed to lead an ACO. In many communities, hospitals employ a large portion of the physician workforce and they may be more likely to provide capital and management skills that ACOs would require to produce the kind of system redesign needed to methodically improve quality and reduce wasteful care in accord with a spending budget.

Indeed, to address the problem of care fragmentation, some think that local hospitals must be included in an ACO. However, others think that the relationship between physicians and hospitals is becoming so severely strained¹⁸ that perhaps we should allow separate outpatient and inpatient ACOs to develop and not force a marriage between feuding partners. While the latter approach might defeat one of the primary purposes of ACOs—accountability for the full continuum of care—it may be more feasible in the short term and potentially allow separate ACOs to come together in the future.¹⁹

Similarly, some would want other provider types, such as post acute care facilities and ambulatory surgery centers, to be part of broad ACOs. In contrast, others would not require their inclusion but would want to hold the ACO accountable for the care—and costs—provided across the range of services beneficiaries might need.

The ACO definition and accompanying qualifying criteria delineated in final legislation or demonstration guidance would strongly influence, if not actually determine, what types of organizations would lead or participate in an ACO and how they would have to be legally structured. For example, if an ACO were defined as a physician-led organization and the minimum number of physicians needed set at 200 or more, as in the PGP demonstration, only a relatively small number of existing physician groups,

mostly MSGs, would be able to meet the criteria. Smaller groups would either have to merge or, more likely, would have to form an IPA to participate. Yet, again, the current interest in ACOs arose from a desire to permit even virtual organizations of physicians working in close proximity and serving the same patients to become ACOs and thus permit looser organizations to constitute eligible ACOs.

Some recommend that even very small physician groups, such as those with three to five physicians, should be allowed to serve as ACOs; the Senate Finance Committee Chairman's Mark also adopts this view.²⁰ However, this approach raises concerns about small practices' ability to fulfill the three key ACO characteristics described in the introduction and would create a much greater administrative burden for the Centers of Medicare and Medicaid Services (CMS) than a program relying on a smaller number of larger physician groups, IPAs, or provider organizations.

Indeed, it is not clear how the expectations for an ACO with a few physicians differ conceptually from a PCMH, and to what extent ACOs and PCMH programs complement or conflict with each other. The PCMH is an enhanced primary care practice model that provides comprehensive and timely care with appropriate reimbursement, emphasizing the central role of teamwork by a group of health professionals and more active engagement by those receiving care. The PCMH concept not only emphasizes enhanced primary care but also incorporates the ideas of provider payment and delivery system reforms, including primary care providers' voluntary acceptance of accountability for the quality of care provided to their patients.²¹ Some believe that ACOs and PCMHs are complementary innovations and discuss ways they could be mutually beneficial and reinforcing.^{22, 23}

Voluntary or mandatory provider participation

The House bill proposes a voluntary ACO provider program²⁴ and MedPAC

describes this approach as well.²⁵ That is, an existing provider organization or new configurations of them (see figure 1 and table 1) would have to indicate proactively a desire to participate. If the traditional Medicare program adopts policies that strictly limit provider payment increases, physicians (with or without hospital partners) might want to opt out of the payment constrained FFS program by selecting the alternative ACO pathway that offers them the potential of both expanding their patient base and achieving financial rewards based on their own actual performance. Another reason physicians might voluntarily want to become an ACO is that some physicians do not like the incentives inherent in standard FFS payments and would like to be rewarded for achieving high standards on quality measurement and prudent management of health resources, which should include building stronger partnerships with patients. In short, physicians and other providers might be both pushed and pulled into an ACO program offered by the nation's largest and most important payer—Medicare.

A voluntary provider program has several potential strengths. First, provider organizations that are able to meet the accountability tests would choose to participate, increasing the likelihood of initial ACO success and providing models for others to emulate. Second, a narrower, voluntary participation program would require fewer resources to administer and oversee initially.

However, relying on voluntary participation might result in relatively little uptake, as occurred with the PSO program. An initiative that is small in scale and involving a unique set of providers might not be particularly relevant to the challenge of fundamentally restructuring payment and practice across the country. In addition, only organizations that feel confident they would earn bonuses might choose to participate, raising concerns that a voluntary ACO program

overall would not generate savings for Medicare.²⁶

Alternatively, in a mandatory provider program, physicians and hospitals would be assigned to a virtual ACO based on analysis of claims data; currently, provider organizations and professionals generally do not know how frequently their patients are flowing to each other's practices and institutions and may not perceive themselves as having a common interest in caring for these patients. Plausibly, their assignment into the same virtual organization would provide them with this key information and a reason to develop their relationships, a culture of collective responsibility, and an effective governance structure.

Accordingly, there are several positive attributes of a mandatory ACO program. First, it can be much more widely applied than a voluntary program because it should engage most physicians, hospitals, and perhaps other key providers that serve Medicare beneficiaries and would provide them a reason to work together. Because of its much broader application, a mandatory program could result in greater Medicare savings²⁷—but only if the selected payment model in fact succeeds in achieving spending reductions.

On the other hand, a broad program of assigning beneficiaries, physicians, and other providers to statistically determined ACOs would be challenging to administer. In addition, some providers would be reluctant or unprepared to alter their practice patterns to reduce cost and improve quality. Merely providing them a mild financial incentive to change their practice patterns would not guarantee that they would actually change. In addition, the physicians assigned to the ACO would need to develop a common vision of how to achieve their organizational objectives and would have to implement a functional governance structure. Some doubt that these ACO prerequisites would be accomplished in many cases. Indeed,

imposing a requirement that key health care providers participate together in an ACO might only exacerbate conflicts between health care organizations and professionals that have developed over the years, such as those between physicians and hospitals and between primary care physicians and specialists.

How beneficiaries participate in ACOs

Beneficiaries' reactions to the ACO concept will also be important, because their perceptions would affect whether they will ultimately select ACOs if given an opportunity or whether they will support or oppose them in other ways, such as a through political activity; further, their responses could affect providers' ability to improve their cost and quality performance. For example, if beneficiaries believe that ACOs are essentially tightly managed "HMOs in drag" that are going to restrict their choices, undermine the doctor-patient relationship, and result in cheaper but lower-quality care, the concept will be met with skepticism, if not overt opposition. On the other hand, if ACOs are viewed as a way to make the health care system easier to navigate and to improve the quality of care, to provide more for their health care dollars, and to put critical health care decisions in the hands of local doctors, hospitals, and the communities and patients they serve, the concept is likely to be more positively received. Whether and how CMS and providers communicate with beneficiaries about these ACO-related issues will influence their response to the innovation, as will two important ACO program features: (1) whether they are assigned to an ACO or, alternatively, are allowed to select participation in an ACO; and (2) whether and to what degree their access to care outside an ACO is restricted in any way.

In some ACO proposals, beneficiaries would be assigned to an ACO based on where claims analysis shows they go for their care; adopting the PGP demonstration approach, they might not even have to be informed of this

assignment because their freedom of provider choice would not be restricted in any way. In this case, ACO assignment is coupled with a “no lock-in” feature. Although providers would be managing their care, beneficiaries would not necessarily even know it. Indeed, if beneficiaries’ care patterns change from one year to the next, their ACO assignments would likely change accordingly. There is a slight difference on this issue between the House Tri-Committee’s and Senate Finance Committee’s proposals, with both proposing beneficiary assignment but the House requiring that beneficiaries must be informed of that assignment and the Senate not stipulating that beneficiaries have to be informed.

Beneficiaries may view claims-based assignment and no lock-in positively, because it does not interfere with their choices or existing doctor-patient relationships; further, these features would simplify the administration of an ACO program. On the other hand, if beneficiaries indirectly and retrospectively learn that their provider had an incentive to reduce cost and improve quality, it might undermine trust in their physicians, as some contend that HMOs and managed care potentially does.²⁸ In addition, this no lock-in feature might negatively affect ACOs’ interest in actually managing patients’ care and their ability to actually do so, making it harder to determine which patients and care management processes to focus on to achieve cost and quality targets.

An alternative is to require beneficiaries to affirmatively select an ACO if one exists in the community, much as patients select an HMO network, and to commit to seeking their care from ACO providers for some set time. This option would require more extensive efforts to help beneficiaries and consumers understand what ACOs are and the respective roles and responsibilities that pertain. The mere process of facilitating beneficiary selection of ACOs would be administratively much more complex than a statistically based assignment.

This approach might invoke the need for additional regulatory oversight if ACOs wanted to use techniques to manage care similar to those used by HMOs and the rare PSOs in the Medicare Advantage program.

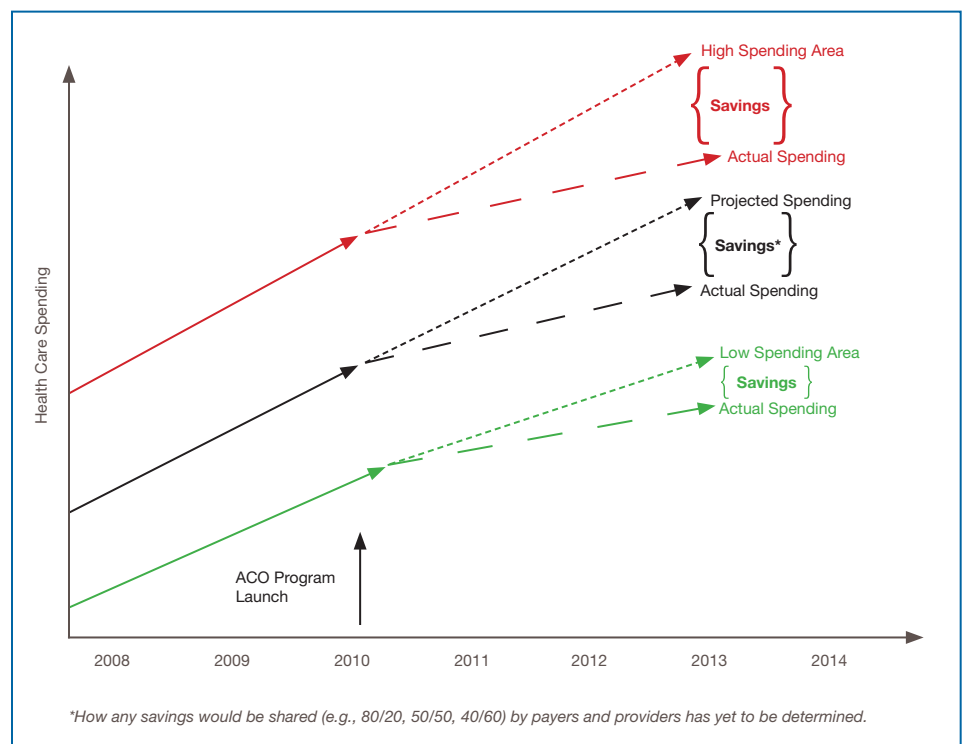
Because of the concern that a true lock-in would discourage beneficiary participation in what would likely be restricted ACO provider networks, variants of what might be called a soft lock-in have been suggested for ACOs where beneficiaries make an affirmative decision to associate with a particular ACO. A soft lock-in might involve financial incentives, such as differential cost sharing, to encourage beneficiaries to seek care mostly from the ACO they have selected, an approach used in preferred provider organizations and point-of-service plans. A soft lock-in might even be as simple as a good faith social contract between beneficiaries and the ACO, outlining the parties’ responsibilities to each other but otherwise not restricting freedom of choice.

Provider payment methods and financial incentives

While a number of payment models to support ACOs are possible, two very different types of ACO payment methods are included in the current House legislative proposals for testing: a shared savings program (SSP) and partial capitation, based on what some call population-based payment (PBP).²⁹

The basic SSP concept is fairly straightforward and illustrated in figure 2. The FFS system remains intact, so providers continue to be paid on that basis. However, Medicare calculates and sets the expected total expenditures for the patients cared for by the ACO while measuring and assessing the quality of care. If the ACO provides the care its patients need for less than expected and the quality standards are met, the ACO is rewarded with a portion of the savings as a bonus. A variant of the SSP is that some portion of billed for FFS payments are withheld and only returned if the ACO provides the care its patients need for less than expected.³⁰

Figure 2. Shared Saving Program (SSP)



A critical issue with the SSP payment method is how to calculate and set the expected total expenditures for patients cared for by the ACO. While the PGP demonstration used a control group as the source of expected expenditures, setting up a control group for every ACO would not be administratively feasible, particularly for a large-scale program. As an alternative, MedPAC proposes determining expected total costs and setting benchmarks based on historical spending over a three-year period, adjusted for patient case mix. Yet, even here, there are options that vary on two dimensions: (1) use of local, regional, or national spending; and (2) a focus on base spending, the rate of spending growth, or some combination of the two. Different configurations for setting spending targets would importantly determine the likelihood that any particular ACO would in fact achieve bonuses based on the success of their spending management.³¹

Whatever variant of the SSP payment options are selected, the anticipated virtue of determining bonuses based on a shared savings approach is that it does not involve financial risk taking, making it more attractive to many would-be ACOs. In addition, SSP should be relatively easy to implement, since the basic FFS payment system remains in place, with determination of bonuses a retrospective accounting matter.

However, there may be a fundamental weakness to the SSP payment method for ACOs—it leaves the “do more, get paid more” incentives of FFS in place. New services or care management approaches that might reduce total expenditures but are not paid for under FFS system, such as greater reliance on nurse care managers for chronic care patients and enhanced patient communication outside of standard office visits by phone or e-mail, may go untried. Otherwise, the ACO would have to finance these activities directly, with uncertain prospects of financial rewards for so doing. It is also hard to see how the prospect of a potential bonus sometime in the future would

counter the real-time FFS incentive to generate more services. The speculative nature of a potential bonus may be too weak to motivate an ACO to commit to innovate, perform well, and sustain gains. Although acknowledging that FFS incentives are a problem, proponents of this approach nevertheless believe that the prospects of a substantial bonus based on achieving overall savings could produce different referral patterns within the ACO such that more care would be channeled to the clinicians who demonstrate more prudent use of health care resources.

In addition, a SSP based on local spending primarily rewards improvement rather than good performance. Communities and providers that have the most to gain from an SSP are the ones seemingly wasting the most resources (see figure 2). Those that are already doing well by being low cost and high quality would have to make greater investments to improve and would be less likely to be rewarded (see figure 2). Indeed, since current SSP models provide no downside risk or penalty to the provider for missing both quality and cost targets, ACOs and affiliated providers would have a perverse incentive to increase utilization and total costs in order to create future opportunities for “savings” and “bonuses.”³²

The alternative to SSP specified in the House legislation is partial capitation or a PBP system, where a predetermined amount is prepaid to a provider for the services needed by a specific group of people for a fixed period. Capitation or PBP payment methods encourages providers to think in terms of the resources required to take care of the overall population they are accountable for and involves a greater degree of financial risk for them which is typically greater than any type of SSP with a withhold. More specifically, capitation prepayments are calculated on a per person, per month—per capita—basis.

Historically, financial risk taking by providers raised complex insurance regulation issues, and there have been

numerous problems with capitated payment approaches. Capitation payments to providers generally were not risk-adjusted for patient health status; capitation payment amounts were sometimes driven down to levels providers found inadequate to support needed care; in some contracting situations, no provisions were made for costly cases, which could deplete the capitation funds.³³ Providers also executed poorly in many cases because they lacked both administrative and clinical infrastructures needed to effectively manage the amount of financial risk they were assuming.³⁴

Imposed administrative requirements undermined the theoretical simplicity of making a single monthly payment rather than paying claims for each service rendered. For example, physicians often still had to submit “shadow” claims as if they were real. Lastly, when capitation was more widely used in the 1980s and 1990s, there was less measurement and reporting of quality information, leading to a public perception that the financial incentives may have resulted in providers’ stinting on care.

Proponents of retesting capitation hope that these problems with capitation can be overcome and that ACOs offer a more promising programmatic vehicle for direct contracting with Medicare than the failed PSO approach.³⁵ They note MSGs, IPAs, and other organizations’ success in managing capitation in California and elsewhere, and so think that providers with more experience and improved infrastructure are more capable of managing financial risk than a decade ago when the PSO experiment fizzled. With payments based on improved risk-adjustment tools, ACOs, which could well have sicker than average patients if they recruit from their own patient rosters, would not be disadvantaged as would have been the case in the 1990s.

An important variation on the BBA-PSO capitation approach would be the introduction of risk and profit sharing, rather than full-risk contracting to ACOs—that is, partial rather than full

capitation. A model here is the Medicare Prescription Drug Program (PDP) established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, in which risk corridors were set up to limit a prescription drug plan's potential losses should the plan happen to experience much higher utilization and costs than expected.³⁶ It could be that with Medicare directly sharing risk under a population-based payment approach, providers would be more likely to participate. And with Medicare's "deep pockets", public policy concerns about provider financial solvency would be mitigated.

If properly designed, partial capitation might have a number of theoretical advantages over the SSP payment method. First, ACOs and affiliated providers would have greater incentives and the flexibility to deploy newer services and care management approaches that are not currently covered or paid for in the FFS system. Second, ACOs would receive funds upfront and on a regular basis, facilitating capital and other investments. Third, and most importantly, the nature of the payment provides fundamentally different payment incentives. For example, under an SSP hospitals remain primarily an accounting "profit center" for an ACO; under a capitated, population-based payment model, the hospital essentially becomes a "cost center." Further, the ACO would have an incentive not only to reduce total costs but also to sustain the improvements over time. Yet, because the ACO must meet the quality targets before they are eligible for retaining their savings, Medicare beneficiaries would have some protection against ACOs stinting on care.

If using capitation, the difficult issues that have caused controversy in determining Medicare Advantage-capitated payments would also arise in determining capitation amounts for ACOs. Would capitation amounts be based on spending in the local area, be ACO specific, or reflect national norms? What would be the basis for

determining annual increases? Aside from these technical issues related to determining ACO payments, the fundamental question is whether there are enough physicians interested in doing the hard work of forming and managing ACOs capable of directly managing even partial capitation risk. It is possible that for all of the theoretical advantages of this approach, there would be few takers in a voluntary ACO program using any form of capitation

Accountability for quality

As already emphasized, whichever payment model is adopted, the financial benefits of achieving cost targets are contingent on quality.³⁷ Thus, another important issue is how quality will be assessed and what level of quality performance or improvement will be required. ACO proponents are concerned that without a serious quality assessment and reporting component, ACOs might emphasize cost cutting rather than improved value. MedPAC suggests that "quality measures and targets could be aggregated into a weighted quality score."³⁸ CMS could begin with a limited set of existing and appropriate risk-adjusted quality measures, improvements in infrastructure that support quality-improvement efforts such as "meaningful use" of electronic health records, and potentially incorporate and align ACO measures with those used in the PCMH demonstration. Additional quality measures could be added to over time.

There also are benefits of applying quality measures at the ACO level, rather than the individual clinician or facility level. First, measures that capture issues in care coordination across different providers could appropriately be applied to ACOs. Second, aggregation to the ACO level provides adequate numbers to assure a level of statistical validity that is lacking when applied to individual clinicians. Finally, theory — and some empirical data — support the notion that some larger organizations are better able to mount and sustain quality-improvement activities than

smaller organizations or individual health professionals, who are typically consumed with the day-to-day pressures of clinical practice.

Implementation challenges

Implementation is always challenging, and decisions about the ACO program features discussed will have a substantial impact on the implementation process. However, there are some core implementation issues that will need to be addressed, regardless of the ACO program specifics.

Participation of, and impact on, other public and private payers

If ACOs provide desirable delivery system enhancements for Medicare, we would hope and possibly expect that they would also be desirable for other payers as well. In fact, some recommend that self-funded employers and commercial insurers should follow Medicare's lead or collaborate with them on an ACO program initiative. Massachusetts is considering ACOs as way to control health care spending as part of the state's continued evolution of comprehensive health reform.³⁹ Arguably, such payer collaboration would align and strengthen providers' financial incentives and avoid conflicting program features and additional administrative burden.

However, an ACO program designed for traditional Medicare beneficiaries, particularly a mandated program based on analysis of Medicare claims data as some proposals call for, might not serve private employers' or health plans' interests very well. The pattern of care for employee or health plan enrollees might be quite different from that of Medicare beneficiaries, reflecting referral patterns characteristic of plan-specific provider networks.

Perhaps even more serious, purchasers and plans are concerned that sanctioning the collaboration of most of the physicians with each other, perhaps also with one or more hospitals in a geographic area, would increase providers' market power and result

in substantially increased provider prices gained through negotiated contracts, costing the payers much more than if the providers remained in their fragmented silos. In short, newly empowered ACOs might be well positioned to reduce spending and spending growth for Medicare, but not for commercial insurers and self-funded employers; providers might be able to demand higher payments from private payers even as their own costs go down.

Further, the Federal Trade Commission (FTC) and Department of Justice (DOJ) might actually want to prohibit for antitrust reasons certain ACO entities that Medicare might want to promote (e.g., loosely affiliated physicians and hospitals constituting an ACO under a share saving payment model).⁴⁰ To date, whether and how ACOs would be allowed to operate in relation to commercial payers, including a possible role for public regulation of private sector prices, have not been explored but likely must be before the ACO concept goes very far.

New roles and responsibilities for providers and government agencies

Clearly, the ACO concept poses a variety of implementation challenges for health care providers and federal government officials. In a new provider payment and delivery system environment—a much more value-focused system—each party would have to change and take on new roles and responsibilities.

To be successful in an ACO program, providers would need to utilize and strengthen a variety of organizational, technical, and clinical skills over time. Some would describe the nature of needed provider changes as truly transformational. Even providers with greater experience with the kinds of payment methods and programs discussed find that it takes time and capacity building in key areas, such as cultural change, managerial and physician leadership, teamwork, health information technology, and care

management process redesign and improvement.⁴¹

Prior experience in health care, as well as other industries, provides practical approaches and lessons for helping providers get started and successfully move forward. For example, technical assistance, quality-improvement collaboratives, coaching, and sharing of key resources, information, and tools are likely to be helpful to providers participating in an ACO program. Provider professional associations and consulting firms may provide these kinds of support and assistance to ACOs, but there is potentially a very important role here for Medicare Quality Improvement Organizations (QIO) and other public entities as well.

Federal officials would also need to make changes and develop new capacities to administer an ACO program, and the more providers and beneficiaries involved, the more difficult these changes are to make. In addition to supporting and assisting providers, there are a range of complementary policies that would have to be reviewed and probably altered to permit ACOs to form and succeed. Some include antitrust enforcement, “gainsharing” (profit sharing between hospitals and physicians), state-based insurance regulation, and issues related to professional and organizational liability. Finally, depending on which ACO approaches are being tested, there might need to be extensive education of beneficiaries about their opportunities, responsibilities, and rights.

All of these activities would require time and expertise. They are much more complex and resource intensive than current administrative payment methods, which essentially require uniform application of national payment formulas. Therefore, to embark down the road of even broad pilots and demonstrations of ACOs, Congress would need to assure that CMS would receive adequate resources for supporting the demonstrations

and assuring adequate evaluation and midcourse corrections.

Skeptics arise

Some experienced hands counsel that ACOs are a bad idea—that Congress should not embark down this road at all. In the words of Jeff Goldsmith, a health care consultant who helped put together prior versions of ACOs more than a decade ago, “The problem with this movie is that we’ve actually seen it before and it was a colossal and expensive failure.”⁴² That experience was related to risk-bearing provider organizations, which imposed restrictions on patients’ freedom of choice. He not only points to the serious problems of execution that plagued these organizations but even more fundamentally challenges the concept itself in concluding that employers and patients preferred open panels managed by health insurers to closed panels managed by providers.

Goldsmith is no less sparing in his criticism of the ACO model that is receiving the most attention now—the shared saving payment approach that does not restrict patient choice or require any providers to take financial risks. He points to the fact that in many medical markets, the physician community has drawn away from the hospital and functions increasingly independently on a day-to-day basis. The weak financial incentives in the SSP payment model, he asserts, would not be able to bring together these increasingly independent professionals, who have interest in preserving the status quo, not participating in substantial collective efforts for nominal shared savings.

Conclusion

There is broad policy agreement on, and an evidence base regarding, the need for provider payment and delivery system reforms that create financial incentives for providers to work together to bend the cost curve and improve quality. The ACO proposals are one of the few serious attempts to move ahead to achieve these objectives.

However, there are quite different interpretations of the current ACO concept and its predecessors. One view is that the ideas are fundamentally flawed and that the conditions are not right for changes of this kind, and may have even gotten worse since the mid-1980s and 1990s. Another perspective is that the flaws with the concept have or could be overcome, and that some conditions have not only improved, but also can be positively affected by the policy decisions made moving ahead.

ACOs will not be a real game changer in the short run but are definitely worth a concerted try, given long-standing problems with the FFS provider payment and delivery systems that impede health care cost control and quality improvement. ACOs can help overcome the impasse of where to start first—provider payment or delivery system reform—by coupling and coevolving them over time. ACO proposals also offer the opportunity

to harness the tremendous purchasing power of the traditional Medicare program, potentially creating a much greater incentive for providers to begin assuming real accountability and making necessary improvements. In addition, the ACO concept may avoid a one-size-fits-all provider payment or delivery system reform approach, which is unlikely to work given the variation in local markets and provider organizations and their capabilities. Lastly, ACOs can potentially complement other reform initiatives, including the patient-centered medical home, meaningful use of electronic medical records, and comparative effectiveness research.

Nevertheless, there still are very challenging implementation issues that need to be recognized and addressed. In order for ACOs to be a real game changer in the long run, the concept needs to move past the rosy-scenario phase that has become common for energetically endorsed new or reprised

concepts and now confront the many evident challenges. Lessons from previous experiences and ongoing demonstrations can help identify potential solutions to the complex financial, organizational, legal and regulatory issues, and provide insight into the trade-offs between various program proposals and options. In addition, the ability to learn from the early ACO efforts and to make program modifications as necessary will be critical, as it is unreasonable to expect substantial changes to occur without some problems or failures or in the short run.

In sum, there is a ripe opportunity for policymakers and providers to get critical provider payment and delivery system reform processes underway, potentially moving us into a new era in which local physicians and provider organizations have not only the accountability but authority, financial incentives, and capacity to redesign the delivery system to add greater value.

Notes

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2 Throughout this Issue Brief, we use the term accountable care organization (ACO) for simplicity because it is the term used in the House Tri-Committee Health Reform Bill (HR 3200), in other proposals and documents out of the Senate, and by MedPac (2009). The term was coined by Fischer et al (2006). However, other terms have been used for similar concepts. Specifically, the term accountable care system (ACS) is the term used by Shortell and Casalino (2007; 2008); "bonus-eligible organization" (BEO) is a term sometimes used by the Congressional Budget Office (CBO); and accountable care entities (ACE) is a term sometimes used by the Medicare Physician Value-Based Purchasing Program.

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CBO, <http://www.whitehouse.gov/omb/blog/09/06/17/CBOpointstheWay/>

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3 Insufficient size makes it difficult to assess the full continuum of care and leads to variation in results because of chance or error, not real cost and quality performance differences. Fisher et al 2009a and MedPac, June 2009 suggest that the minimum size is 5,000 or more beneficiaries.

4 Shortell and Casalino 2007, 2008

5 Shortell and Casalino (2007) mention organized or integrated delivery systems when they discuss multispecialty groups. However, there are a variety of ODS or IDS types, some that have an exclu-

- sive arrangement with a multispecialty group and some that do not. Similarly, some types of organized or integrated delivery systems include a health plan and some do not. See, for example, the work by Bazzoli et al. (1999), Shortell et al. (2000), and Dubbs et al. (2004) on different types of systems.
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- 6 Fischer et al. 2006 and 2009a from above (footnote 2).
- 7 Health care provider organizations that exist today use vertical (i.e., ownership, joint ventures) and virtual (i.e., contractual) integration strategies, emphasizing one or the other or blending them in different ways. However, the "virtual" organization that Fisher and his team propose is a specific type of virtual provider organization, defined not by how different provider organizations relate to each other but by where beneficiaries or enrollees receive their care.
- 8 The Physician Group Practice (PGP) Demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration creates incentives for physician groups to coordinate the care delivered to Medicare patients, rewards them for improving the quality and cost efficiency of health care services, and creates a framework to collaborate with providers to the advantage of Medicare beneficiaries. CMS selected 10 physician groups on a competitive basis to participate in the demonstration. The groups in the PGP demonstration are large, averaging 500 doctors and 22,000 beneficiaries. They also tend to be tightly managed groups that have the ability to take joint actions to change care protocols, improve quality metrics, and constrain capacity growth.
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- Also see Medicare Physician Group Practice Demonstration Fact Sheet, Center for Medicare and Medicaid Services, August, 2009, http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf.
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- 9 Fisher 2009 above (footnote 2)
- 10 The most recent MedPAC Report to Congress (June, 2009, full citation above in footnote 2)
- reflects this genesis of the ACO concept, particularly the convergence of Fisher's work and lessons from the PGP demonstration.
- 11 House Resolution 3200, Tri-Committee Health Reform Bill, July 14, 2009. Available at <http://docs.house.gov/edlabor/AAHCA-BillText-071409.pdf>.
- 12 Senate Finance Committee Chairman's (Baucus) Proposal above (footnote 1).
- 13 Clinton, B. The President's Health Security Plan: The Complete Draft and Final Reports of the White House Domestic Policy Council. New York: Times Books, 1993
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- 15 Besides the House Tri-Committee Health Reform Bill, see the documents cited below from the Senate Finance Committee and proposed legislation from the Senate HELP Committee, which discusses the ACO concept.
- See Description of Policy Options—Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs. Senate Finance Committee, April 29, 2009. Available at: <http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf>.
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- Chairman's Mark, America's Healthy Futures Act of 2009, Amended http://finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf.
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- 16 HR 3200, first cited above in footnote 2.
- 17 Forty-seven percent of all U.S. physicians practice in medical groups with five or fewer physicians. Thirty-two percent of physician practice in solo or two-physician practices, and fifteen percent practice in groups with three to five physicians.
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- 22 Rittenhouse, D.R., S.M. Shortell, and E.S. Fisher, "Primary Care and Accountable Care - Two Essential Elements of Delivery System Reform," *New England Journal of Medicine*, October 28, 2009, www.NEJM.org and <http://healthcarereform.nejm.org/>
- 23 The House Tri-Committee's draft legislation has a "no duplication in pilot participation" clause, which states that a physician in a group practice that participates in the PCMH pilot program will not be eligible to participate in the ACO pilot program. Whether this restriction reflects a judgment that PCMHs represent a fundamentally different approach that should not be intermingled with ACOs or, more pragmatically, is designed to support a demonstration strategy permitting clear-cut evaluations of different approaches (which then might be merged subsequently) is not clear. If not changed, the clause in the House draft legislation might create a conflict between these two programs and force some primary care practices and physicians (PCPs) to choose to participate in one or the other program.
- 24 HR 3200, first cited above in footnote 2.
- 25 MedPac, June 2009 first cited above in footnote 2.
- 26 MedPac June, 2009, pg. 48, first cited in 2 above.
- 27 MedPac June 2009 report first cited in 2 above
- 28 See for example: Mechanic, D and Schlesinger, M. The impact of managed care on patients' trust in medical care and their physicians. *JAMA*. 1996 Jun 5; 275(21):1693-7
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- ²⁹ See section on population based health (pg. 94) in Institute of Medicine (IOM), Performance Measurement: Accelerating Improvement, Washington, DC: National Academies Press, 2006.
- ³⁰ The SSP approach is based on the one used in the PGP demonstration, in which Parts A and B but not D spending for the medical group was compared to spending for a control population in the same geographic area. The spending for the control group became the projected expenditures to determine whether the group received a bonus.
- ³¹ For example, expenditure targets to determine eligibility for bonuses could be based on a local area or ACO-specific data, with a focus on the rate of spending growth. Alternatively, one could use a national spending norm and focus on absolute spending. Use of local trends or ACO-specific data might reward savings but would accept the historical geographic differences in costs. Some might view this as advantaging those areas and ACOs with high baseline spending (see figure 2—top trend line and related savings in red). In contrast, using national levels to calculate and set total expenditure targets would address unwarranted geographic variation, but such targets might not be achievable for many providers in traditionally high-cost areas. Further, recent work suggests there is not a good correlation between baseline spending and spending growth, and it is not inherently clear which spending parameter should be emphasized in an SSP. Basing rewards on targets of spending growth might have the perverse effect of rewarding high-baseline spending ACOs that successfully come in under their target based on high prior-year spending growth while not rewarding ACOs with low baseline spending that happen to have targets based on low prior-year spending growth.
- ³² See for Miller, HD, How to Create Accountable Care Organizations, Center for Healthcare Quality & Payment Reform, www.CHQPR.org, 2009, on these and other problems with the SSP provider payment model.
- ³³ Goroll AH, Berenson RA, Schoenbaum SC, and Gardner LB, Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. *Journal Of General Internal Medicine*, 2007 Mar;22(3):410-5.
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- ³⁴ As Hurley et al (2002) point out, financial risk involves both (1) actuarial or insurance risk that is subject to random fluctuations providers have no control over and (2) more technical risk for the cost of care that providers have more control over, although patient decisions also have a significant impact. A key challenge is how to put providers at technical risk, for example, for avoidable costs but not subject them to any or little actuarial or insurance risk. Several refinements to capitated payments have been developed—such as better risk adjustment, exclusion of high-cost cases, and establishment of risk corridors—in an attempt to achieve this aim. Other provider payment methods have also been developed in an attempt to achieve similar aims—to give providers a financial incentive for technical risk and associated avoidable costs while eliminating or minimizing any actuarial or insurance risk over which they have no control. See, for example, the discussion of alternative provider payment methods in:
- Rosenthal, M. Beyond Pay for Performance: Emerging Models of Provider Payment Reform: *New England Journal of Medicine*, September 18, 2009, 359 (12): 1197-1200
- ³⁵ The BBA provided for PSOs to be state licensed as insurers but provided a fallback mechanism to allow the CMS to license them directly if necessary, guided by somewhat lesser solvency and enrollment requirements.
- ³⁶ Risk corridors may make an ACO program more attractive for providers to participate in, as they did in the case of the prescription drug program (PDP), because they reduce risk associated with new programs and payment methods or random fluctuations in cost. Risk corridors are centered on a target point, such as the total annual insurance premiums (excluding administrative costs) in the PDP program or the total annual projected expenditures for care in an ACO program. Gains or losses within a given percentage above or below the target point are assumed by the insurer or provider. Gains or losses beyond the established risk corridor are shared by the payer, in this case, CMS.
- For example, if the target amount were set at \$10,000, and a provider assumed full risk for costs 10 percent above or below that amount, the provider would keep the gains or savings if costs totaled \$9,000 to \$10,000 and would assume the losses if they totaled \$10,000 to \$11,000. If costs fell below \$9,000, the gains or savings would be shared by the provider and CMS in predetermined percentages (e.g., 50/50), and if costs exceeded \$11,000, the losses would also be shared (e.g., 50/50).
- ³⁷ This has been well described for the Shared Savings Program, but in a partial capitation payment model, the mechanism for doing this would need to be worked out.
- ³⁸ MedPac, June 2009 report first cited in 2 above
- ³⁹ Kowalczyk, L, Pay for Care a New Way, State is Urged, *Boston Globe*, July 17, 2009 http://www.boston.com/news/local/massachusetts/articles/2009/07/17/pay_for_care_a_new_way_state_is_urgued/?page=1
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- Payment Reform Commission Unanimously Supports Move to Global Payment System to Improve Patient Care and Contain Health Care Costs http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Special+Commission+on+the+Health+Care+Payment+System&sid=Eeohhs2&b=terminalcontent&f=dhcfp_payment_commission_pr_2009_07_16&csid=Eeohhs2
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