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HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS

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How to Create Accountable Care Organizations

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PREFACE

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EXECUTIVE SUMMARY

HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS

WHAT WOULD ACCOUNTABLE CARE ORGANIZATIONS BE ACCOUNTABLE FOR, AND WHAT WOULD THEY DO DIFFERENTLY?

- The goal of Accountable Care Organizations should be to reduce, or at least control the growth of, healthcare costs while maintaining or improving the quality of care patients receive (in terms of both clinical quality and patient experience and satisfaction). There are many opportunities that exist for improving quality and reducing healthcare costs without the need to ration care. These include improved prevention and early diagnosis, reductions in unnecessary testing and referrals, reductions in preventable emergency room visits and hospitalizations, reductions in infections and adverse events in hospitals, reductions in preventable readmissions, and use of lower-cost treatments, settings, and providers. (See pages 3-5 for more detail.)
- Although Accountable Care Organizations should accept greater accountability for reducing costs, they should not be expected to take on insurance risk, i.e., the risk associated with whether the patients who come to them are sick or well (unless they choose to do so). Insurance plans should continue to manage insurance risk, and Accountable Care Organizations should manage performance risk, i.e., the ability to successfully treat an illness in a cost-effective way. (See page 5 for more detail.)
- Accountable Care Organizations should not be expected to take responsibility immediately for all possible opportunities for cost reduction. They can be accountable for total costs and make significant impacts on those costs just by pursuing a subset of the many opportunities for cost reduction. (See page 6 for more detail.)

WHAT KINDS OF ORGANIZATIONS CAN SERVE AS ACCOUNTABLE CARE ORGANIZATIONS?

- To the maximum extent possible, an organization's ability to serve as an Accountable Care Organization should be determined by its success in improving outcomes – controlling costs, improving quality, and providing a good experience for patients – not on its organizational structure or even the specific care processes it uses. In the short run, since outcomes can only be known after the fact, some structural and process criteria are needed to define which organizations have the greatest probability of success. (See page 7 for more detail.)
- The core of an Accountable Care Organization is effective primary care. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in specialty and hospital expenditures are prevention, early diagnosis, chronic disease management, and other tools which are delivered through primary care practices. (See pages 7-8 for more detail.)
- In order for primary care practices to become an Accountable Care Organization, they will need to have at least eight things:
 - 1) Complete and timely information about patients and the services they are receiving;
 - 2) Technology and skills for population management and coordination of care;
 - 3) Adequate resources for patient education and self-management support;
 - 4) A culture of teamwork among the staff of the practice;
 - 5) Coordinated relationships with specialists and other providers;
 - 6) The ability to measure and report on the quality of care;
 - 7) Infrastructure and skills for management of financial risk;
 - 8) A commitment by the organization's leadership to improving value as a top priority, and a system of operational accountability to drive improved performance.(See pages 8-10 for more detail.)
- Efforts to help primary care practices become more effective, such as the tools of Patient-Centered Medical Homes, the Chronic Care Model, etc., are helpful, but not sufficient. In order to create a successful Accountable Care Organization, primary care practices must add the capability to manage both cost and quality outcomes. Moreover, not all of the standards in current Medical Home accreditation programs may be necessary to success as an Accountable Care Organization. (See page 10 for more detail.)

- Small primary care practices that work together through organizational mechanisms such as an Independent Practice Association (IPA) have a better ability to form an Accountable Care Organization if the number of participating physicians and their organizational structure gives them:
 - 1) The ability to manage and coordinate patient care;
 - 2) The ability to manage financial risk associated with the costs of patient care; and
 - 3) The ability to measure cost and quality in a statistically valid way.
 (See pages 10-12 for more detail.)
- It is undesirable to require or encourage all physicians in a geographic area to form a single Accountable Care Organization. Participation should be voluntary – based on a commitment to success. There are advantages to having multiple Accountable Care Organizations in a region, but also some additional challenges, and the best approach will vary from region to region. (See pages 12 and 17 for more detail.)
- Specialists will continue to play an important role in patient care, but their roles relative to primary care will need to be rationalized and better coordinated, and the volume of referrals to specialists will need to decrease in most regions. Although an Accountable Care Organization will need to have effective working relationships with specialists, specialists do not necessarily need to be part of the Accountable Care Organization itself. (See pages 13-14 for more detail.)
- It can be very advantageous to have a hospital included in an Accountable Care Organization if the hospital is committed to the goals of reducing total costs and improving quality. However, Accountable Care Organizations should not be *required* to include a hospital, since the interests of hospitals and physicians may be in conflict in the early stages of development of Accountable Care Organizations. (See pages 14-16 for more detail.)
- Integrated Delivery Systems could serve as an ideal model for Accountable Care Organizations if they have true clinical integration and a commitment by their leadership to fulfill the vision of an Accountable Care Organization. (See page 16 for more detail.)
- Since providers in different parts of the country differ dramatically in terms of size, clinical and corporate integration, and skills in managing costs, there is no single definition of “Accountable Care Organization” that will work everywhere. Four different levels of Accountable Care Organizations (ACOs) should be considered:
 - Level 1 ACO: Primary care practices functioning together through an IPA or other organizational mechanism and focusing on prevention and improvement of care for ambulatory care-sensitive conditions.
 - Level 2 ACO: Primary care practices and frequently-used specialties, working together through an IPA or multi-specialty group practice, and focusing on prevention and improvement of care for ambulatory care-sensitive conditions and common specialty procedures.
 - Level 3 ACO: Primary care practices, specialists, and hospitals, working together through an integrated delivery system or other organizational mechanism, and focusing on all or most opportunities for cost reduction and quality improvement.
 - Level 4 ACO: Healthcare providers, public health agencies, and social service organizations working jointly to improve outcomes for a very broad patient population, including homeless individuals and the uninsured.
 (See pages 18-19 for more detail.)

WHAT PAYMENT REFORMS ARE NEEDED TO SUPPORT ACCOUNTABLE CARE ORGANIZATIONS?

- Payment systems need to be changed significantly to support Accountable Care Organizations (ACOs). Payment reforms should achieve five goals:
 - 1) Provide the ACO with the flexibility to deliver the right services to patients in the right way at the right time;
 - 2) Enable the ACO to remain profitable if it keeps people healthier or reduces unnecessary services;
 - 3) Pay the ACO more for high-quality care than for low-quality care, and encourage patients to use higher-quality ACOs;
 - 4) Pay the ACO adequately, but not excessively, to cover the costs of the services it provides for all of its patients; and
 - 5) Avoid penalizing the ACO for caring for sicker patients (unless the sickness was caused by the ACO itself).
 (See pages 20-21 for more detail.)
- Offering arbitrarily defined “shared savings” to an ACO is not sufficient to encourage the formation of ACOs and to enable ACOs to truly transform the way they deliver care. To be effective, shared savings would need to be based on net savings (including unreimbursed costs of changes in care delivery) and combined with other payment changes. (See pages 22-23 for more detail.)

- A properly-structured Comprehensive Care Payment (or global payment) system can achieve all of the goals of payment reform, as long as it is structured so as to avoid the problems of traditional capitation payment systems. (See pages 24-25 for more detail.)
- Episode-of-Care Payment can serve as both a transitional payment reform and as an important long-run component of an overall payment system. (See pages 26-27 for more detail.)
- Hybrid payment models (e.g., partial comprehensive care payments with bonuses and penalties based on savings and quality) can also be used as a transitional payment reform. (See page 27 for more detail.)
- In addition to implementing new payment *methods*, effective mechanisms for setting appropriate payment *levels* will also be needed. The appropriate mechanisms will vary from region to region and provider to provider, depending on the structure of local healthcare markets. (See page 28 for more detail.)

WHAT SHOULD COMMUNITIES DO TO ENCOURAGE AND SUPPORT THE DEVELOPMENT OF ACCOUNTABLE CARE ORGANIZATIONS?

- Comparable changes in payment systems should be made by all payers, but as a minimum, changes need to be made by the payers that provide health insurance coverage for a majority of an Accountable Care Organization's patients so that the ACO has the resources and ability to change the way it cares for all patients. Medicare needs to have the flexibility to change its payment systems to match the changes local payers make. (See pages 29-30 for more detail.)
- The outcomes and measures of success for Accountable Care Organizations should be defined by the community they serve, rather than by individual payers. States, Regional Health Improvement Collaboratives, large payers, and consortiums of payers can play a key role in building consensus among payers and providers on what the standards for success should be and on the appropriate transitional paths. (See pages 30-31 for more detail.)
- It is critical to build support among consumers and patients for changes in care delivery and payment, and to have consumers actively engaged in achieving the desired outcomes, rather than trying to hold Accountable Care Organizations solely accountable for improving quality and reducing costs without adequate patient support and involvement. (See pages 31-32 for more detail.)
- Other changes in laws and policy would be helpful in encouraging and supporting Accountable Care Organizations, such as malpractice reform, changes in accreditation processes, and modifications to anti-trust laws and gain-sharing laws. (See pages 32-33 for more detail.)

HOW CAN THE TRANSITION TO ACCOUNTABLE CARE ORGANIZATIONS BE FACILITATED?

- It is unreasonable to expect healthcare providers in most parts of the country to successfully accept full accountability for costs and quality quickly or in a single step. Transitional approaches will be needed. (See page 34 for more detail.)
- Support should be made available to willing providers to help them get started, including coaching and technical assistance, information on their current costs and quality, shared services for improved care management, financial resources to support changes in care, and financial modeling to help in taking on financial risk. (See pages 34-35 for more detail.)
- A multi-year process for transitioning to full accountability should be used, such as focusing initially on subgroups of patients and subsets of costs. Measures of success should be based on absolute standards of performance, relative performance compared to other providers, and improvement relative to a provider's own baseline. (See pages 35-36 for more detail.)
- Special attention should be given to underserved communities and consumers to ensure they participate in and benefit from improved care delivery. (See page 37 for more detail.)
- Payment changes should also transition over time in ways that support the transitional changes in care processes. Since initial payments will be based on the fee-for-service system, reforms to the current fee-for-service system, particularly its support for primary care, should be a high priority. (See pages 38-40 for more detail.)
- Medicare should encourage and participate in regionally defined Accountable Care Organization initiatives by waiving Medicare requirements and changing payment rules to match what other major payers in the region, including commercial payers and Medicaid, are doing. (See pages 38-39 for more detail.)

I. INTRODUCTION: CREATING GREATER ACCOUNTABILITY IN HEALTHCARE DELIVERY

Over the past decade, there has been a growing focus on holding healthcare providers more accountable for the quality of the healthcare they deliver. Studies showing high rates of medical errors and hospital-acquired infections, and low rates of delivering immunizations, screenings, and other important services have led to a wide range of quality measurement and reporting programs and pay for performance programs designed to ensure that healthcare providers deliver a minimum level of quality and to raise the standard for quality over time.

In contrast, however, healthcare providers are typically *not* held accountable today for the aggregate costs of the healthcare services delivered to any patient or group of patients. Under the Medicare fee-for-service program, if a service is covered by Medicare, a healthcare provider can deliver that service to a Medicare beneficiary and be paid for it, even if a cheaper service, or no service at all, would have achieved a similar or better outcome. Under most commercial insurance plans and Medicare Advantage plans that pay providers on a fee-for-service basis, steps may be taken to discourage the use of services viewed as unnecessary or unnecessarily expensive, but these steps are taken by the health plan, not by the provider, and both patients and providers often resist efforts by health plans to manage costs in this way.

In light of the high and rapidly growing cost of healthcare in the U.S., there has been growing interest both in the federal government and in states and regions across the country in finding ways to encourage health care *providers*, rather than *health insurance plans*, to take greater accountability for the overall cost as well as the quality of healthcare delivered to patients. An entity that would accept this greater accountability has been variously called:

- an “accountable care organization” or ACO. MedPAC defines an ACO as “a set of providers [which are held] responsible for the health care of a population of Medicare beneficiaries.”¹ In their papers on the concept, Elliott Fisher and colleagues do not directly define an ACO, but use the term to describe a provider or group of providers which would receive new forms of payment designed to encourage accountability for costs.²
- an “Accountable Care System” or ACS. Stephen Shortell and Lawrence Casalino define an ACS as “an entity that can implement organized processes for improving the quality and controlling the costs of care and be held accountable for the results.”³ They say that an ACS “may be made up of several or many accountable care organizations covering the continuum of care (i.e., outpatient, in-patient, home health, rehabilitation, long-term, and palliative care),” which implies that Accountable Care Systems involve more types of providers than ACOs. On the other hand, Elliott Fisher and colleagues state that their concept of an ACO would satisfy the Shortell/Casalino definition of an ACS, and that “any of the specific organizational models [Shortell and Casalino] describe could clearly become ACOs...”⁴
- an “Accountable Care Network” or ACN. The Pittsburgh Regional Health Initiative and Jewish Healthcare Foundation have proposed an ACN as a transitional stage for small hospitals and physician practices as they work toward becoming an ACO.⁵
- a “Bonus-Eligible Organization” or BEO. The Congressional Budget Office defined a BEO as “a group of providers... able to work together to manage and coordinate care for patients.” It noted “the concept of BEOs is similar to the accountable care organization models proposed by some researchers.”⁶
- an “Organized System of Care.” Blue Cross Blue Shield of Michigan is working to create Organized Systems of Care through its Physician Group Incentive Program.⁷

In this report, the term “Accountable Care Organization” or “ACO” will be used to describe a healthcare provider or group of providers that accepts accountability for the total cost of care received by a population, since the term “organization” seems the most generic and could be applicable to the broadest array of structures. (In contrast, the term “bonus-eligible” is narrowly focused on a particular payment model, rather than an organizational structure or method of delivering healthcare. Although in many ways, the term “system” better describes the fact that accountability will actually be achieved by having providers managing care more systematically, the term “system” connotes for many people a large, horizontally-integrated set of hospitals or other facilities, and as noted above, in proposing the term “Accountable Care System,” Shortell and Casalino explicitly indicate that Accountable Care *Organizations* may be building blocks for Accountable Care *Systems*.⁸)

Although there has been growing support for creating such Accountable Care Organizations, there has been relatively little exploration of how an ACO would actually achieve the goals envisioned for it, what it would look like organization-

ally, or how it would come into existence. This report attempts to fill that gap.

Section II explores what an Accountable Care Organization should be accountable for, and the likely strategies it would use in order to be successful.

Section III discusses the types of healthcare providers that can and should be included in an Accountable Care Organization, which organizational structures would support success in managing the desired accountability, and which organizational characteristics might present barriers to success.

Section IV discusses the changes in healthcare payment systems which would need to be made in order to encourage and support the creation and operation of Accountable Care Organizations.

Section V examines what governments and communities can and should do beyond payment reforms to create an environment that encourages the formation and successful operation of Accountable Care Organizations.

Section VI describes transitional approaches that can help healthcare providers begin accepting greater accountability on a path toward becoming Accountable Care Organizations.

II. WHAT WOULD ACCOUNTABLE CARE ORGANIZATIONS BE ACCOUNTABLE FOR, AND WHAT WOULD THEY DO DIFFERENTLY?

The primary goal of creating Accountable Care Organizations is to enable and encourage healthcare providers to take greater responsibility for reducing, or at least controlling the growth of, healthcare costs for a given population of patients, while maintaining or improving the quality of care those patients receive from both a clinical perspective and in terms of patient experience and satisfaction.

For many people, “reducing healthcare costs” implies rationing of healthcare services, i.e. denying care or delaying people from getting care they think they need.⁹ This, in turn, creates tremendous public fear and resistance to reforms designed to reduce or control healthcare costs. However, there are tremendous opportunities to reduce healthcare costs without even coming close to “rationing” of services. Understanding these opportunities is important for building public support for the creation and use of Accountable Care Organizations, as well as for helping providers understand what would be involved in creating a successful ACO.

A. OPPORTUNITIES FOR REDUCING HEALTHCARE COSTS WITHOUT RATIONING

The specific mechanisms that Accountable Care Organizations will use to reduce healthcare costs will also be important for defining what kinds of organizations can serve as ACOs and what kinds of support, such as payment changes, they will need to succeed. Some of these mechanisms can be pursued primarily through the actions of primary care practices; some can be achieved primarily through the actions of hospitals and specialists; and some will require efforts by a broad range of providers in the community acting in concert. Consequently, ACOs involving different combinations of these providers will be able to achieve different types and magnitudes of cost reductions. The common element of all the changes is finding better ways to deliver and coordinate services so as to ensure all patients get the right care, at the right time, at the right place, from the right provider.

1. PRIMARY CARE-DRIVEN OPPORTUNITIES

There is growing recognition and evidence of the potential role that a strengthened primary care system can play in reducing healthcare costs.¹⁰ Some examples of the opportunities for reducing costs solely or primarily through the efforts of primary care practices include:

- **Improved Access to Care.** Use of physician extenders, email and phone calls, same-day scheduling, group visits, school clinics, urgent care centers, and other techniques can reduce costs and improve patients’ access to effective primary care.¹¹
- **Improved Prevention and Early Diagnosis.** Many illnesses can be prevented through interventions such as immunizations, weight management, and improved diet, and the severity of other illnesses can be reduced through regular screenings (e.g., for cancer or heart disease) that lead to early diagnosis and prompt treatment.
- **Reductions in Unnecessary Testing, Referrals, and Medications.** Use of evidence-based treatment guidelines and shared decision-making tools can enable reductions in unnecessary or even potentially harmful tests, interventions, and medications.¹²
- **Use of Lower Cost Treatment Options.** For example, use of generic drugs or lower-cost alternatives where available and appropriate can reduce expenditures on pharmaceuticals and increase patient adherence to treatment regimens that prevent the need for more expensive services.¹³
- **Reductions in Preventable Emergency Room Visits and Hospitalizations.** Studies have shown that rates of emergency room visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced by 20-40% or more through improved patient education, self-management support, and access to primary care.¹⁴

2. HOSPITAL/SPECIALIST-DRIVEN OPPORTUNITIES

Hospitals represent 40% of healthcare costs, and studies continue to show significant inefficiencies and quality problems in hospitals. Some examples of the opportunities for reducing costs and improving quality solely through the efforts of hospitals and specialists include:

- **Improved Efficiency of Patient Care.** Hospitals that have utilized industrial techniques have been able to significantly reduce waste and improve efficiency.¹⁵ Gain-sharing and bundled payment demonstrations have found that the costs of surgeries can be reduced by 10-40% through improved cooperation between hospitals and surgeons to achieve greater overall efficiency, through means such as more efficient scheduling and more efficient purchasing of medical devices.¹⁶
- **Use of Lower-Cost Treatment Options.** For example, reductions in pre-term elective inductions and reductions in the use of Cesarean sections for normal deliveries can reduce labor and delivery costs as well as improving outcomes for both mothers and babies.¹⁷
- **Reduction in Adverse Events.** A significant number of patients still experience preventable healthcare-acquired infections and other adverse events. Work pioneered by the Pittsburgh Regional Health Initiative and replicated in other parts of the country proves that such events can be dramatically reduced or even eliminated through low-cost techniques.¹⁸
- **Reduction in Preventable Readmissions.** Some hospital-acquired infections and adverse events manifest themselves after discharge and result in preventable readmissions to the hospital; these can be reduced through the same techniques described above. In addition, several studies have shown that readmission rates can be reduced for a broad range of patients by improving the patient's transition to home or another setting following discharge, through a combination of improved preparation for discharge and improved support services following discharge.¹⁹

OPPORTUNITIES FOR HEALTHCARE COST REDUCTION

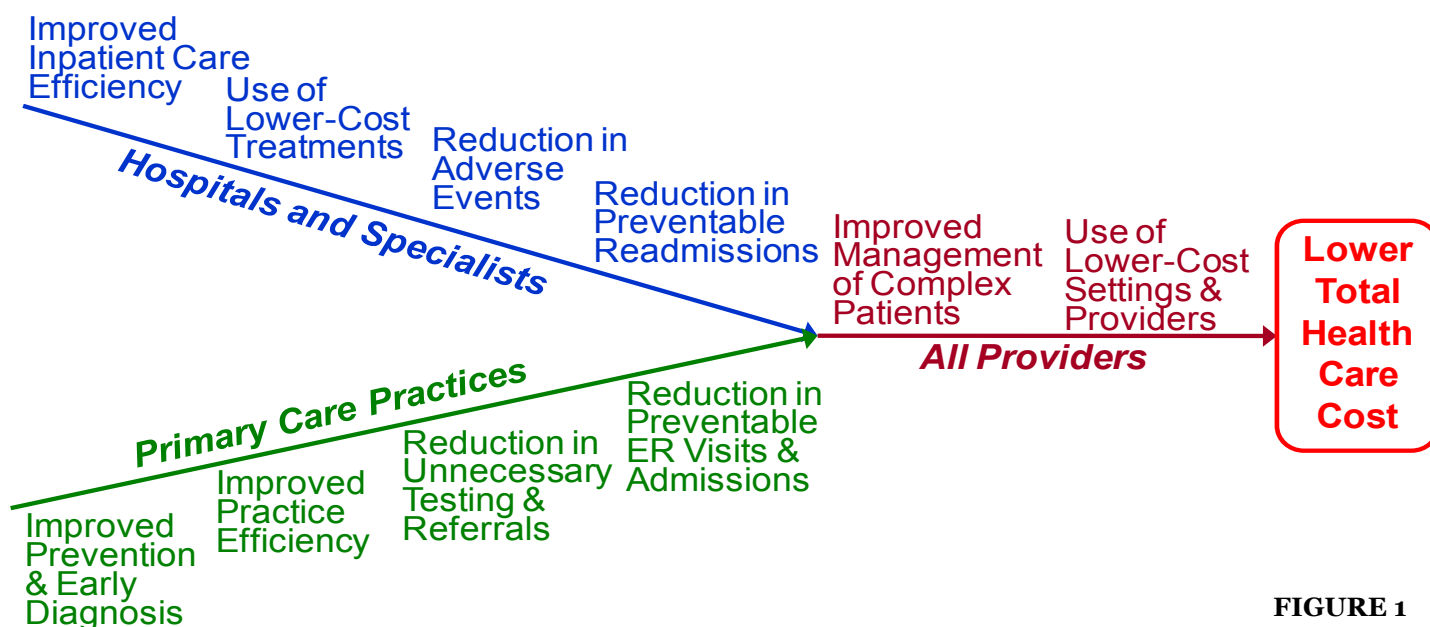


FIGURE 1

3. OPPORTUNITIES INVOLVING MULTIPLE PROVIDERS AND NON-HEALTHCARE SYSTEMS

Some opportunities for cost reduction require coordinated involvement of primary care practices, hospitals, specialists, and patients; some require the presence or development of new methods or settings for care; and some require coordination between healthcare and non-healthcare services. For example:

- **Improved Management of Complex Patients.** Patients with multiple diseases, individuals with rare conditions, drug abusers, the chronically mentally ill, etc. require multiple, often expensive services from multiple physi-

cians and/or facilities. Lack of coordination among these various providers can lead to overuse of testing, overmedication and potential adverse reactions to medications, or even misdiagnosis and inappropriate treatment. Managing these patients cost-effectively requires a coordinated effort among multiple physicians, facilities, and services.²⁰

- **Use of Lower-Cost, More Accessible Settings and Methods for Delivery of Care.** In a number of situations, alternative approaches to treatment and different settings for care can significantly reduce the costs of care while maintaining or improving quality. For example, an uncomplicated labor & delivery in a birth center costs only one-fourth as much on average as a comparable delivery in a hospital.²¹ Improving prenatal care outreach to low-income expectant mothers can improve birth outcomes and reduce costs.²² However, these alternative settings and care approaches need to exist in each community, and the patient's insurance or some other funding source is needed to cover the costs.
- **Use of Lower-Cost, High Quality Providers.** For many kinds of treatment in many communities, there are multiple high-quality providers of the treatment, and costs may differ significantly between the providers. Spending on those treatments could be reduced if more patients would use the lower-cost, higher-value providers; however, this would require those providers to have a clear "price" for these services, the patient would need coverage and a financial incentive to use the lower-cost providers, and for hospital care, the patient's physician would need to have admitting privileges.²³
- **Coordinated Health and Social Services Support.** Many individuals' health problems are caused or exacerbated by non-medical challenges they are facing, such as homelessness or poverty. Effective solutions to their health needs will likely require access to social service supports as well as health care services.

It is important to recognize that all of the above opportunities can not only reduce costs, but also improve outcomes for patients. Preventing illnesses benefits patients in addition to reducing costs (assuming, of course, that the prevention program is cost-effective). Helping chronic disease patients stay out of the hospital and preventing hospital-acquired infections benefits the patients as well as reducing costs.

B. ACCOUNTABILITY FOR COSTS OF CARE VS. ACCEPTING INSURANCE RISK

It is important to distinguish between giving healthcare providers greater accountability for the cost of the care their patients receive and transferring insurance risk to them. A major reason for the consumer and provider backlash against managed care in the 1990s was that many health insurance plans transferred *all* risk to the provider (through mechanisms such as traditional non-risk-adjusted capitation), including some or all of the "insurance risk" (e.g., whether an individual gets ill), rather than just the "performance risk" (i.e., the ability to successfully treat the illness in a cost-effective way).²⁴ This creates a strong and undesirable incentive for providers to avoid patients who have multiple or expensive-to-treat conditions, and makes providers financially vulnerable if they have an unusually high-cost patient or an unusually high number of patients with multiple or severe conditions.²⁵

It seems clear that a health care provider should not be required to accept insurance risk (i.e., be at risk for how sick or well their patients are, except for conditions the providers cause themselves, such as nosocomial infections) in order to be considered as an Accountable Care Organization. An ACO might *choose* to accept all or most of the insurance risk, but this would be voluntary, rather than an expectation by payers or others.²⁶

This means that the cost the ACO is accountable for (and the payment mechanisms used to operationalize that accountability, as described in Section IV) should be risk/severity-adjusted. In other words, if an ACO is caring for a population of patients and the costs of that care goes up, the cost increase would need to be divided into the estimated share due to an increase in risk factors (e.g., the population simply got older) versus the estimated share due to an increase in the cost of treating individuals with the same level of disease severity (e.g., a higher proportion of people with mild coronary artery blockage received cardiac bypass surgery). The ACO would be accountable for the latter share of the cost increase, but not the former.

It is important to recognize that there is no absolute dividing line between insurance risk and performance risk. A variety of mechanisms – risk/severity-adjustment systems, stop-loss provisions, reinsurance, etc. – can help to keep insurance risk with payers and away from providers, but random and unmeasurable differences among patients may result in a particular provider experiencing unusually high or low costs. It will be important to design and monitor the payment methods used to support ACOs to ensure they do not inappropriately transfer insurance risk.

C. ACCOUNTABILITY FOR ALL OR SOME COSTS?

Ideally, an Accountable Care Organization would take responsibility for pursuing all possible opportunities for reducing or controlling costs while maintaining or improving the quality of care for the population of patients they are caring for. For example, pursuing the full range of examples listed in Section II-A would provide the maximum impact on total costs as well as improving quality.

Although some provider organizations could accept this maximum level of accountability almost immediately, such as integrated delivery systems and physician groups with experience operating under full-risk capitation payment systems, it is probably unrealistic to expect that the majority of providers across the country will be able to do so in the near future. It will be particularly difficult for most providers to pursue cost reduction opportunities that require intensive coordination among multiple practitioners or the development of new modes or sites of treatment. Fee-for-service payment systems have rewarded volume, not quality, efficiency, or coordination of care, so it is likely that skills in designing and managing care processes to improve quality and control costs and the organizational mechanisms to coordinate care among multiple providers will be in short supply until the incentives change.²⁷

This is a case where health policy should not let the perfect be the enemy of the good, i.e., a provider organization should not be precluded from functioning as an Accountable Care Organization simply because it cannot expect to impact *all* costs for a given population of patients, particularly in the short run. An ACO can be *accountable* for total costs without needing to directly *control* every element of those costs. Significant impacts on total costs could be achieved by successfully pursuing subsets of the examples cited earlier, and this should be encouraged and facilitated in as many parts of the country as possible. This is discussed in more detail in the following sections.

III. WHAT KINDS OF ORGANIZATIONS CAN SERVE AS ACCOUNTABLE CARE ORGANIZATIONS?

Section II outlined the types of cost reduction opportunities that Accountable Care Organizations would likely pursue in order to achieve improvements in cost and quality. The next logical question is: which types of providers have the capability to successfully pursue these opportunities?

Despite growing interest in the concept of Accountable Care Organizations, there is little agreement on which types of providers could play this role or the organizational structure under which they should operate. For example:

- MedPAC proposed that an ACO “would consist of primary care physicians, specialists, and at least one hospital,” and suggested that it could be formed from an integrated delivery system, a physician-hospital organization, or an academic medical center.²⁸
- Stephen Shortell and Lawrence Casalino suggested five different models of an Accountable Care System: a Multispecialty Group Practice; a Hospital Medical Staff Organization; a Physician-Hospital Organization; an Interdependent Practice Organization; and a Health Plan-Provider Organization or Network.²⁹
- Elliott Fisher and colleagues proposed designating all of the physicians in a geographic area whose patients are admitted to a particular hospital (the “extended hospital medical staff”) as an Accountable Care Organization.³⁰
- The Congressional Budget Office suggested that Bonus-Eligible Organizations could consist of “physicians practicing in groups, networks of discrete physician practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, integrated delivery systems, or community-based coalitions of providers.”³¹

None of these proposals is based on much, if any, analysis or evidence indicating that a particular option or options is better than others, since there is very little evidence to prove that any particular type of provider or organizational structure *cannot* successfully manage total costs and quality for a defined population. If anything, this wide range of alternative models emphasizes that the heart of the concept of an Accountable Care Organization is not a structure, or even a process, but an *outcome* – reducing or controlling the costs of health care for a population of individuals while maintaining, or preferably improving, the quality of that care.

Indeed, ideally, designation as an Accountable Care Organization (and corresponding changes in payment methods) would be based solely or primarily on whether the provider organization actually achieves better cost and quality outcomes, not on the structure of the organization or even the processes it uses to improve outcomes. In the longer-run, this pure outcomes-based approach may be possible, but because outcomes can only be known after the fact, and because there are risks to patients, payers, and providers if organizations are designated as ACOs and paid differently without the ability to succeed, there is a need to define which organizational structures and care processes offer the greatest probability of success in the near term. Over time, as evidence emerges as to the relative ability of different organizational structures to achieve the goals of an ACO, the definitions can be modified accordingly, until ultimately, organizations would only be supported as ACOs if their outcomes justified it.

A. THE CENTRAL ROLE OF PRIMARY CARE

The discussion in Section II makes it clear that many of the most important opportunities for controlling costs can and should be addressed through effective primary care. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in those expenditures are prevention, early diagnosis, chronic disease management, and other tools – tools which are delivered primarily through primary care.³²

Although some patients with chronic diseases or complex conditions will receive their “primary care” through a specialist, the majority of individuals who are well or have mild to moderate chronic diseases will receive most or all of their care through a primary care practice. Moreover, in many parts of the country, particularly rural areas, primary care physicians manage not only ambulatory care, but also hospital care for a number of patients, such as patients admitted to the hospital for exacerbations of a chronic disease, women delivering babies, etc. In these areas, some of the cost reduction

opportunities associated with hospitals may also be driven by primary care physicians.

Consequently, it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role.³³ However, these primary care practices will have to function very differently from the way most primary care practices function today.³⁴

1. WHAT DO PRIMARY CARE PRACTICES NEED TO DO DIFFERENTLY TO BECOME ACCOUNTABLE CARE ORGANIZATIONS?

At the simplest level, in order to achieve the outcomes expected of an Accountable Care Organization, a primary care practice will have to focus resources and attention on the types of opportunities identified in Section II-A1 that can reduce costs while actually improving outcomes for patients. What does a primary care practice need in order to do that?

Although there is not enough experience to definitively say which factors are essential to success, self-reports and observations from providers that are viewed as models for quality and efficiency suggest that at least the following eight elements are key to primary care that is effective in ensuring patients receive high-quality care at the lowest cost possible:

a. Complete and Timely Information About Patients and the Services They Are Receiving. As the saying goes, “you can’t manage what you can’t measure.” Most primary care practices do not know how much is currently being spent for healthcare on their patients, so they can’t manage total costs even if they want to. This problem is not limited to primary care practices – the fragmentation of health care means that most providers, even large integrated systems, do not have a complete picture of the services received by the patients they treat or the costs of those services. Filling this information gap is not easy; even health plans struggle to develop comprehensive, accurate measures of the costs associated with the patients of individual physicians and physician groups. Merely having an Electronic Health Record system in a primary care practice is inadequate, since it only tells the practice about the services it has or has not delivered to the patient, not about the services *other* providers have delivered. Most Accountable Care Organizations will likely need significant assistance from payers or Health Information Exchanges in order to obtain the information about their patients that is needed in order to successfully accept accountability for total costs as well as to improve the quality of care delivered.

Timeliness of data is critical – if data on costs are only available many months or years after the costs are incurred, it does little to help providers identify and intervene early in areas where costs are increasing or to identify and capitalize on opportunities for savings. For example, the providers participating in the Medicare Physician Group Practice Demonstration (which gives them incentives to function like ACOs) have to wait 18-24 months to receive data on the costs of services for the patients they are responsible for³⁵, which is much too slow to allow continuous improvement.

b. Technology and Skills for Population Management and Coordination of Care. Health professionals are trained and experienced in caring for patients one by one, and this should continue. However, accepting accountability for the total costs and quality of care associated with a group of patients requires an additional set of skills and the technology to support it. For example, successful practices find that using clinical guidelines and monitoring compliance with those guidelines (while allowing for exceptions when appropriate) improves overall outcomes for patients,³⁶ and that analyzing data on resource use can help reduce overuse and unnecessary spending.³⁷ Similarly, having a Patient Registry enables the practice to ensure that patients are receiving recommended care and to identify potential ways to improve outcomes, but the practice needs to redesign its internal processes so that it can use the information in the registry to change the way it delivers care.³⁸ (Having an EHR system does not automatically mean that a practice will have patient registry capabilities or know how to use them, and a practice can successfully maintain a Patient Registry without an Electronic Health Record (EHR) system.³⁹) For more complex patients, successful coordination of care requires information systems that easily enable access at the point of care to complete information about the services delivered by different providers.

c. Adequate Resources for Patient Education and Self-Management Support. As noted earlier, there is a growing body of evidence indicating that relatively low-cost enhancements in patient education, goal-setting, and self-management support can significantly reduce hospital admissions, readmissions, and emergency room visits among many types of patients with chronic disease. However, even large primary care practices do not typically provide these services because the services are not paid for under most fee-for-service systems. (Changes in payment systems to address this are discussed in Section IV.) Consequently, primary care practices will need to develop ways of delivering these services efficiently and effectively in order to succeed as Accountable Care Organizations.⁴⁰ In addition, primary care practices will need better ways of ensuring that patients can obtain the medications and other services they need; for example, high co-pays and “doughnut holes”⁴¹ in pharmacy benefits can make it impossible for patients to adhere to the treatment plans that will keep them out of the hospital.⁴²

- d. **A Culture of Teamwork Among the Staff of the Practice.** Both greater efficiency of operations and greater effectiveness in addressing the needs of patients can result from a coordinated, team effort by physicians, nurses, and other practice staff. An ACO will need policies and processes which support the ability of frontline caregivers to work together in teams both across disciplines and across the continuum of care.
- e. **Coordinated Relationships with Specialists and Other Providers.** In order to provide comprehensive but efficient care for its patients, a primary care practice will need to have good working relationships with specialists, hospitals, and other providers in order to avoid overlaps and gaps in treatment and testing and to achieve the best outcomes for its patients. When referrals are made to specialists for treatment, each specialist will only be providing a portion of the care that patients need, so the primary care practice must serve as a coordinator if coordination is to occur. Moreover, although many patients can be managed appropriately by primary care practices without direct treatment by a specialist, primary care practices can often benefit from help from specialists in developing appropriate guidelines for managing patients with chronic diseases and in customizing treatment in order to effectively manage the care of certain patients with advanced stage chronic diseases or multiple chronic diseases. When hospitalizations occur, the

primary care practice may need to work with a hospitalist and/or other specialists to coordinate the hospital treatment with the patient's overall plan of care and to ensure that appropriate follow-up care is delivered after discharge.

Being a *coordinator* does not mean being a "gatekeeper," which was the criticism made of how primary care practices were forced to function under many managed care programs.⁴³ If the primary care practice has the time to adequately coordinate care and explain choices to patients, it is

likely that many patients will voluntarily follow the practice's advice about how to best manage their care and avoid unnecessary treatment and duplicative testing.

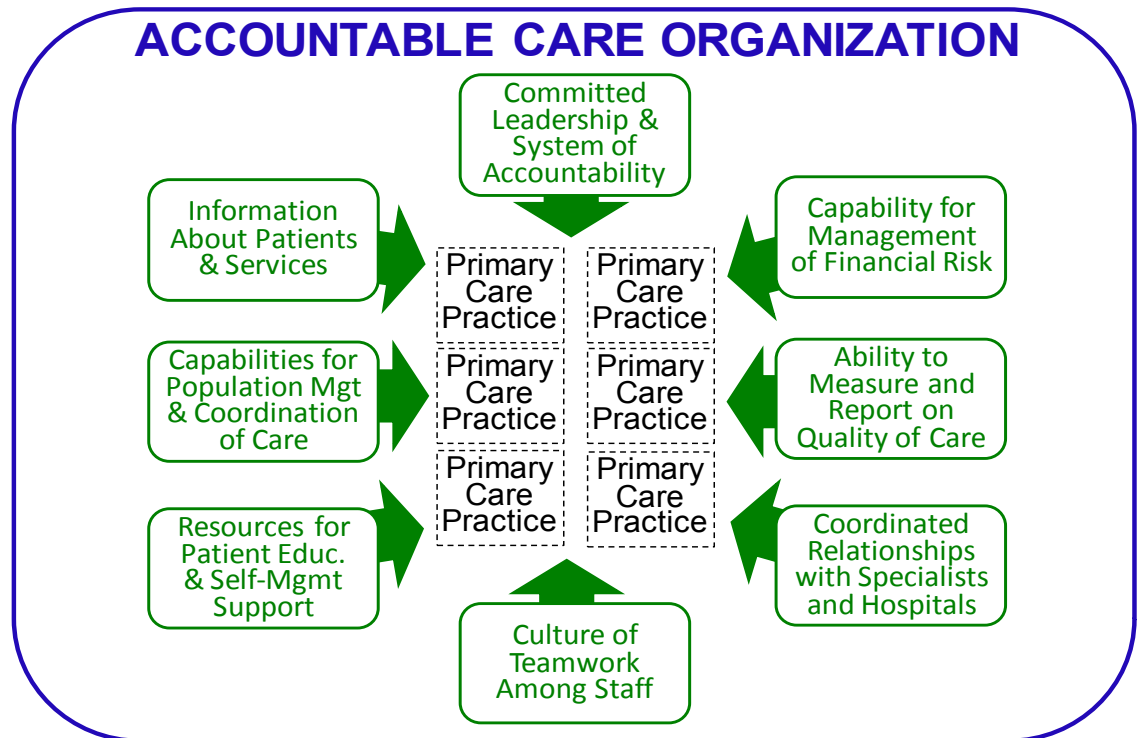


FIGURE 2

- f. **The Ability to Measure and Report on the Quality of Care.** The goal of creating Accountable Care Organizations is not just to reduce costs, but to do so while maintaining or improving the quality of care, i.e., to actually improve *value*. Moreover, a concern that consumers and patients will naturally have about ACOs is whether the ACO is reducing costs at the expense of the quality of care for patients. Addressing this concern, and ensuring that ACOs are truly achieving the best possible results, requires the ACO to be able to measure its quality and report those quality measures publicly in comparison to other providers.

A variety of programs have been developed to measure and report on the quality of provider services. The most successful systems for primary care have been developed by Regional Health Improvement Collaboratives which actively engage physicians in the development of the measures and in checking the validity of the data before the data are used (particularly when the measures are based on claims data which were designed for payment purposes rather than quality measurement).⁴⁴ A neutral source such as a Regional Health Improvement Collaborative, which involves physicians as well as other stakeholders, is more likely to generate measures that are viewed as credible by all parties and which result in appropriate actions. Many of these Collaboratives also work with the physicians to ensure that the measures are actionable (or can be disaggregated into actionable measures) and to provide assistance to physicians in redesigning care delivery processes in order to maximize the likelihood that the measures will actually result in improved performance.

- g. Infrastructure and Skills for Management of Financial Risk.** In order to survive, primary care practices have had to organize themselves in ways that are designed to maximize revenue under the fee-for-service system. Many of their processes will need to be significantly redesigned in order to accept responsibility for managing costs of care, and most practices will require new skills and new infrastructure to do so, such as financial modeling capabilities. As noted in Section II-B, physicians in an ACO should be protected from *insurance* risk, but they should be responsible for *performance* risk (i.e., controlling the costs of care for individuals with a particular set of health conditions, while maintaining or improving outcomes), and this will create new financial risks that most practices are not accustomed to dealing with.
- h. A Commitment by the Organization’s Leadership to Improving Value as a Top Priority, and A System of Operational Accountability to Drive Improved Performance.** Although the types of tools and resources defined above are likely necessary for success, they are not sufficient; the primary care practice needs to be committed to applying the tools and resources in a continuous improvement process focused on improving outcomes.

2. WHAT’S THE DIFFERENCE BETWEEN A MEDICAL HOME AND AN ACCOUNTABLE CARE ORGANIZATION?

Many of the items defined in the previous sub-section are similar to the kinds of improvements in primary care that are being pursued through initiatives to create “patient-centered medical homes.”⁴⁵ If so, how does a Medical Home differ from an Accountable Care Organization?

The most fundamental differences are the Accountable Care Organization’s commitment to improve cost and quality outcomes and its ability to manage under a performance risk-based payment system. Most initiatives today to help primary care practices become Medical Homes do not require that the primary care practice accept any accountability for the total costs of care for their patients or for population-level quality outcomes. Even though many of the enhanced resources and tools being developed and used by Medical Homes, such as electronic health records, patient registries, patient education on chronic disease management, and more responsive scheduling, could help improve quality and reduce total costs, there is no guarantee that they will do so unless the primary care practice actually focuses on improving those outcomes as an explicit goal and uses the medical home tools to achieve the goal. Indeed, the Congressional Budget Office, in evaluating various health delivery reform options, estimated that paying for Medical Homes for chronically ill beneficiaries in Medicare would increase spending by \$5.6 billion, rather than reduce costs.⁴⁶

This implies that while becoming a Medical Home could help a primary care practice become an Accountable Care Organization, it is not sufficient. Conversely, in order to function effectively as an Accountable Care Organization, it may not be necessary for a primary care practice to meet all of the detailed standards that organizations such as the National Committee for Quality Assurance (NCQA) require of primary care practices in order to be formally designated as a “Patient-Centered Medical Home.”⁴⁷ Indeed, detailed accreditation standards are being used in medical home programs partly because payers are concerned about whether making higher payments to primary care practices to enable them to serve as medical homes will actually result in improved outcomes for patients and lower costs for payers. Since there is not strong evidence that all of the structural and process standards established for medical homes are necessary for improved patient outcomes and some may be difficult or expensive for practices to achieve,⁴⁸ and because some practices that would not meet these standards have been successful in proactively managing and coordinating their patients’ care, a primary care practice should not be precluded from serving as an Accountable Care Organization simply because it has not met accreditation standards as a Medical Home.

3. CAN SMALL PRIMARY CARE PRACTICES BECOME AN ACCOUNTABLE CARE ORGANIZATION?

In most regions of the U.S., a majority of primary care physicians practice alone or in very small groups, typically five or fewer doctors. Consequently, it will be difficult to create Accountable Care Organizations in most parts of the country unless there is a way for small primary care practices to successfully evolve into an ACO. Is it feasible for small primary care practices to successfully become an Accountable Care Organization?

A. ABILITY TO MANAGE AND COORDINATE PATIENT CARE

The first test is whether a small primary care practice can implement the eight key elements described above or have equivalent capabilities needed to be accountable for total costs. Some solo and very small physician practices have been

able to create a delivery model that impacts population health, experience of care, and reduced total cost of care.⁴⁹ However, most will likely have great difficulty implementing all of these elements by themselves, since it is difficult for a small practice to afford, develop, and effectively utilize the kinds of care management services, after-hours accessibility, decision support systems, etc. needed to coordinate all of the types of care that complex patients need and to change the way that care is delivered to those patients in order to reduce costs and maintain or improve outcomes.⁵⁰ Moreover, if physicians and other primary care practitioners do not have the opportunity to discuss different approaches to care with other physicians/practitioners and compare the results of these approaches, it is difficult for them to identify opportunities for improvement.

Although very small practices may not be able to do these things on their own (or do so efficiently), they can work together to do so. Many small physician practices already collaborate with each other to provide backup coverage, and a growing number are working together more formally to provide or jointly purchase patient supports such as care management, after-hours response to patient calls, etc. that have traditionally been associated only with large practices. Although these small practices may be unable *individually* to serve as an Accountable Care Organization, they could join with other small practices to form an organizational structure such as an Independent Practice Association (IPA) or a Physician Organization (PO) to enable them to efficiently provide the services needed to serve as an ACO. This organizational structure could efficiently provide shared services that each of the practices need, but are individually too small to provide on their own, such as patient education, after-hours response, quality measurement, quality improvement, etc.⁵¹

B. ABILITY TO MANAGE FINANCIAL RISK

The second test is whether a small practice can financially manage the performance risk associated with a population of patients. As noted above, even if there are systems designed to protect the practice from insurance risk, there will still be financial risk associated with the practice's performance in managing the costs and quality of care for a population with a given set of health conditions. In addition, however, the smaller the number of patients, the more likely it is that costs will vary significantly from year to year due to one or two unusually expensive patients. Although severity (case mix) adjustment systems and risk corridors can compensate for this somewhat, they cannot do so completely, and it becomes increasingly difficult to adequately risk-adjust payment to avoid insurance risk if a practice has only a small number of patients.

Here again, although very small practices cannot easily do this separately, they can work together to do so. There are several examples around the country of Independent Practice Associations (IPAs) contracting with health plans on a full-risk or almost-full-risk basis to manage the care of their patients from both a cost and quality perspective.⁵² Although each of the members of the IPA is a very small practice, collectively they have enough volume of patients to be able to manage financial risk. In effect, these IPAs are already serving as Accountable Care Organizations under these contracts, and could do so for other payers, too.

C. ABILITY TO MEASURE COST AND QUALITY

Finally, as noted earlier, it will be important to both payers and patients to assure that an Accountable Care Organization is not reducing costs at the expense of care quality, and so quality measurement and reporting will be critical. Moreover, payers will want to be assured that the ACO is actually controlling or reducing costs, and that changes in costs are not due to either random fluctuations in patient characteristics or a systematic effort by the ACO to avoid high-cost patients. However, it is impossible to generate statistically meaningful measures of the cost and quality of care delivered to the small number of patients managed by most individual doctors or small practices. In other words, when a practice is small, it is difficult for both the practice itself and any payer (which will only be concerned about its own subset of the practice's patients) to accurately determine whether the practice is improving cost and quality outcomes. Moreover, small practices may not have either the information systems or staff with the time and expertise to analyze data in a meaningful way.

Analyses by Elliott Fisher and colleagues at the Dartmouth Center for Health Policy Research have been used to recommend that if ACOs are to be supported through Medicare, they would need to serve a minimum of 5,000 Medicare patients in order for Medicare to measure their performance on cost with sufficient accuracy to support a payment system based on shared savings.⁵³

Since a typical primary care physician cares for 1,500 – 2,000 patients and usually fewer than half are Medicare patients, this implies that at least 10 primary care physicians would need to be in an Accountable Care Organization in or-

der to meet this standard. For payers with a smaller proportion of patients and for patients with less intensive needs, an even larger number of patients and physicians would be needed to meet these statistical tests.

However, even a practice with 10 primary care physicians would be larger than the majority of physician groups in the country today. Here again, though, even a small Physician Organization, Independent Practice Association, or other virtual organization of small primary care practices could potentially meet this threshold in order to serve as an ACO. It is also important to recognize that the 5,000 Medicare patient threshold was calculated in conjunction with a specific payment model – namely a plan to share savings if costs were reduced by at least 2% over projected levels. Outcomes (both quality and cost) can still be measured for fewer patients, but larger changes in outcomes would be needed to statistically “prove” that those changes were not due to random variation.

Rather than establishing an absolute standard based on the number of patients, it may make sense to have a more flexible standard that jointly considers all of the elements described above. For example, if a primary care practice or IPA has only 4,000 Medicare patients, but it demonstrates that it has all of the capabilities in place to effectively manage the care needed by those patients and the willingness and ability to accept financial risk, the practice could be designated as an Accountable Care Organization but with a more stringent standard for outcomes, i.e., it would need to achieve a bigger impact on outcomes (higher quality, lower cost, or both) than would a larger practice in order to prove that its impact was not due to random variation. This provides an *incentive* to the smaller practice or IPA to join with other practices to form a larger Accountable Care Organization (thereby allowing it to receive “credit” for smaller outcome changes) without *requiring* it to do so. At the same time, it allows a high-performing small physician practice to remain small and still be rewarded for its high performance. This could also facilitate the creation of Accountable Care Organizations in rural areas and even some inner-city areas where the minimum number of primary care providers does not exist at all. Conversely, simply because a primary care practice or group of practices has 5,000 Medicare patients does not mean it can successfully manage costs and quality for those patients, so the size threshold remains merely one criterion, not the principle criterion, for determining which providers have the ability to succeed as an ACO.

4. SHOULD ALL PHYSICIANS IN A GEOGRAPHIC AREA BE INCLUDED IN A SINGLE ACCOUNTABLE CARE ORGANIZATION?

As noted earlier, Elliott Fisher and colleagues have suggested that payers should create virtual Accountable Care Organizations by designating all physicians in a particular geographic area as an ACO (or alternatively, designating all physicians who admit patients to a particular hospital as an ACO) and paying those providers in ways that hold them collectively accountable for the cost and quality of healthcare for the population in that region.⁵⁴

The advantage of this approach is it avoids or minimizes the potential for a subset of physicians to form an ACO and then select the patients who are least likely to need large amounts of costly care. However, requiring that all physicians in an area participate in an ACO is very problematic, because if any particular physician or small group is unwilling to change the way care is delivered, it can both impede the process of transforming care among the willing providers and/or weaken the overall outcomes the ACO can achieve. Several of the key elements cited earlier – a commitment by the organization to improving value, a culture of teamwork, and a system of operational accountability – cannot be assured unless participation is voluntary. Participating physicians have to *want* the Accountable Care Organization to work in order for it to be successful (and also to be paid in ways that enable them to do so).

In addition, creating any kind of organizational structure that requires all providers in a particular area to participate is, in perception or reality, creating a monopoly and the potential for price-fixing, and even if the providers are participating willingly, there will inherently be less pressure or incentive for them to improve their performance since there would be no other local providers to which the Accountable Care Organization could compare its performance, and no alternative provider for a payer or patient to choose if the performance of the Accountable Care Organization is unsatisfactory.

Finally, the reality is that, in most regions, there are natural communities of caregivers who already share some level of responsibility for a population of patients through arrangements such as cross-coverage, referral, and hospital staff membership, who feel some level of affinity with one another, who are inclined to cooperate with and trust one another, and who may already have a nascent organizational structure. It makes more sense to use these relationships as the basis for creating an ACO, rather than to artificially combine providers using arbitrary rules.

B. WHAT IS THE ROLE OF SPECIALISTS IN AN ACCOUNTABLE CARE ORGANIZATION?

If an Accountable Care Organization is created by a large group of primary care physicians or an association of multiple small primary care practices, that does not mean that only those primary care physicians will provide healthcare services to the patients of the ACO. For many kinds of conditions, ranging from chronic disease to major acute conditions, patients will still require specialists to provide all or part of the care they need. For example, patients needing heart bypass surgery will need care from a cardiac surgeon, and patients with diabetes will need to see an ophthalmologist regularly to ensure that retinal problems are diagnosed and treated early in order to prevent or minimize loss of vision. (Technically, many primary care physicians are also “specialists,” specializing in family practice, internal medicine, or pediatrics. For simplicity, however, the term “specialist” will be used here to refer to physicians and other practitioners who focus on particular conditions or body systems.)

However, one of the problems with healthcare in the U.S. is that there is little or no coordination between primary care physicians and specialists, or between multiple specialists treating different conditions affecting the same patient. This can result in problems such as duplication of testing and conflicts between medications ordered by different physicians that lead to higher costs and poorer outcomes. Moreover, a recent study suggests that many of the visits made to specialists after initial referral are for routine or preventive care that could be more cost-effectively delivered through the patient’s primary care practitioner.⁵⁵ In the United Kingdom, for example, primary care practices play a much more comprehensive role in managing care for patients, particularly those with chronic disease, than in the United States. Although specialists are used in the U.K., the rate of referral from primary care physicians is only one-third as high as in the U.S, even after controlling for level of illness.⁵⁶

This is likely in part a result of the dysfunctional fee-for-service system in the U.S., which pays each specialist independently for whatever they choose to do, including ordering duplicative tests, but pays no one to provide coordination. In many cases, more coordinated care could be provided by having the specialist consult with the primary care physician about how the primary care practice can comprehensively manage the patient’s care, rather than having the specialist separately manage a portion of the care. Here again, the fee-for-service system is a barrier, since the specialists are paid for face-to-face visits with patients, but are typically not paid when they provide advice directly to the primary care physician.

Clearly, one of the opportunities for improving the efficiency and effectiveness of healthcare in the U.S. is rationalizing the roles of primary care physicians and specialists. As noted in Section III-A1, to be successful as an Accountable Care Organization, a primary care practice will need to have good working relationships with special-

ists in order to avoid overlaps and gaps in care and to achieve the best outcomes for their patients. Almost by definition, each specialist will only be providing a portion of the care that patients need, so the primary care practice must serve as a coordinator if coordination is to occur. Moreover, primary care practices will likely benefit from advice from specialists in order to effectively manage the care of patients with chronic diseases, particularly those with advanced stage chronic diseases or multiple chronic diseases. For example, if primary care physicians work with cardiologists to implement information systems and standards of care which facilitate successful management of coronary artery disease and heart failure, they may be able to achieve better outcomes for their patients than if the pri-

Accountable Care Requires Coordinated Relationships, Not Necessarily Corporate Integration

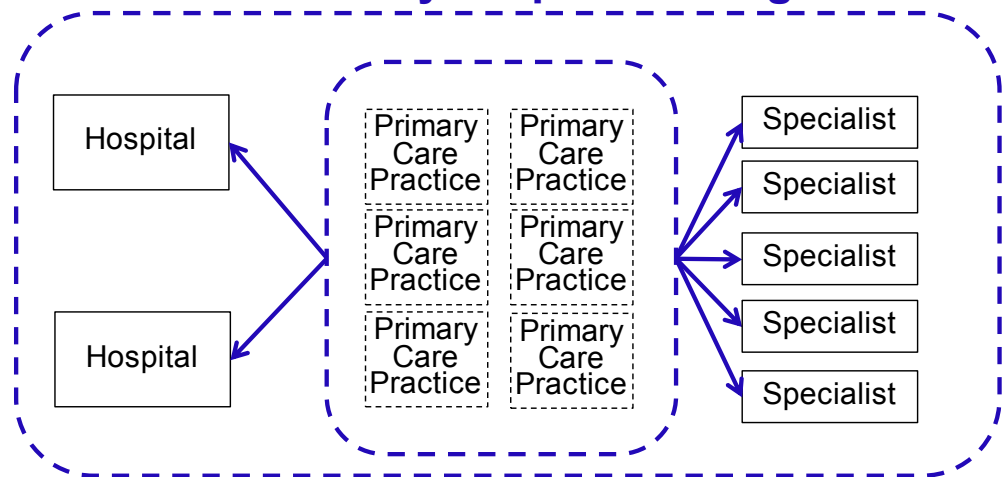


FIGURE 3

mary care physicians attempt to manage the patients on their own, with referrals made to the cardiologists only when serious problems arise. Similarly, if primary care practices work with psychiatrists, they can better manage the care of patients who also have depression.⁵⁷

Having good working relationships between the primary care physicians in an ACO and specialists does not necessarily mean that the specialists must be part of the Accountable Care Organization itself, however. In some cases, they may be; for example, an integrated delivery system or a large multi-specialty group might become an Accountable Care Organization and use its own specialists to provide specialty care when such care is needed. But a primary care practice or an IPA could also function as an ACO by developing contractual arrangements or merely solid professional relationships with independent specialists in the community in order to ensure efficient, effective, coordinated care for the ACO's patients. Many multi-specialty groups do not directly employ physicians from all specialties, requiring them to develop relationships with other specialists in order to manage the care of all of their patients.

It is important to recognize that the goal of the Accountable Care Organization is to take responsibility for *managing* the costs and quality of healthcare for a population of patients, not necessarily to *deliver* every healthcare service itself. When consumers buy a product from a manufacturer, they hold the manufacturer accountable for the quality of the product, but they don't expect all of the product's components to be produced by the manufacturer's own facilities or staff. Even in health care, health plans are, at least in principle, accountable for the cost and quality of care their members receive, but other than health plans structured as staff model HMOs, the plan's members don't expect that the health plan itself will actually deliver healthcare services. Similarly, even though an ACO is designed to shift much or all of a health plan's accountability for population-level outcomes to healthcare providers, that does not necessarily mean that every provider that touches a patient will have to be part of the Accountable Care Organization.

In fact, the willingness of specialty physicians to participate in the Accountable Care Organization, at least initially, will likely depend on the extent to which specialty care is being overused in a particular community and the way the specialists themselves are organized. If there is a high rate of referrals to a particular specialty in the community, then a natural opportunity for the ACO to reduce or control total expenditures is to reduce unnecessary referrals, which in turn would reduce revenues to the specialists. If those specialists have joined together in a single group, they may simply raise their fees for the patients in the ACO to offset the lower volume, thwarting the ACO's efforts to reduce total costs. Research shows that a primary reason for the consolidation of specialty physicians into larger groups has been to negotiate higher fees.⁵⁸ On the other hand, if there are competing specialists in the community, the ACO has an opportunity to choose the specialists who will best support the goals of the ACO.

Consequently, some ACOs may decide to have specialists as part of the organization itself, and other ACOs may not. Some ACOs may have a subset of specialists included in the organization, and have contractual or other relationships with the remaining specialists in the community. The important factor will be the ACO's ability to successfully work with a comprehensive set of specialists to achieve the most coordinated, efficient care of the patients for whom the ACO is accountable.

C. SHOULD HOSPITALS BE PART OF AN ACCOUNTABLE CARE ORGANIZATION?

Obviously, some of an Accountable Care Organization's patients will need hospital care at some point. Hospitals provide critical services for the sickest patients who require the most costly services. As with specialists, however, this does not necessarily mean that a hospital must be part of the ACO itself.

There are many potential advantages to having one or more hospitals as an integral part of an ACO. In general, the hospitals in a community are larger organizations than any of the individual primary care practices, and they have more extensive administrative resources and skills, ranging from information technology to finance to quality improvement tools. These kinds of capabilities could potentially be used to develop and implement the key functions of an ACO described earlier.

Moreover, in many communities, hospitals have acquired primary care practices and now employ many primary care physicians;⁵⁹ in other communities, hospitals and primary care physicians work together through Physician-Hospital Organizations (PHOs). In these situations, the hospital may be in a natural position to facilitate the steps needed to help primary care physicians make the transition to functioning as an ACO.

However, a key issue will be whether the hospital embraces the goal of cost reduction and control underlying the formation of Accountable Care Organizations and whether the hospital is prepared to take the steps needed to transform itself in order to achieve that goal. Approximately 40% of the growth in total health care spending in recent years is due to growth in hospital spending, and hospital care has been the second fastest growing component of healthcare services.⁶⁰ A study by McKinsey & Company found that spending on hospitals was the biggest reason that healthcare costs in the U.S. are higher than in other countries.⁶¹ Consequently, reducing and controlling hospital spending will be essential if total healthcare costs are to be controlled.

As noted in Section II, several of the most important ways to reduce spending on hospitals would be to prevent the need for hospitalizations, through more effective prevention programs, early detection, improved chronic disease management, etc. These initiatives would be achieved primarily or exclusively through the actions of primary care practices, not by hospitals themselves. Moreover, to the extent that these initiatives are successful, they will not only reduce the hospitals' revenues, but they may well have a negative impact on the hospitals' margins, particularly in the short run, if revenues decline more than costs can be reduced.⁶²

As a result, at least in the short run, the interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in *opposition* to each other. In any region where primary care physicians are actively working to reduce preventable admissions, the natural desire of any hospital which is not over-capacity will be to either (a) increase other services to offset the revenue loss (thereby offsetting the effect of the ACO's efforts to reduce spending), or (b) increase its prices for services to offset the loss (again offsetting broader efforts to reduce spending). (Although the hospital cannot increase prices under the Medicare fee-for-service program, it may well be able to do so for patients covered by commercial insurance or Medicare Advantage plans.⁶³) Moreover, under a "shared savings" payment model (see Section IV), the hospital will likely want to capture most or all of the savings attributed to an Accountable Care Organization in order to offset the hospital's loss of revenue, whereas the primary care physicians will need to use some of the savings to pay for the more intensive care management services and information infrastructure they create to improve quality and reduce preventable admissions. This may exacerbate tensions in those regions where hospitals and physicians have poor relationships.⁶⁴

Consequently, although coordinating outpatient and inpatient care is certainly desirable, and having a willing hospital as part of an Accountable Care Organization could have clear advantages, in many regions it would be inappropriate or infeasible to *require* that a hospital be part of an Accountable Care Organization along with primary care physicians, particularly in the short run. Where hospitals and primary care physicians are already working together effectively, such as in an integrated delivery system (IDS) or a physician-hospital organization (PHO), they could be encouraged to serve as an Accountable Care Organization, but where such working arrangements do not exist, a payment system based on total costs may not be the best context in which to forge such partnerships for the first time.

In addition, in a community where there is only one hospital (or where one hospital is the exclusive provider of certain services), it may be undesirable to have that hospital exclusively join with a subset of physicians in the community to form an ACO, since that may preclude the ability of other physicians to develop an ACO, particularly if the hospital refuses to accept the patients of the second ACO or will only accept them if they pay high charges. (This is more of a problem for ACOs serving commercially-insured patients than for Medicare patients.)

Consequently, particularly in the short run, the most appropriate approach in many regions may be a split path, i.e., for primary care physicians to form one or more Accountable Care Organizations without hospitals, and for hospitals to establish gain-sharing arrangements with their hospitalists and specialists (either directly or through bundled payment systems) so that they can find ways to cut costs, improve efficiencies, and otherwise adapt to lower rates of inpatient admissions (whether that be through downsizing or specializing in treating more complex patients). For example, hospitals and specialists could form "Care Delivery Teams" for specific types of care⁶⁵ and accept bundled/episode payments as described in Section IV.

After a period of right-sizing each component separately (i.e., more and better primary care, and smaller, more efficient inpatient care), it may be more feasible to consider bringing the primary care physicians and one or more hospitals in a community together into a joint Accountable Care Organization in order to focus on additional opportunities to improve quality and cost.

Where this transitional split path is pursued, however, it will still be important for the primary care physicians to work as closely as possible with their hospitals to ensure the transition is successful. An ACO cannot ensure that its pa-

tients receive a full range of high-quality, efficient care without a high-quality, efficient hospital in the community, and if dramatic changes in hospital admission rates caused by the ACO make the hospital financially unviable, the ACO and the community as a whole could suffer. Payers can help by aligning payment incentives between primary care practices and hospitals, e.g., by rewarding hospitals which reduce admissions for ambulatory care-sensitive conditions and/or reduce elective procedures in situations where conservative options offer equal potential benefits to patients. Payers can also help by working with hospitals to adjust payment rates to facilitate the hospitals' transition to lower admission rates.

D. ARE INTEGRATED DELIVERY SYSTEMS THE IDEAL MODEL?

Although significant impacts on costs can be achieved through Accountable Care Organizations built solely around primary care practices, there are many additional opportunities to reduce costs and improve quality through improved inpatient care and improved management of complex patients that can only be accomplished through the involvement of and coordination with hospitals and specialists. Consequently, as noted in the previous sections, while it is probably inappropriate or infeasible in many regions to *require* that Accountable Care Organizations include hospitals or specialists, it would seem desirable to encourage and support the use of Accountable Care Organizations which do include hospitals and/or specialists.

Because of this, Integrated Delivery Systems (IDSs), i.e., organizations that combine hospitals, specialists, primary care physicians, and in some cases health plans, could be viewed as the ideal model for an Accountable Care Organization. Such systems have many assets that can be used to accept accountability for cost and quality more easily than providers in non-integrated systems; for example, an integrated delivery system is more likely to have the kind of comprehensive data on services and costs for patients that are needed to succeed as an ACO, since the system provides a greater share of those services itself. Not surprisingly, therefore, several large IDSs, such as Denver Health, the Geisinger Health System, Group Health Cooperative of Puget Sound, Intermountain Health Care, Kaiser Permanente, and the Mayo Clinic, are routinely cited as national models of quality and efficiency (although this does not mean that they cannot improve further on both measures).

However, there are other large integrated delivery systems that are not cited as models for either quality or efficiency or both. In some cases, their size and integration have been used more as a way of controlling market share and increasing prices rather than reducing costs and improving quality.

Just as a primary care practice could meet NCQA standards as a Patient-Centered Medical Home without the ability to serve as an Accountable Care Organization, merely having a group of primary care physicians, specialists, hospitals and other providers combined in an integrated corporate structure is neither a necessary nor a sufficient condition for achieving success as an Accountable Care Organization. Indeed, it is *clinical* integration that achieves better outcomes and lower costs, not necessarily *corporate* integration. Clinical integration enables primary care physicians, specialists from different disciplines, and inpatient and outpatient facility-based providers to communicate and collaborate in ways that ensure the most efficient and effective patient care. Corporate integration may achieve some economies of scale in administrative functions, but there is no evidence that either horizontally- or vertically-integrated systems are always lower cost than non-integrated systems or that corporate integration automatically leads to more clinical integration.⁶⁶ Conversely, clinical integration can and does occur without corporate integration.

However, even clinical integration is not sufficient for success as an Accountable Care Organization. Leaders of some of the model Integrated Delivery Systems say that while their clinical integration helps them in fulfilling the vision of Accountable Care Organizations, the most important cause of their success is setting clear goals for the management of population-level costs and quality and developing the skills in operational execution needed to achieve those goals. (The leaders of these systems also note that current healthcare payment systems tend to penalize them for these successes.⁶⁷)

Consequently, the test of whether an Integrated Delivery System can serve as an Accountable Care System should not be based on its structure alone, but on whether it has the appropriate processes in place (particularly the eight elements outlined in Section III-A1 in conjunction with primary care practices), and, ultimately, on the outcomes it achieves. If it does, then it would likely be an excellent example of an Accountable Care Organization.

E. CAN THERE BE TOO MANY ACCOUNTABLE CARE ORGANIZATIONS IN A SINGLE REGION?

Obviously, the smaller the minimum size for an Accountable Care Organization, the more Accountable Care Organizations there can be in a particular geographic region. As noted earlier, in order to create a basis for comparison, choice, and competition on costs and quality, it is undesirable to have a single Accountable Care Organization in a region. Although some forms of “competition” in healthcare in the past have contributed to higher costs (e.g., overbuilding of facilities and duplication of equipment), this is partly a function of current healthcare payment systems which pay providers more for delivering more services. What would be different from the past about Accountable Care Organizations is that there would be an explicit accountability by the ACO itself for cost.

If each Accountable Care Organization is accountable for the costs of services for the patients under its care as well as the quality of the care, then for many types of patients and services, it makes no difference whether there are 2 Accountable Care Organizations, each managing approximately 1/2 of the total cost in a region, or 10 Accountable Care Organizations, each managing 1/10 of total costs. Competition around costs as well as quality could encourage more rapid improvements in the value of care. (Indeed, competition among health insurance plans – the closest thing to Accountable Care Organizations that exist today in most regions – is generally viewed as desirable as long as it is based on quality and cost, not on differential underwriting standards.)

Although each ACO could still choose to create its own facility or service rather than using those provided by another ACO or independent provider, thereby potentially increasing overall costs, there would be an incentive for providers to pursue economies of scale where they exist. For example, if an ACO could use an independent laboratory at a lower cost than building its own while maintaining the quality of the service, it would have an incentive to do so. If two Accountable Care Organizations could reduce overhead costs significantly (without jeopardizing quality) by combining into a single, large ACO, they would have an incentive for doing so because they would be rewarded for reducing costs, whereas today they might be penalized. This would reduce unnecessary or inefficient proliferation of separate Accountable Care Organizations, without requiring any specific maximum number to be imposed.

The limited research literature suggests that the size of a physician practice where maximum efficiency is achieved is actually quite small – 10-15 physicians.⁶⁸ Even where there may be significant opportunities for efficiencies or greater clinical integration resulting from consolidation of providers, this will need to be balanced against the possible creation of a monopoly provider. Making the tradeoff between these opposing considerations will continue to be a challenge for federal and state antitrust enforcement efforts.

Although there are clearly advantages to having multiple ACOs in a region, there are also complexities that will need to be addressed:

The more ACOs there are in a region, the greater the need will be for an appropriate risk/severity adjustment mechanism in the payment system in order to avoid having some ACOs selecting healthy patients or excluding sick patients in order to improve their quality or cost performance, and to avoid having the ACO financially hurt by random variations in patient needs.

In addition, the more ACOs there are in a region, particularly if hospitals or specialists are part of one or more of the ACOs, the more likely it will be that the patients of one ACO will need or want to use specific providers or services that are part of a different ACO. Although such patient choice is desirable, it will require more complex payment arrangements.

The resolution to these tradeoffs will likely differ from region to region. They will depend on the existing structure of the healthcare delivery system, the extent of the collaborative relationships among the independent providers, and the existence of effective mechanisms to counteract anti-competitive behaviors.

F. BUILDING ON WHAT EXISTS – LEVELS OF ACCOUNTABLE CARE ORGANIZATIONS

Although an “Accountable Care Organization” sounds like a brand-new concept, as noted earlier, there are already many healthcare providers across the country that are accepting significant accountability for cost and quality. Moreover, these providers are very diverse, ranging from Independent Practice Associations composed of small primary care practices to large integrated delivery systems, all of which are accepting population-based payments from some payers and managing overall costs and outcomes for their patients.

The fastest way to move toward a nationwide system of ACOs will be to build on the foundation already established by these high-performing organizations. Consequently, it will be important to avoid creating extensive and detailed regulations or accreditation standards for ACOs that could exclude these existing organizations or preclude new, innovative models from forming.

On the other hand, it will also be important to avoid designating providers as ACOs if they don’t have the capacity for success, since their failure could cause a backlash against the entire effort before it has had an adequate opportunity to develop and prove itself, much as the problems caused by some managed care providers in the 1990s sparked a backlash that led to the loss of many desirable programs.

Taking a cue from the medical home movement, rather than having a single definition of an Accountable Care Organization, the most appropriate approach may be to recognize that there will be different “levels” of Accountable Care Organizations, at least initially. For example:

- A “**Level 1 Accountable Care Organization**” could consist solely of primary care practices, and it could be held accountable either for total costs and quality of the patients being seen by those practices or for the types of costs and quality measures within the control of primary care physicians (e.g., physician office visits, diagnostic testing, and

DIFFERENT FORMS OF ACCOUNTABLE CARE ORGANIZATIONS

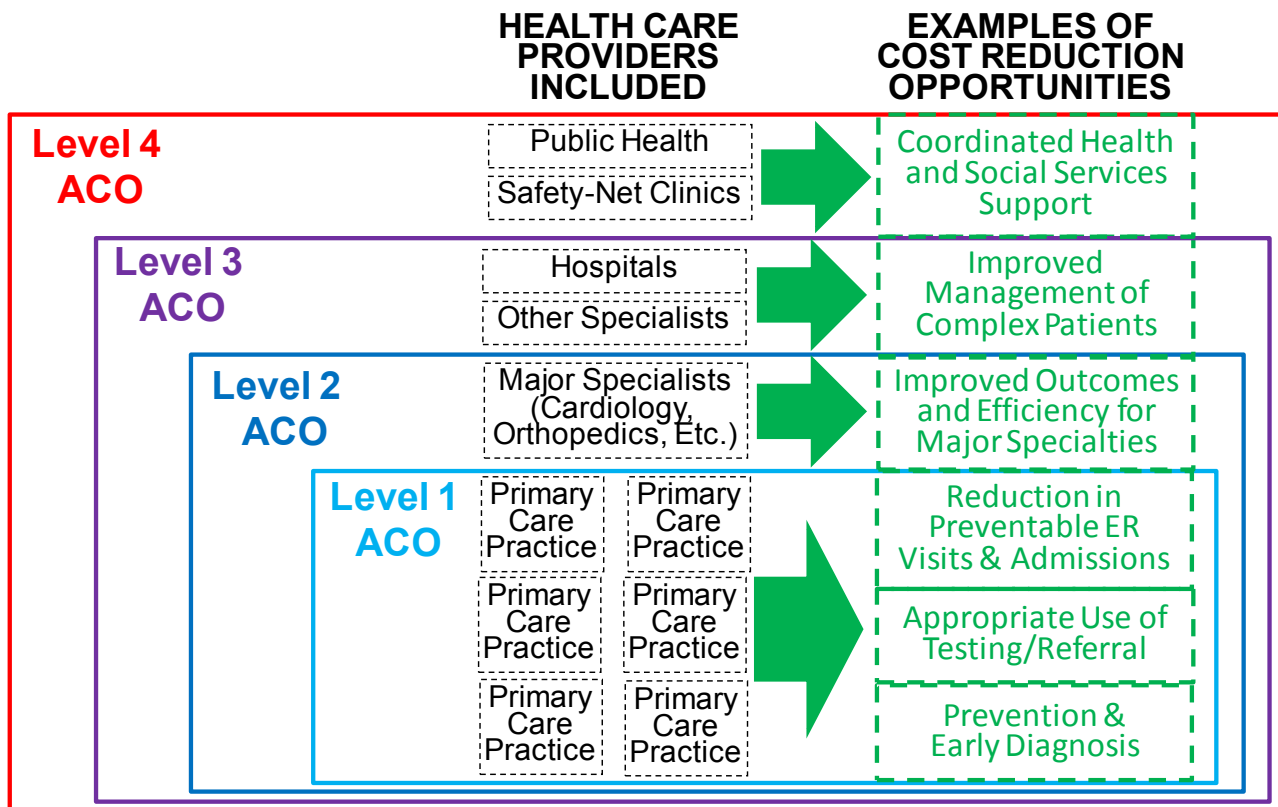


FIGURE 4

emergency room visits and hospitalizations for ambulatory-care sensitive conditions). A number of Independent Practice Associations around the country could likely become Level 1 ACOs immediately or very quickly with the appropriate changes in payment systems.

- A “**Level 2 Accountable Care Organization**” could consist of both primary care physicians and specialists in the most common fields, such as cardiology, cardiac surgery, orthopedics, gynecology/obstetrics, etc., and potentially one or more hospitals, and it could be held accountable for the costs and quality of both ambulatory-care sensitive conditions and also the most common types of specialty procedures (e.g., coronary artery angioplasty or bypass surgery, hip and knee replacements, labor and delivery). Many multi-specialty group practices and physician-hospital organizations could likely become Level 2 ACOs immediately or very quickly with the appropriate changes in payment systems.
- A “**Level 3 Accountable Care Organization**” could consist of primary care physicians, specialists, one or more hospitals, home health agencies, and even long-term care facilities, and it could be held accountable for all or almost all costs and quality associated with a patient population, with the possible exception of highly specialized services or rare conditions such as organ transplants or rare forms of cancer. (Such quaternary care might best be delivered through national centers of excellence used by all ACOs, rather than being part of any individual ACO). Many integrated delivery systems could become Level 3 ACOs immediately with the appropriate changes in payment systems. (A Level 3 ACO might also be called an “accountable care system,” using the terminology suggested by Shortell and Casalino.)
- A “**Level 4 Accountable Care Organization**” could go beyond traditional healthcare providers to include services such as public health and social services. It could be held accountable for all costs and quality associated with a very broad patient population, including the uninsured. A few systems are already functioning as Level 4 ACOs, and they could likely do even more with the appropriate changes in payment systems.⁶⁹

Some parts of the country would likely start with primarily Level 1 ACOs, whereas others would have organizations already positioned to serve as Level 3 or Level 4 ACOs, since the structure of healthcare providers differs dramatically from state to state and region to region. This approach would enable Medicare and other national payers to take advantage of what could be achieved by Level 3 ACOs in some parts of the country without losing the benefits that could be provided by Level 1 ACOs in others.⁷⁰

IV. WHAT PAYMENT REFORMS ARE NEEDED TO SUPPORT ACCOUNTABLE CARE ORGANIZATIONS?

It is now widely accepted that one of the greatest barriers to providers taking on greater accountability for costs and quality is the structure of current payment systems, particularly the uncoordinated fee-for-service payment system for physicians. Under current payment systems, physicians or hospitals or both will lose revenues if they pursue the kinds of opportunities identified in Section II; for example, doctors will lose money if they keep patients well, since their income is generated from treating patients when they are sick, and hospitals will likely see their operating margins decline if they aggressively eliminate hospital-acquired infections.⁷¹ Moreover, under current payment systems, physicians cannot be paid for the kinds of services described in Section III that can help to improve patient outcomes, such as resolving patient problems over the phone or hiring a nurse to make home visits rather than requiring the patient to come in to the office for a face-to-face visit with a doctor.

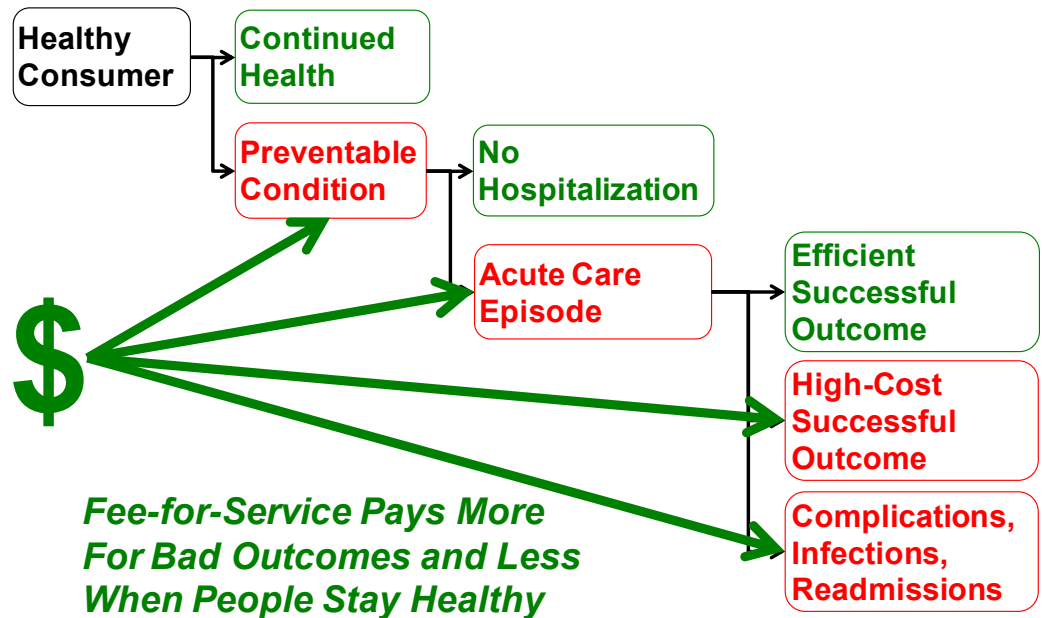


FIGURE 5

A. THE GOALS OF PAYMENT REFORM

There are five principal goals that payment reforms need to address in order to enable Accountable Care Organizations to tackle the kinds of cost-saving opportunities identified in Section II, and to implement the care and organizational changes described in Section III:

1. An Accountable Care Organization needs the flexibility to provide the right services to patients in the right way at the right time, and it should not be constrained by external definitions of the services that are reimbursable.
2. An Accountable Care Organization should be able to remain profitable if it keeps people healthier or reduces unnecessary services.
3. An Accountable Care Organization should not be paid the same (or more) for low-quality care as for high-quality care, and an Accountable Care Organization should lose patients if it provides the same or lower quality care as another provider but at a higher cost.
4. An Accountable Care Organization needs to be paid adequately (but not excessively) to cover the costs of the services it provides for all of its patients, and it should not feel compelled to provide unnecessary high-margin services simply to offset losses in other necessary services.
5. An Accountable Care Organization should not be penalized financially for caring for sicker patients, unless the sickness was caused by the ACO itself (e.g., through a hospital-acquired infection or an error in treatment).

GOALS OF PAYMENT REFORM

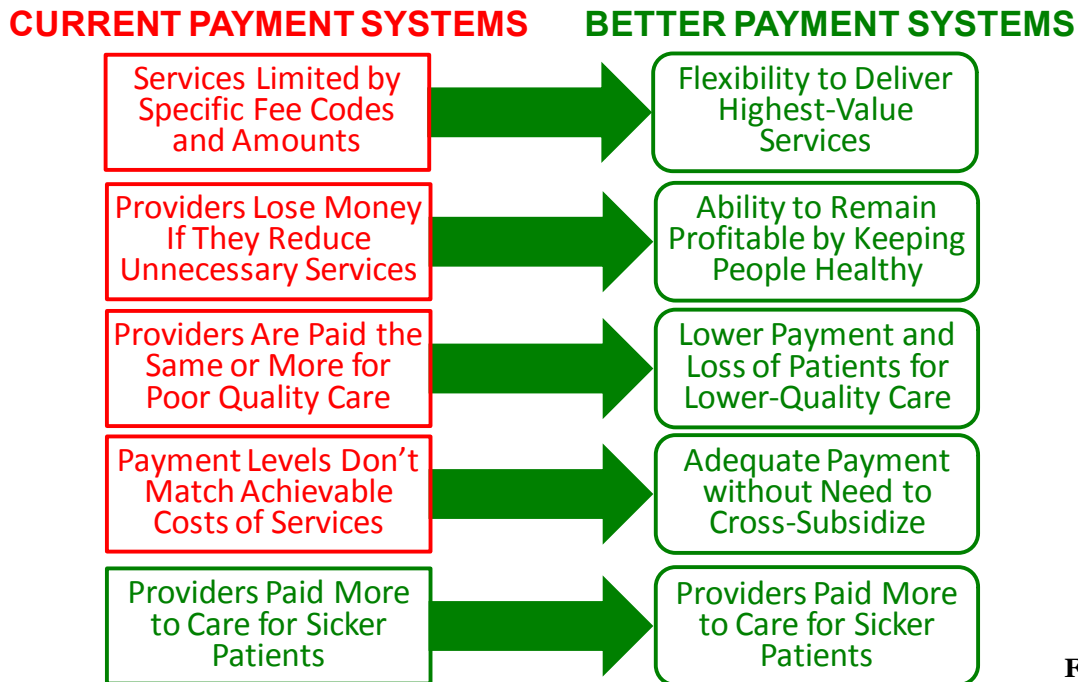


FIGURE 6

B. ALTERNATIVE MODELS OF PAYMENT FOR ACCOUNTABLE CARE ORGANIZATIONS

As shown in Figure 7, one can think of healthcare payment systems along a continuum. At one extreme is fee-for-service, which provides the maximum rewards for healthcare providers which deliver the maximum number of services and gives them little responsibility for controlling overall costs. Under fee-for-service payment, payers (e.g., Medicare, Medicaid, or health insurance companies) take on not only “insurance risk” (whether an individual will get sick) but also “performance risk” (how much it will cost to treat the illness). Almost by definition, fee-for-service payment fails to achieve the first three goals described above, and it typically fails on the fourth goal as well, since the primary tool that payers have to control costs is to reduce the size of the fees paid for services, and this may result in providers being paid less than the actual costs of delivering a service in a high-quality way. The one advantage of fee-for-service payment is that it achieves the fifth goal (avoiding penalties for taking sicker patients), since a provider who is caring for a sicker patient will be paid more for delivering more services to that patient. Overall, however, it is quite clear that it would be extraordinarily difficult for an Accountable Care Organization to succeed if it were paid on a pure fee-for-service basis. Although many payers have been using pay-for-performance systems to try and offset the undesirable incentives included in fee-for-service, it is increasingly clear that these programs can only have a limited effect on the very powerful forces in the underlying payment system.⁷²

At the other extreme of the payment continuum is capitation. Under many traditional capitation systems, payers gave healthcare providers a fixed amount of money for every patient the provider took responsibility for, regardless of how healthy or sick the patients were. (Although many capitation systems made adjustments for the age and sex of the population, few adjusted for differences in the health of a given age/sex group that different providers were caring for.) In effect, these types of capitation payment systems transferred virtually all risk – both insurance risk and performance risk – to the capitated provider. There are many desirable aspects of capitation, since it supports the first two goals above in ways that fee-for-service payment does not – the capitated provider has the flexibility to decide which services to deliver, rather than being constrained by specific fee codes, and if the provider keeps a patient healthy, the payment does not decrease.⁷³ However, many capitation systems have failed on the third and fifth goals – a provider is penalized for taking on patients who are sicker to begin with, and the provider can benefit financially from delivering fewer services than a patient needs, particularly if the negative impacts of doing so would not be realized until after the end of the capitation contract (e.g., if the provider fails to deliver preventive services, the unprevented illnesses might not occur during

the time period for which the provider is financially responsible). Capitation also does not automatically achieve the fourth goal; that depends on whether the amount of the capitation payment is adequate to cover efficiently and effectively delivered services. Many of the criticisms of capitation systems in the 1990s were due as much to inappropriately low payment amounts as to the structure of the capitation payment.

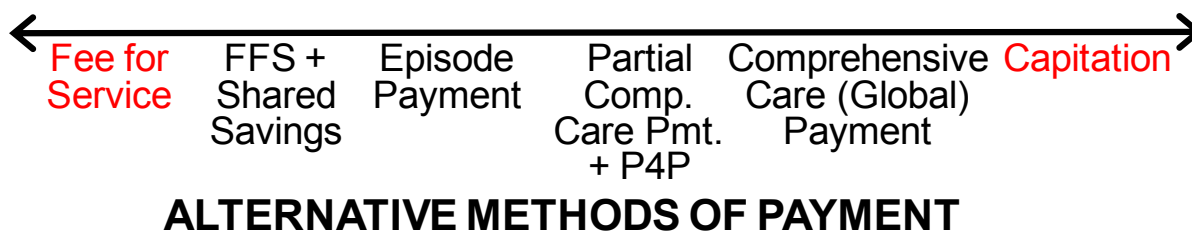


FIGURE 7

Between these two extremes, however, there are a range of payment options which may strike a better balance among the goals described above. Three that are being widely discussed today are “shared savings,” “episode/bundled payment,” and “comprehensive care payment/global payment.”

C. THE INCREMENTAL APPROACH: SHARED SAVINGS

The most incremental payment approach being discussed for support of Accountable Care Organizations is called “shared savings.” The basic concept is fairly simple: an Accountable Care Organization would continue to be paid on a fee-for-service basis, but if it reduces total healthcare spending for its patients below the level that the payer (e.g., Medicare or a private health insurance plan) would have otherwise expected, the ACO is rewarded with a portion of the savings, i.e., the payer still spends less than it would have otherwise, and the provider gets more revenue than it would under a pure-fee-for service system. This is the approach Medicare has used as the key element of its Physician Group Practice Demonstration.⁷⁴

An advantage of this approach is that it partially addresses the second goal defined in Subsection A above, i.e., that an Accountable Care Organization should not become less profitable by keeping people healthier or reducing unnecessary services. By enabling the ACO to obtain a portion of the savings achieved through reduced utilization of services or more successful prevention efforts, the ACO is less likely to become unprofitable than it otherwise would have under a pure fee-for-service payment system.

However, the fact that shared savings provides more revenue to the Accountable Care Organization does not necessarily mean that the ACO’s operating margins will not be harmed. For example, if a primary care-based ACO implements a care management program for chronic disease patients which increases its costs by \$100,000 (in ways that are not reimbursed under fee-for-service) and successfully reduces hospitalizations by \$150,000, the program would clearly be beneficial in terms of total cost and patient outcomes. But if the payer only shares 50% of the savings (i.e., \$75,000)⁷⁵ with the ACO, then the ACO will lose \$25,000, making the program a bad investment for the ACO, even though the payer could still have saved money if it had shared more of the savings with the ACO. (In this case, a 70% sharing arrangement would actually leave both the ACO and the payer better off.)

Moreover, the shared savings approach doesn’t address the first goal of payment reform, i.e., giving the ACO the flexibility to provide the right services to patients in the right way at the right time. This is because it doesn’t actually change the current payment system at all – key primary care services that aren’t paid for today (like nurse care managers for chronic disease patients, phone and email consultations with physicians, etc.) still wouldn’t be recognized, services where fees are too low to cover costs would still lose money, etc. In other words, it provides no direct means for greater flexibility or adequacy in payment to enable changes in care delivery.

Although proponents would argue that the shared savings payment does help cover an ACO’s costs for things that are under-compensated or not compensated at all today, the problem is that the payment, if it comes, arrives long after the service is delivered, and it may or may not be adequate to cover the cost of the services delivered. Even if the shared savings payment would ultimately cover the ACO’s costs, the ACO has no way of knowing whether this will be the case.

There is a non-zero risk that even if it reduces total costs, it will not meet the threshold established by the payer to declare “savings,” or it will end up spending more money on a net basis even after a pre-defined share of savings is paid. This risk is likely to deter a nascent Accountable Care Organization from even making the attempt to radically change care, especially given that undertaking such changes in themselves take time and money.

These problems could be partially addressed if the amount of the “shared savings” were developed through a collaborative process between the ACO and the payer(s), rather than chosen in an arbitrary fashion by the payer. Following the example given above, if the ACO identified in advance how much it expected to spend on a new program and what result it expected to achieve, then the payer and ACO could agree to divide the *net* savings, after factoring in any unreimbursed costs incurred by the ACO, rather than the gross savings based only on fee-for-service payment outlays. In some cases, there may be no net savings, but the quality of care would improve; in other cases, the net savings might be significant. However, even this approach still requires the ACO to incur the additional costs up front, and it may not have the resources to do that.

Shared savings will likely be more attractive to primary care-only Accountable Care Organizations than to ACOs with hospitals or specialists included. As noted earlier, many of the biggest opportunities to achieve savings are based on keeping patients well enough to avoid hospitalizations. If a group of physicians successfully reduces hospitalizations, they will be able to “keep” more of the savings that are generated if they don’t have to share a portion of those savings with the hospital(s) that experience the reduced admissions, and if a group of primary care physicians reduces the need for specialty care (either inpatient or outpatient), they will be able to keep more of the savings generated if they don’t have to share a portion with the specialists who will be losing patients or procedures.

Another problem with a shared savings structure is that it primarily rewards *improvement* rather than good performance. The communities and providers that have the most to gain from shared savings are the ones that are spending the most resources today, through high rates of hospital admissions, use of unnecessary procedures, etc. Encouraging reductions in spending in those communities is very desirable and a shared savings approach can help. However, in the communities that have relatively low costs and high quality of care, the providers are already “saving” Medicare and other payers significant amounts of money but with no reward. Although nothing would preclude forming an Accountable Care Organization in these low-cost, high-quality regions, the incentive to do so using a pure shared savings approach would be much smaller, since there would be no change in the underlying fee-for-service system and the potential to earn additional revenues through shared savings would be much lower. Even if an ACO in such a region could still improve further, it may need to invest significantly more resources to do so relative to other regions which have “lower-hanging fruit,” yet the shared savings payment it could expect to receive would likely be smaller than in high-cost regions.

Finally, it’s not clear that shared savings is a sustainable approach to payment reform. If shared savings is viewed as a one-time bonus payable after savings are achieved, then the motivation it creates for providers to change disappears when there is little no additional bonus to be achieved in the future. From the ACO’s perspective, it would need to understand in advance the requirements to achieve shared savings payments over an extended period of time in order to make investments that require a multi-year payback period. Moreover, if there is no downside risk to the provider for increased costs, one-time shared savings payments create the perverse incentive for the provider to again increase utilization of services in order to create a new pool of potential “savings” to go after in the future. Otherwise, there would be no opportunity to maintain revenue, and presumably profitability, after substantial efficiencies are achieved.

This does not mean that the shared savings concept is without merit, but unless it is redefined to be based on net savings and combined with other payment changes, it is, at best, a transitional strategy, rather than the kind of fundamental payment reform needed to support Accountable Care Organizations in the long run.

D. MORE FUNDAMENTAL REFORM: COMPREHENSIVE CARE PAYMENT OR GLOBAL PAYMENT

An alternative payment reform for supporting Accountable Care Organizations is to pay a single price for all of the healthcare services needed by the people cared for by the ACO for a fixed period of time, with the amount of the payment adjusted based on the types and severity of the conditions those patients have and on the quality of care delivered. There is no standard term for this; it has been called “Comprehensive Care Payment,” “Condition-Adjusted Capitation,” “Risk-Adjusted Global Fees,” and “Global Payment.”⁷⁶

The adjustments for patient conditions and for quality are what make this payment model different from traditional capitation. As noted earlier, many traditional capitation payment systems failed to achieve the third and fifth goals of payment reform, since they penalized providers for taking on sicker patients and typically had no mechanisms for ensuring the delivery of high-quality care. In contrast, an appropriately designed Comprehensive Care Payment system has the potential to achieve all five of the goals of payment reform defined earlier. If the healthcare provider receiving it keeps patients well and out of the hospital, or avoids providing unnecessary services, the provider’s payment would not go down, and its margins could increase. Healthcare providers would have the flexibility to decide what services should be delivered and the upfront resources to deliver them, rather than being constrained by fee codes and amounts, detailed rules and regulations for billing, or waiting for uncertain, after-the-fact shared savings payments to be made, and hospitals would become viewed as cost centers, rather than revenue centers as they are today.

The downside of Comprehensive Care Payment is directly related to one of the things it is designed to achieve – it makes a provider accountable for the cost of care given to patients. That requires a very different set of skills than many providers have today, and creates the risk of financial failure even with appropriate risk-adjustment to avoid imposing insurance risk on the provider. However, if a provider is not prepared to take on these risks and develop these skills, then it cannot be an Accountable Care Organization and should not be given the Comprehensive Care Payment.

To be successful, Comprehensive Care Payment would need to be structured so as to avoid the problems that traditional capitation systems experienced. In particular:

- The amount of the payment must be adjusted based on the types of conditions, severity of conditions, and other characteristics of the patients being cared for, so that the ACO is not forced to take on insurance risk.⁷⁷ Although current risk/severity-adjustment mechanisms are not perfect, they are much better than in the past, and they will likely improve more rapidly if they are used more broadly for payment.⁷⁸ This will be easier to do for ACOs managing large numbers of patients.

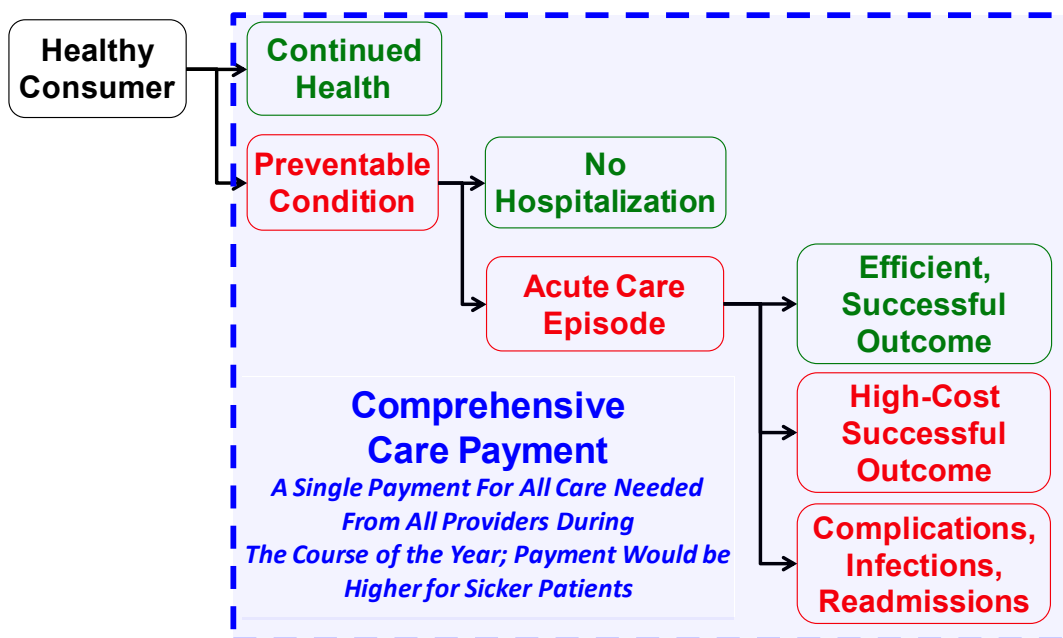


FIGURE 8

- Special provisions would be needed for unusually high-cost cases, such as outlier payments, reinsurance, etc., to avoid having a few expensive cases cause financial problems for providers who are doing a good job of managing typical cases. This will be particularly important for smaller Accountable Care Organizations, as described in Section III.
- An Accountable Care Organization should not be required to establish its own claims-payment system. An ACO contracting for a Comprehensive Care

Payment should be expected to manage the total cost and quality of care, not necessarily to directly pay other providers delivering care. The payer can still process claims from other providers using its existing claims-processing system, essentially treating the Comprehensive Care Payment as a debit account, as long as the ACO gets detailed and timely reports on the payments that are being made. However, if an ACO does not have its own claims payment system, then it will also have to rely on the payer to provide timely and complete data on services and costs, which is critical to the ACO's success.

- Accountable Care Organizations should be expected to collect and publicly report regionally- or nationally-vetted measures of quality of care and patient satisfaction, in order to assure both patients and payers that there is no inappropriate stinting on care.

Although Comprehensive Care Payment could ultimately allow dramatic simplifications in billing and payment systems for ACOs and payers, the ACO would still need to collect and submit detailed information about patient conditions to payers in order to support severity/risk adjustment of payments, and the ACO would need to collect and submit detailed information about services and/or outcomes to payers and/or community organizations in order to support quality measurement and reporting programs. These data are currently collected through claims forms, so an alternative mechanism would be needed. An ACO with a fully-functioning Electronic Health Record (EHR) system should be able to do this using the EHR, rather than having to continue submitting claims forms solely for the purpose of data collection; indeed, it would be preferable to collect quality data through a clinical information system rather than a billing system.

There are payment systems in several regions that are making population-based payments in ways that meet many of these criteria. For example, in Minnesota, Medica's Patient Choice system pays providers the equivalent of a Comprehensive Care Payment by using the standard fee-for-service claims payment system and adjusting fee levels based on the severity-adjusted total cost of care.⁷⁹ In Massachusetts, the Alternative Quality Contract offered by Blue Cross Blue Shield of Massachusetts is paying providers a severity-adjusted capitation payment combined with quality incentives for patients in its HMO program.⁸⁰

It is important to note that Comprehensive Care Payment defines how the payer pays the *Accountable Care Organization*, not how individual physicians, hospitals, or other practitioners within the ACO are compensated. For example,

physician groups and integrated delivery systems that accept capitation contracts pay their physicians using a wide range of methods, ranging from salaries to fee-for-service.⁸¹ The ACO should retain the flexibility to decide what the best compensation methods are for its individual practitioners, and it may well choose to make a gradual transition in those methods over time. (Even for Medicare, this is not as radical a change as it may seem; under Medicare Advan-

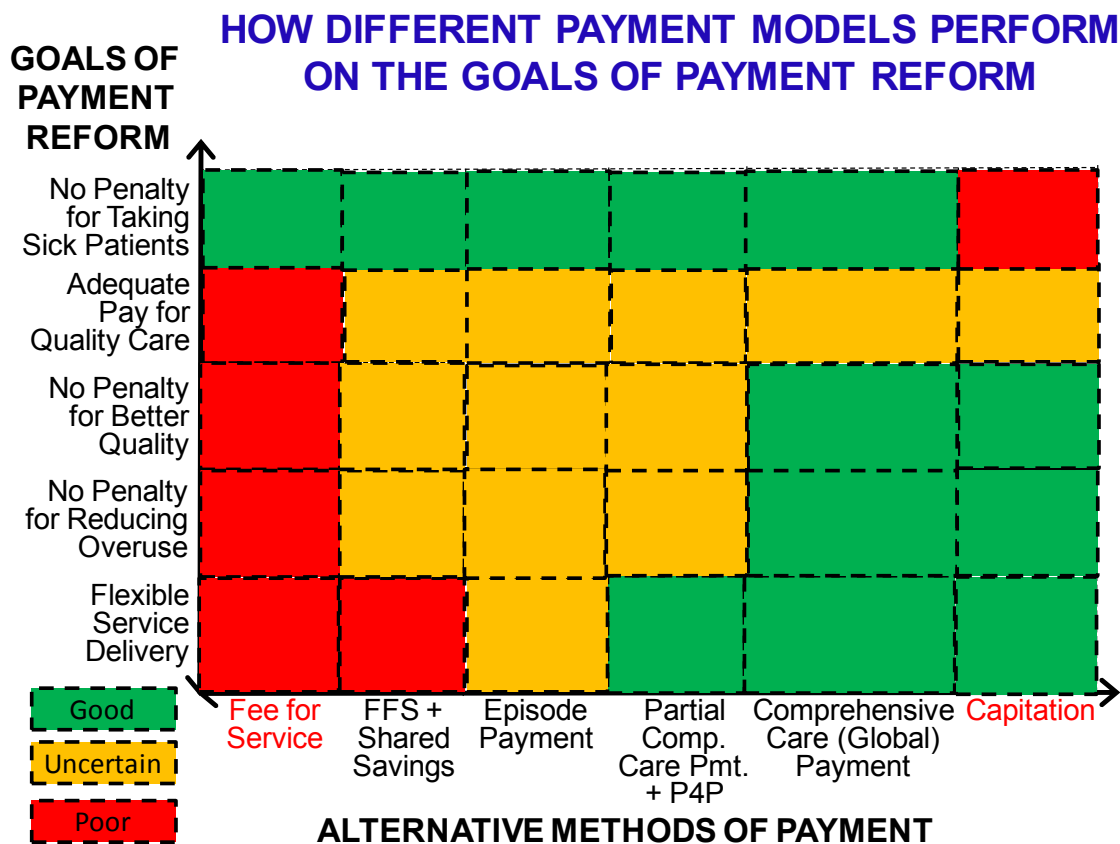


FIGURE 9

tage, CMS pays the Medicare Advantage plan a severity-adjusted global payment, similar to a Comprehensive Care Payment, and then the Medicare Advantage plan determines how it will pay individual providers.)

E. EPISODE/BUNDLED PAYMENT

A third option is to pay on an “episode-of-care basis,” i.e., a *single* amount to cover *all* of the services which are provided to an individual patient during a single episode of care (e.g., the treatment of a heart attack), rather than making either a single payment for *all* care during a year (including multiple episodes) as in Comprehensive Care Payment, or separate payments for each individual service as in fee-for-service payment. Episode-of-Care Payment gives the involved providers an incentive to coordinate their activities, eliminate unnecessary services, and avoid complications that require additional services.⁸²

When an episode payment covers services that are delivered by two or more providers that would have been paid separately under fee-for-service, that is referred to as “bundling” the payment. However, one can bundle payment without creating a full episode of care payment; for example, a hospital and a surgeon could be paid jointly for the cardiac surgery in the hospital, but they could still be paid additionally and separately if the patient requires additional services due to a hospital-acquired infection.

Episode-of-Care Payment is ideally suited for the kinds of opportunities described in Section II that are driven by hospitals and specialists. For example, making an episode-of-care payment that precludes separate payment for the costs of treating infections gives the hospital and physicians involved in a case the ability and incentive to reduce the number of infections (the hospital and physicians would, in effect, be providing a “warranty” on their care).⁸³

Despite the many improvements of Episode-of-Care Payment over current fee-for-service payment systems, it still does not encourage *preventing* episodes of care from occurring in the first place. For example, the opportunities defined in Section II for patients with chronic diseases are not based on reducing the *cost of each episode of hospitalization*, but on reducing the *number of hospitalizations*.

PROMETHEUS Payment, Inc. is attempting to address this by not only testing episode-of-care payments for major acute episodes, but also “year-long episode of care payments” for patients with chronic disease.⁸⁴ These would function in the same way as the Comprehensive Care Payment concept, but for specific groups of patients. In fact, there is little practical difference between an ACO that accepts year-long chronic disease Episode Payments for all types of chronic disease and an ACO that accepts a severity-adjusted Comprehensive Care Payment for all of those patients. Consequently, year-long episodes of care for specific types of patients/conditions could provide a mechanism for supporting a transition process to Comprehensive Care Payment based on patient groups, such as described in Section VI-B1.

In addition to serving as a transitional step toward Comprehensive Care Payment, Episode-of-Care Payment could also serve as a *complement* to Comprehensive Care Payment for Accountable Care Organizations which cannot deliver a full set of services for all patients or conditions, particularly Level 1 ACOs. One of the administrative challenges faced by any ACO is how to deal with payment for services for those patients who need or prefer to use a pro-

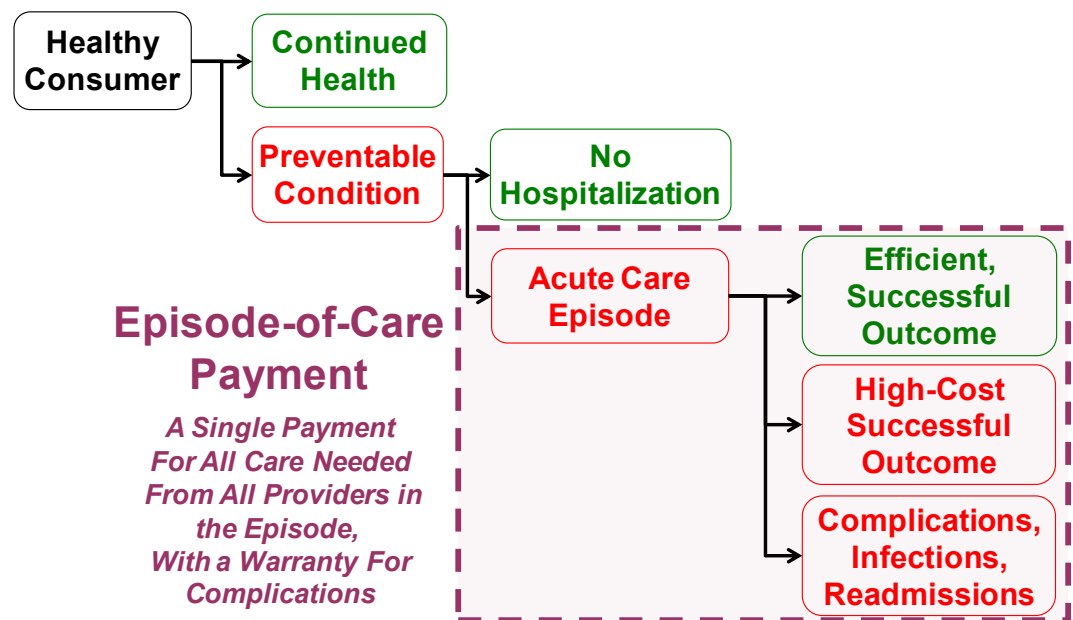


FIGURE 10

vider or service that is not part of the ACO, since the price charged for the services may be dramatically higher than the costs of services provided by the ACO, but forcing the patient to use the ACO's services (particularly if they are of lower-quality than the outside service) could significantly reduce the number of patients willing to participate in the ACO model. These "out-of-network" services are a challenge to health insurance plans today, and the creation of ACOs will shift that challenge to the ACO. However, if all providers were to charge Episode-of-Care prices for their services, it would be easier for an ACO to predict the costs of the outside services and easier for either the health plan or the ACO to create an appropriate cost-sharing arrangement for the patient, thereby giving the patient maximum choice and using that choice both to improve quality and reduce costs.

F. HYBRID PAYMENT MODELS

There are many variations of these payment models, and payment models can be adjusted to adapt to the specific capabilities of a particular ACO at a particular point in time.

For example, just as some providers are currently paid on a "partial capitation" basis and others are paid on "full capitation" basis, a payer could agree to pay an ACO a "partial comprehensive care payment." Under a partial comprehensive care payment, the ACO could receive a single payment to cover all of the costs associated with ambulatory care services (but not for inpatient services) for the population of patients the ACO is responsible for, and then have a significant withhold/bonus payment based on the costs of inpatient care services associated with those patients.⁸⁵ In effect, the bonus/withhold would be equivalent to providing shared savings and a shared penalty based on cost decreases and increases, but the underlying payment mechanism would also be changed to provide more flexibility to the ACO about how to deliver care. This approach would avoid putting the ACO fully at risk for costs associated with inpatient care as would be the case under a full comprehensive care payment arrangement, but still make the ACO far more accountable for the costs of inpatient care than under a fee-for-service system. It would also give the ACO the flexibility to use a different combination of services than would be possible under a pure shared savings approach.

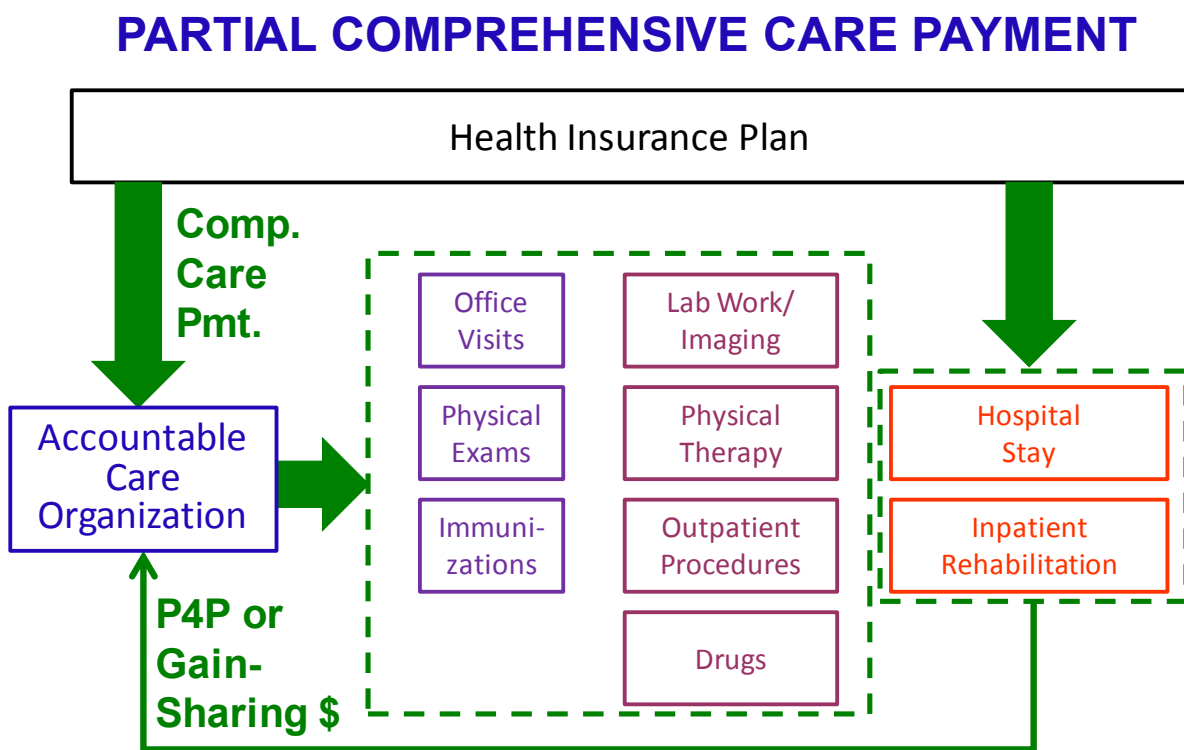


FIGURE 11

Another hybrid approach has been developed by Blue Cross Blue Shield of Michigan (BCBSM); it is paying Physician Organizations for population-level performance on cost and quality, and it is augmenting fee-for-service payments with payments for care coordination and patient self-management support and higher office visit fees for physician offices which have achieved designation as a Patient-Centered Medical Home.⁸⁶ (See Appendix A for a more detailed description of their approach.)

G. SETTING THE PAYMENT LEVEL

Goal 4 makes clear that successful payment reform involves not just changing the payment method, but also setting the right payment amount (i.e., a fair price). Even though a Comprehensive Care Payment provides most of the right incentives for higher-value care, if the payment amount is too low, providers will be unable to deliver quality care, and if it is too high, there is no incentive to seek out efficiencies. In many traditional capitation systems, payments were often arbitrarily set at levels far below the average cost of care experienced prior to introduction of the capitation system, were not increased adequately over time to reflect inflation, or were even reduced from year to year as a way of increasing profits for health plans with no evidence that the lower payment amount could be justified by legitimate strategies to reduce utilization or cost.

There are several alternative methods of setting payment amounts, each with advantages and disadvantages:

- **Regulation.** Government defines the prices that a provider can charge. For example, the Maryland Health Services Cost Review Commission sets all-payer rates for hospitals.⁸⁷
- **Price-Setting by Large Payers.** For example, Medicare defines the amounts it will pay providers.
- **Negotiation Between Payers and Providers.** In most markets, commercial health insurance plans negotiate payment rates with major providers.
- **Competition by Providers.** Under competitive pricing, providers would set prices in order to attract consumers, as businesses do in most other industries.
- **Evidence-Based Estimation.** Where a complete evidence-based care protocol for care exists or can be developed, the cost of each component could be estimated and then summed to create an appropriate price for care of the condition or episode.⁸⁸

Different price-setting approaches will likely be needed in different regions and for different providers and services depending on the local market structure; for example, regulation may be needed in regions where providers have a monopoly on particular services, whereas competition can be used in regions where there are multiple providers for most services. Regardless of the price-setting method used, payments to ACOs must be sufficient to support the capitalization of the improvements needed to permit effective management of patients, particularly those with multiple chronic diseases.

Having an effective price-setting mechanism for services in a community is particularly important for Accountable Care Organizations which are not fully integrated systems. As noted earlier, if the number of admissions to a hospital goes down, the hospital will likely try to raise its prices to offset the reduced revenue. Some price increase is likely to be necessary (since the hospital's average costs will inherently increase as volume decreases, even if it is operating at maximum efficiency), but in monopoly situations, the price increase could be so large as to completely offset any savings that would otherwise be achieved, preventing the Accountable Care Organization from showing a reduction in costs. This is not a major concern in the Medicare fee-for-service system because hospital prices are dictated by Medicare regardless of the hospital's monopoly position in a local market, but it can be a serious problem if Accountable Care Organizations are expected to serve commercial patients in a region as well.⁸⁹ Either regulation of prices⁹⁰ or proactive efforts to create competitor providers (including use of "medical tourism") may be the only solution in such situations.

Price-setting will also need ways of adjusting for the fact that some providers have higher costs for socially desirable reasons that are unrelated to the costs of caring for individual patients. For example, academic medical centers and other teaching hospitals incur greater costs than community or non-teaching hospitals simply due to the additional personnel and time associated with teaching. Even if quality is the same, a teaching facility will be more expensive than a non-teaching facility, and if patients are encouraged to use lower-cost facilities without adjusting for this, it could jeopardize the ability of teaching hospitals to train new generations of physicians and other health care professionals. Medicare explicitly computes the portions of its hospital DRG payments that are attributable to medical education, but commercial payers generally do not. Some states, such as Minnesota, have established a separate community-wide mechanism for paying for medical education, but other states have not.⁹¹ Similar issues arise with rural hospitals, inner-city providers, etc. that must incur higher costs for serving low patient volumes, providing greater security, caring for more uninsured patients, etc. Methods for adjusting for these special costs in price comparisons, or paying for these costs separately, will be needed.

V. WHAT SHOULD COMMUNITIES DO TO ENCOURAGE AND SUPPORT THE DEVELOPMENT OF ACCOUNTABLE CARE ORGANIZATIONS?

Although actions by providers and changes in payment systems are critical to the creation and successful operations of Accountable Care Organizations, ACOs are not just about a new type of relationship between individual providers and individual payers. They should represent a fundamentally new approach to healthcare – one that strives to improve the value of healthcare for patients on a community-wide basis. To achieve that, several types of support will be needed beyond those discussed in previous sections.

A. HOW MANY PAYERS NEED TO SUPPORT AN ACCOUNTABLE CARE ORGANIZATION?

It is both very difficult and very inefficient for any set of providers to serve as an Accountable Care Organization for just one payer, particularly a small payer. If one payer enables and rewards higher-value care delivery, but other payers continue to pay in a way which rewards volume, the Accountable Care Organization may find itself unable to change care at all.⁹² If it improves care for all patients (rather than distinguishing which payer is involved), the penalties from non-participating payers may outweigh the rewards from the participating payers; if the ACO attempts to change care only for the patients of participating payers, it may have an insufficient volume of patients to justify the costs and it may also spend too much time and effort trying to create and implement two different care pathways, depending on which payer is involved. Care processes need to be modernized through the practice for *all* patients or they will not be sustainable or efficient.

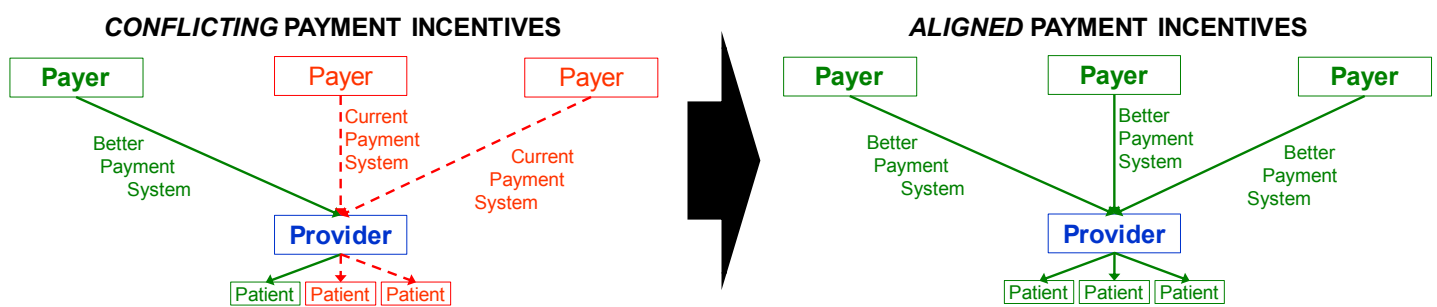


FIGURE 12

Alignment of multiple payers does not mean that every payer has to have a completely *identical* payment system, but their payment systems should be substantially similar in addressing the goals defined earlier. For example:

- The payment systems should provide flexibility and sufficient funding in aggregate to enable Accountable Care Organizations to develop and deliver key services needed to address health conditions in a higher quality, more efficient way.
- The payment systems should not penalize Accountable Care Organizations for delivering fewer procedures, as the current fee-for-service system does.
- The payment systems should not use different measures of quality or cost to reward or penalize Accountable Care Organizations, particularly conflicting measures of what is ostensibly the same outcome. Even if all of the measures are technically valid, it is more difficult and expensive for an Accountable Care Organization to track and analyze different measures for similar patients, and it is even harder to determine whether statistically significant changes in outcomes have occurred if the measures are collected only on subsets of patients.

Although having *all* payers involved would be ideal, what is essential is having *enough patients* supported by compatible payment systems to make it feasible and desirable for the Accountable Care Organization to change its care deliv-

ery processes. In this respect, aligning payment structures for 5 small payers in a market which collectively cover 20% of an Accountable Care Organization's patients is less desirable than having a supportive payment system from a single large payer which covers, say, 60% of the ACO's patients.

MEDICARE SHOULD SUPPORT LOCAL COLLABORATIONS AMONG STAKEHOLDERS COMMITTED TO TRANSFORMING THE QUALITY AND COST OF HEALTHCARE

Achieving alignment of multiple payers likely requires external support. Even if payers are not discussing or agreeing on the actual amount to be paid for care, discussions or agreements about changes in the structure of payment systems raises concerns about whether payers will be violating anti-trust laws. Consequently, a neutral party, such as a non-profit organization or state agency, may need to serve as the convener of such discussions and the facilitator of consensus on alignment. There are several regions around the country (e.g., Minnesota, Pennsylvania, and Rhode Island) in which a Regional Health Improvement Collaborative or state government has successfully used this approach to achieve alignment among their commercial payers and state Medicaid plan.

States and regions cannot do this alone, however. Given its size, Medicare also needs to participate in aligned payment systems, at least for categories of patients that include both seniors and those under 65. Although Medicare and other national payers would likely prefer to have a single payment reform they can implement nationally, there is too much diversity in healthcare delivery across the country and too little understanding of how improved payment systems should work to enable any "one size fits all" approach. Medicare would serve the country and its beneficiaries best by supporting local collaborations among stakeholders committed to transforming the quality and cost of care the beneficiaries receive.

Doing so would also accelerate the pace of learning "what works" in payment reform, since there is currently insufficient experience or data to definitively support one national approach.

B. TO WHOM SHOULD AN ACCOUNTABLE CARE ORGANIZATION BE ACCOUNTABLE?

The implicit presumption in most discussions about Accountable Care Organizations is that such systems would be accountable to *payers*, i.e., health insurance plans, Medicaid, or Medicare. However, the current concern about high costs and poor quality that is driving the desire for more accountability by providers is coming primarily from purchasers and consumers/patients, not from payers. In the case of private insurance, it's a combination of employers and consumers who are footing the bill for high costs, and in the case of public insurance (Medicare or Medicaid), it's taxpayers.

More importantly, the benefits (and costs) of greater accountability in the delivery of healthcare services will differ from community to community across the country:

- Because healthcare is organized and delivered locally, and because costs and quality vary widely across the country, the specific improvements needed in quality and the types of services where reductions in costs are needed will also vary from community to community.
- Because much of healthcare spending is financed at the state or regional level (through the premiums and out-of-pocket payments from employers and workers and the taxes collected from workers in those areas), the savings from reduced spending will vary from region to region. Even in the case of Medicare, provider payment rates and Medicare tax contributions vary from region to region, so the costs and benefits of greater value will vary from region to region.
- Because the structure of healthcare delivery differs from region to region, the structure of Accountable Care Organizations will also differ, particularly in the near term as providers transition from their current structures and processes.

In addition, as noted in the previous subsection, it is essential that the payment methods used to support Accountable Care Organizations and the quality/cost measures be as similar as possible across multiple payers, and some neutral party will need to facilitate this payer alignment. This will be particularly important during the transition process, since there will need to be agreement on which patients and which outcomes should be the initial focus of efforts.

All of this implies that Accountable Care Organizations should be accountable to the *communities* they serve, not to payers *per se*. Indeed, payers themselves are ultimately accountable to the purchasers and consumers that they serve in individual communities, through a combination of competition and regulation. What is needed is a mechanism for defining and managing that community accountability.

One approach is for this accountability to be managed by state government. Indeed, there is a long tradition of state oversight and regulation of healthcare delivery, ranging from licensing of healthcare providers, inspection of healthcare facilities, certificate-of-need reviews for new services, and even rate regulation for hospitals. As noted earlier, several states have taken lead roles in convening multiple health insurance companies to reach agreement on payment reforms designed to support the development of medical homes, so a next logical step would be for states to forge agreement among payers on the payment terms, quality standards, etc. needed to create Accountable Care Organizations.

An alternative approach is to use non-profit Regional Health Improvement Collaboratives in the growing number of regions (i.e., states or metropolitan areas) where they have been created.⁹³ Regional Health Improvement Collaboratives bring all of the key stakeholders together – purchasers, consumers, providers, and payers – to build consensus on the goals for healthcare improvement in their communities, and they organize efforts to help achieve those goals. Moreover, most Regional Health Improvement Collaboratives have already established the foundation for a system of holding providers accountable for outcomes by collecting multi-payer data on the quality and/or cost of healthcare delivered by individual providers and using those measures to (a) encourage providers to improve their performance and (b) encourage consumers to choose higher-value providers. Some Collaboratives are working with providers, either individually or in groups, to help them better organize and deliver healthcare in order to improve quality and efficiency. A few Collaboratives are working to build consensus on multi-payer payment reforms.

Consequently, states or Regional Health Improvement Collaboratives can be viewed as an important complement to, and structural support for, Accountable Care Organizations. Either states or Collaboratives would provide the mechanism for the stakeholders in the community to define the specific outcomes for which the Accountable Care Organizations would be held accountable, the mechanism for measuring and publicly reporting on those outcomes (including specific indicators of quality), the mechanism for evaluating the success of individual Accountable Care Organizations, the mechanism for reaching agreement on the payment reforms and other changes needed to support the Accountable Care Organizations' efforts, and even the technical assistance that Accountable Care Organizations may need in organizing themselves and improving care delivery.

C. HOW SHOULD CONSUMERS BE INVOLVED?

Although the issues involved in designing and implementing Accountable Care Organizations tend to be focused on providers and payers, the fundamental goal in creating an ACO is to improve the quality and affordability of care for *consumers and patients*. It is quite conceivable that an Accountable Care Organization structure could be developed that is perfectly satisfactory from the perspectives of payers and providers but unacceptable to a significant number of consumers and patients, either because of the actual problems it creates for them or because of the problems they *perceive* it will create for them. The history of managed care systems in the United States demonstrates that consumer acceptance of reforms to payment and care delivery systems will be critically important.

Consequently, it will be important for ACOs to measure, report on, and be accountable for patients' *experience* of care, not just clinical outcomes and cost. Medicare has begun collecting and reporting measures of patient experience of care in hospitals,⁹⁴ and a number of Regional Health Improvement Collaboratives measure and report on patient experience of care with physicians.⁹⁵

In addition, the accountability of Accountable Care Organizations for cost and quality can only go so far, since many outcomes depend as much on what consumers do (e.g., adherence to medication regimens, use of a consistent medical home) as what providers do. Clear definitions of the roles and responsibilities of consumers in management of their health will be needed, defined in ways that consumers believe is feasible and appropriate for them to carry out, and ideally, there should be measures of the extent to which consumers are carrying out those roles and responsibilities, to help determine the extent to which lack of progress on overall outcomes is attributable to consumers or providers.

At a minimum, Accountable Care Organizations will want to know which patients they will be held accountable for *in advance*, not after the fact. However, most proposals for accountable care payment to date have proposed calculating outcome measures, shared savings payments, etc. based on patients who are "attributed" to a provider *retrospectively*.⁹⁶

Where such systems have been used, providers feel they are being held responsible for some patients inappropriately. Ideally, only those patients who have made some type of formal commitment to receive their care through the ACO or to have the ACO help them manage their care should be included in calculations of ACO performance, since these are the patients the ACO can genuinely help with care management.

To facilitate this, consumers first need to understand the need for change in both care delivery systems and payment systems and the importance of moving aggressively to implement these changes. Although there is growing recognition by health care professionals of the key role that health care payment systems play in fostering the cost and quality problems plaguing the health care system, this causal relationship is not widely understood by consumers. For example, although research has shown that more care and higher costs do *not* result in better patient outcomes, it's likely that most consumers still believe that they *do*. Consumers will need greater sensitivity to the costs/prices of care in order to foster

A CORE COMPONENT OF A TRULY VALUE-DRIVEN HEALTHCARE SYSTEM IS A GREATER CONSUMER ROLE IN DECISION-MAKING ABOUT PROVIDERS AND SERVICES

competition on value,⁹⁷ but they need to be sensitive to the “last dollar” of costs (i.e., the difference in prices), whereas most health insurance plans today force them to pay the “first dollar” (through co-pays, co-insurance, and deductibles).⁹⁸

Moreover, it is not enough to merely produce information for consumers on what they can or should do to improve outcomes. Truly proactive efforts to ensure that consumers receive, understand, and have the ability to utilize the information are critical to success, since a core component of a truly value-driven health care system is a greater consumer role in decision-making about providers and services.

Although individual providers and payers can certainly help to educate consumers about these issues and engage them in improved care processes, community-wide efforts will likely be necessary. If one payer or provider is seen as requiring or expecting more of consumers than others, it could become a competitive disadvantage for that payer or provider in attracting and retaining members or patients unless it is also promoted neutrally in the community as a positive thing. This process of community education and engage-

ment is yet another role that Regional Health Improvement Collaboratives can play in the transition to Accountable Care Organizations, since consumer engagement is a priority focus for many Collaboratives.

In the future, systems should be created to make it easy for consumers to identify the Accountable Care Organization they intend to use to coordinate their care and to meet their basic health needs. Such systems, while voluntary, will make the nature of the relationship and the accountability explicit to all parties. They will help bind doctor and patient together in a more productive relationship. They will facilitate proactive outreach to populations of patients by health care teams. And they will support independent, methodologically sound measurement of cost and quality, and of patients' experience of care.

Once Accountable Care Organizations demonstrate success in improving both the quality of care and patients' experience of care while reducing and controlling costs, then consumers will be more likely to choose them voluntarily and to work with them to improve their health and healthcare outcomes. It will be important for consumers to have a trusted, independent source of information in the community reporting on quality and patient experiences in order to encourage and facilitate their decision-making.

D. WHAT ELSE IS NEEDED?

Although changes in payment systems and consumer support are likely the most critical changes for success of Accountable Care Organizations, other changes in laws, regulations, policies, and practices could significantly assist in the formation and success of Accountable Care Organizations. Some of these include:

- **Changing Malpractice Laws.** Although there is not strong evidence that better malpractice laws significantly affect overuse or costs,⁹⁹ it is clear that concerns about liability affect physician and hospital decisions about the way care is delivered, and those concerns could impede the ability for Accountable Care Organizations to institute significantly new approaches to care. One approach that could be used to address this problem without directly impacting the ability of patients to sue or recover damages would be to move to “enterprise liability” instead of individual pro-

vider liability for physicians associated with an Accountable Care Organization.¹⁰⁰ Under this approach, the ACO would assume liability for any claims filed against its member practitioners, rather than the individual practitioners being held individually liable. Since the ACO would be monitoring the overall quality of care delivered by its member practitioners, developing care processes designed to improve quality, and managing overall costs, it would make sense to also have it take responsibility for lawsuits challenging the results of those care processes.

- **Improving Accreditation Processes.** Since the true measure of success for an ACO is its outcomes, it would be inappropriate to create an elaborate new accreditation system with detailed standards for structure and processes in order to define or reward Accountable Care Organizations. In addition, it would be desirable to modify existing accreditation systems, since they will likely impede the ability of individual providers within the Accountable Care Organization to change the way they deliver care. Even if the accreditation standards are not in conflict with the processes and structures that the ACO wishes to use, the time and resources associated with complying with accreditation standards, particularly standards of limited value, will inherently limit the time and resources which providers can devote to transforming the way they deliver care.¹⁰¹
- **Modifying Anti-Trust Laws, Gain-Sharing Laws, Etc.** Existing laws and regulations which limit the ability of providers to collaborate and coordinate on care, or which limit the ability of payers to collaborate on payment structures, will likely impede the ability to develop Accountable Care Organizations.¹⁰² Even if existing requirements do not explicitly prohibit particular kinds of actions, legal costs and delays in developing legal opinions will likely deter or delay efforts by providers and or payers to develop Accountable Care Organizations and the payment systems to support them.

On the other hand, the consolidation of providers into large organizations that focus primarily on negotiating higher prices for services and fail to pursue clinical integration could severely undermine the ability to develop Accountable Care Organizations in a region or limit the ability of smaller ACOs in the region to effectively manage costs for the patients they do serve.¹⁰³ Consequently, it will be critical to clearly define and encourage the “safe harbors” which promote better care coordination and cost management without leading to monopolies, price restraints, etc.¹⁰⁴

VI. HOW CAN THE TRANSITION TO ACCOUNTABLE CARE ORGANIZATIONS BE FACILITATED?

It is unrealistic to expect that most providers, even many integrated delivery systems, will be able to accept full accountability for the costs and outcomes of all of their patients without a transition process. Even the most sophisticated physician groups in the country have indicated that it takes several years just to get started on a more value-conscious approach to healthcare, much less to address the full range of cost and quality problems which exist in health care today. The problems caused by fee-for-service payment systems have developed over many decades, and they cannot be reversed overnight.

This means that in addition to defining the ultimate vision for what Accountable Care Organizations should achieve and how they should be paid, it will also be essential to define and support a transition process to enable providers to move toward that vision as quickly but successfully as possible. Given the diversity of payer and provider structures across the country, and the variation in quality and costs that exists, these transitional processes will also vary from community to community. This is another potential role that state governments, Regional Health Improvement Collaboratives, and large payers can play – defining and helping to coordinate the transition process in each community. For example, in a region with many small primary practices, a Regional Health Improvement Collaborative could convene meetings of those physicians to discuss the opportunities associated with Accountable Care Organizations and the kinds of assistance that the physicians would need to organize themselves into one or more ACOs. (For example, the Pittsburgh Regional Health Initiative is pursuing this approach in Southwestern Pennsylvania through several projects, including its Preventable Admission Reduction project, its Accountable Care Network project, and its CMS EHR Demonstration.) A Collaborative could also convene payers, providers, consumers, and purchasers to reach agreement on the kinds of payment structures that would be needed to support such ACOs.¹⁰⁵

Despite the likely variation in the transition processes from community to community, there are several specific steps which would likely be helpful in most communities.

A. HELPING WILLING PROVIDERS GET STARTED

As noted previously, one of the keys to success for an Accountable Care Organization is a commitment by the organization's leadership to improving value as a top priority, and so the foundation for a successful ACO is one or more providers who have that commitment and are willing to work together to achieve success.

Willingness, however, does not automatically translate into the skills needed for success. In health care, current payment systems primarily reward volume, not quality or efficiency, so it's likely that skills in designing and managing care processes to improve quality and control costs, such as the eight elements described in Section III-A, will be in short supply until the incentives change. Moreover, without concurrent changes in payment structures, even providers with the right kinds of skills may not have the time or resources to reinvent all of the administrative systems and processes of care that were designed to achieve different goals.

Although the most committed and entrepreneurial providers may overcome these barriers, more Accountable Care Organizations will be created more quickly if external support is provided. Key elements of this support include:

- **Convening:** Interested providers may need a neutral convener, such as state government, a Regional Health Improvement Collaborative, a dominant payer, or a group of collaborating payers, to help them come together and explore the possibility of working together as an Accountable Care Organization. This may be particularly important to avoid concerns about anti-trust violations.
- **Coaching:** Providers may need training and technical assistance from experts to help them reinvent their operations to achieve higher quality and lower cost. Special attention is needed to teambuilding and leadership skills. This assistance may initially be provided by external parties, such as Regional Health Improvement Collaboratives or payers, but ultimately, it would need to become an integral part of the services provided by the Accountable Care Organization to its members, through learning collaboratives and shared training resources.

- **Information:** In order to define outcome targets and strategies for reaching them, providers need information about the *current* costs and outcomes associated with their patients. Because only payers generally have this type of information, and because the information about any particular provider’s patients is fragmented across multiple payers, it is difficult for any provider or group of providers to know how they are doing today and where improvements may be possible. This is another important role that states, Regional Health Improvement Collaboratives, or Regional Health Information Exchanges can play, since many already have assembled multi-payer databases and work with providers to issue reports on the quality of care. Medical societies, hospital associations, and other professional associations can also play an important role in facilitating the collection and reporting of quality and cost information.
- **Shared Services:** As noted in Section III-A, many primary care practices may not be large enough to provide certain key services individually, but they could do so collectively. These shared services might be delivered by organizations that are part of the ACO (e.g., a hospital in the ACO might provide an organizational home for nurse care managers who work for multiple primary care practices) or by independent organizations (e.g., a home care agency that is not in the ACO might provide nurse care managers who would work for the multiple primary care practices or a Medicare/Medicaid Quality Improvement Organization could provide a home for shared services).
- **Resources:** Providers will need upfront resources to enable them to improve their infrastructure for care management and to deliver different services in different ways, and special financing and payment arrangements may be needed for care changes where the return on investment will occur over many years. For example, installing an Electronic Health Record system not only requires significant capital costs, but also reduces productivity initially during the training and learning process. It takes time to recruit and train nurse care managers before they can begin improving the support for chronic disease patients. Although improved payment systems may provide revenue streams to cover those costs over time, ACOs may need loans or front-loaded payment arrangements to enable them to afford the upfront costs.
- **Financial Modeling:** As noted in Section III, adequate infrastructure and skills to manage financial risk will be important for an ACO to succeed under new payment models. Many providers considering forming an ACO would need assistance in doing the financial modeling necessary to understand what a reasonable payment arrangement might be and what they would need to do to be successful.

Particular attention and assistance will likely be needed to help small physician practices organize themselves to become Accountable Care Organizations. As noted in Section III, since effective primary care would be at the core of a successful ACO, but the majority of primary care physicians in the country are in small practices, the concept of Accountable Care Organizations will not be successful unless small physician practices can make the transition successfully. One model for doing so is the Physician Group Incentive Program (PGIP) created by Blue Cross Blue Shield of Michigan (BCBSM). The PGIP program has enabled small physician practices to remain independent but to work in collaborative organizations with a focus on improving patient outcomes, and BCBSM is providing additional and different resources to these practices to take on greater accountability for care. A more detailed description of the program is provided in the Appendix.

B. CREATING A MULTI-YEAR TRANSITION PROCESS

The transition process can be facilitated by establishing short-term objectives that will have a meaningful impact on cost and quality, but which are feasible for providers to achieve and which provide a foundation for additional progress in the future. This approach may take longer to achieve full success than some might hope, but it may also be more successful and sustainable.

1. ACCOUNTABILITY FOR SUBGROUPS OF PATIENTS

One approach to this transition would be to focus initially on improving quality and controlling costs for a subgroup of the individuals who are cared for by an Accountable Care Organization, and then add additional subgroups over time until accountability can be accepted and managed for the full population of individuals cared for by the ACO. An appropriate subgroup would need to meet at least three conditions:

- The size of the subgroup would need to be sufficiently large to (a) enable statistically valid measures of cost and quality, and (b) achieve meaningful impacts on overall costs;
- The defining characteristics of the subgroup would need to be sufficiently objective and distinct from other subgroups to ensure that “success” in improving quality or costs was not achieved by reclassifying individuals into other

subgroups. Accountable Care Organizations should not be able to “cherry pick” cases in order to show good outcomes.

- The principal payers who pay for the individuals in that subgroup would need to be willing to support the necessary payment and care delivery changes.

One potential approach to population segmentation is called the “Bridges to Health” model.¹⁰⁶ The authors suggest 8 population segments that are reasonably distinct and have differing needs for healthcare management:

- Healthy individuals
- Pregnant mothers and infants
- Acutely ill individuals
- Individuals with serious disabilities who are stable
- Individuals with chronic conditions but have normal functioning
- Individuals with chronic conditions who have limited reserve and experience exacerbations
- Frail individuals (with or without dementia)
- Individuals in a short period of decline before dying

For example, an Accountable Care Organization might focus efforts initially on improving maternal and infant care. The costs associated with maternal and infant care are the second largest category of hospital costs in the country (and the largest category for the under-65 population), and as noted in Section II, there are significant opportunities to reduce spending and improve outcomes (e.g., by using birthing centers instead of hospitals for normal deliveries and reducing the number of pre-term elective inductions).

Alternatively, an ACO might focus on individuals with moderate to severe chronic conditions who have frequent exacerbations. These individuals are hospitalized and re-hospitalized frequently, and as noted in Section II, there are significant opportunities to reduce admissions and readmissions through improved patient education, self-management support, access to maintenance medication, etc.

The most challenging subgroup of those defined in the Bridges to Health structure may well be the first – healthy individuals. For them, the primary goal is *health*, not healthcare, and the most successful strategies for improving health likely require involvement of the community as a whole, and go far beyond what any healthcare provider or Accountable Care Organization can be reasonably expected to be fully accountable for. Moreover, the most significant cost reductions will likely manifest far in the future.

It is important to recognize that focusing on these population segments would only be a transitional strategy. Moreover, the goal would be to have a single ACO phase in its accountability for these populations, not to have 8 separate Accountable Care Organizations, each focusing on a different subpopulation.

2. ACCOUNTABILITY FOR SUBSETS OF COST AND QUALITY

Another transitional approach would be to have an Accountable Care Organization focus on improving a particular subset of costs and/or quality, either for its entire population of patients or for one or more population subgroups. For example, an ACO might focus initially on reducing hospital readmissions directly related to chronic disease exacerbations, while deferring efforts to reduce initial admissions until later.

It would clearly be important to explicitly see any such partial outcome measures as transitional steps, with a plan for expanding the measures over time to capture the full range of costs and quality. This would reduce any incentive for a provider to shift costs from a measured outcome to a non-measured outcome (e.g., to significantly expand the use of home health care for chronic disease patients discharged from the hospital, thereby reducing hospital costs due to readmissions but increasing home health care costs).

Some of these partial outcomes will be based on the market structure of healthcare delivery in individual communities. The Accountable Care Organization should not be held accountable for increases in spending caused by price increases by providers (e.g., hospitals) or suppliers (e.g., pharmaceutical manufacturers) that are not part of the ACO and

hold monopoly or near-monopoly positions in the community. For services delivered by such providers, the ACO could be held accountable for the *utilization* of their services, but not the total cost. Different mechanisms will be needed to address this in different markets and for different payers. For example, although it is not an issue for hospital prices for Medicare patients regardless of the market share the hospital holds, it is an issue for non-Medicare patients in non-competitive markets.

In addition, during any transitional process, and potentially in the long run as well, it will be important to protect Accountable Care Organizations from the impacts on cost and quality of rare and expensive cases. Regardless of how effective a severity/risk adjustment system is, and even with a relatively large population of patients, a small number of patients with unusual conditions can dramatically affect overall results. The primary goal of creating Accountable Care Organizations is to improve cost and quality for the vast majority of patients. Special provisions may need to be made to deliver high quality care at an affordable cost to the rare cases. These protections may need to be greater in the early years of a transition to ACOs, when the ACOs may be smaller and the providers are still learning how to manage costs on a population basis.

3. REWARDS FOR BOTH IMPROVEMENT AND ABSOLUTE SUCCESS

Analyses show that there is tremendous variation in costs and quality both across the nation and within individual regions. This means that different providers will be starting from very different positions in moving toward greater accountability – some will already have much lower costs and/or higher quality than average, while others will have much higher costs and/or lower quality.

Many pay-for-performance systems have grappled with the question of whether to reward absolute performance (and if so, what standard to establish), to reward performance relative to other providers, or to reward improvement in performance relative to a provider's own baseline. Although there is no "right" answer, there seems to be broad agreement that, in general, some combination of the three needs to be used: Rewards based on absolute standards where it is clear what is achievable; rewards based on relative standards where it is not clear; and rewards based on improvement to recognize that not all providers will be able to be excellent right away.¹⁰⁷

The same approach would seem to make sense in helping providers transition to become Accountable Care Organizations, i.e., recognition as an ACO and rewards for its performance should be based on a combination of absolute standards, relative performance, and improvement. The bar should not be set too high, otherwise providers may be deterred from even starting down the path, but there also needs to be a mechanism for avoiding complacency with mediocre outcomes.

4. SPECIAL EFFORTS FOR UNDERSERVED AREAS AND CONSUMERS

Special efforts will be needed in areas with a shortage of primary care providers. In many ways, these are the areas with the greatest opportunity for cost savings, since a lack of effective primary care can result in high rates of hospitalizations, ER visits, etc. But these are also the areas where it may be most difficult to find enough primary care providers to form an ACO of reasonable size. Moreover, it may be particularly difficult for the primary care providers who do exist to find the time and resources needed to transform the way they deliver care as part of an ACO.

Special efforts will also be needed to ensure that underserved consumers – minorities, individuals with special needs, etc. – can benefit from the increased value delivered by an Accountable Care Organization. Here again, there may be especially large opportunities for cost savings and improved outcomes through better managed care for these consumers, but improving care delivery for them may also present unique challenges and higher initial costs.¹⁰⁸ ACOs may need to receive extra assistance and special incentives from payers to encourage and enable them to reduce disparities in care in the community.

C. SUPPORTING CO-EVOLUTION OF PAYMENT REFORM AND CARE CHANGES

It is clear that changes are needed both in the way providers deliver care and the way payers pay for care in order for Accountable Care Organizations to develop and be successful. Changes in care cannot proceed without supportive payment systems, but changes in payment systems cannot be made without providers willing and able to operate under them. Moreover, not only will changing care processes be challenging for providers, changes in payment systems will be complicated and expensive for payers.

1. TRANSITIONING TO COMPREHENSIVE CARE PAYMENTS

If providers follow a transition process as suggested above, i.e., focusing initially on subgroups of patients and subsets of costs, then it would make sense to transition payment systems in a complementary fashion. For example, payers could provide flexibility in payment structures, measure outcomes, reward success, etc. just for the patient subgroups being addressed initially, without having to change the payment structure for all subgroups at once. As noted in Section IV-F (Hybrid Payment Models), there are ways to give ACOs more flexibility and accountability than they have today, without jumping in a single step to full accountability for costs, particularly for services they do not control or have not yet restructured.

Moreover, there are ways to build comprehensive care payment and year-long episode payments on top of existing fee-for-service systems, so that providers in an ACO do not need to replace their existing billing systems and payers do not need to completely change their payment systems, particularly since only a subset of providers will be paid as Accountable Care Organizations in the short run. For example, claims could continue to be submitted for individual services and paid through fee-for-service codes, with adjustments made later based on a comparison of cumulative costs to comprehensive care payment budgets and a determination as to whether quality targets were met. Both the Patient Choice and PROMETHEUS payment models described earlier do this.

In the long run, more fundamental changes in payment and billing systems may be possible, potentially resulting in savings in administrative costs over time. However, as noted earlier, it is important to recognize that in order to adequately measure and report on the quality of care, and to enable analyses of the factors affecting both quality and cost, there will be a continuing need for much of the level of detail on patient care that is currently maintained through billing records, so even if billing itself can be simplified, alternative mechanisms of data collection and reporting will be needed.

2. WAIVERS VS. DEMONSTRATIONS AND PILOTS IN MEDICARE

Medicare participation in new payment approaches to support Accountable Care Organizations will be highly important, if not essential to their success, given the number of Medicare patients that most providers care for. How should Medicare support the development of ACOs?

Although there are many unknowns about how Accountable Care Organizations should be structured, how they should be paid, and how to ensure that they successfully improve quality and reduce the costs of healthcare, it is unlikely that having Medicare support the creation of ACOs through “demonstration projects,” at least as they have traditionally been defined in the Medicare program,¹⁰⁹ are an appropriate way to proceed. In order to create a successful ACO, healthcare providers will have to make dramatic changes in the way they organize and deliver care, which will in turn require considerable investments of both time and money. If commercial payers are being asked to participate in order to achieve multi-payer alignment, they will have to make dramatic changes in their payment systems and benefit designs, which will require major investments of both time and money. Neither payers nor providers are likely to be willing to make these kinds of investments for a demonstration project, since it is inherently time-limited, with no assurance that it will continue.

“Pilot projects,” which is the term Medicare uses for test projects that are specifically authorized to continue if they are successful, will probably be more attractive to providers than demonstration projects. But the lack of a clear up-front commitment to continue the project for the long-term may discourage participation by all but the providers who are already well down the path toward implementation, thereby limiting the number of participating regions and delaying the cost and quality improvements which are so desperately needed.

Moreover, because it will likely take multiple years to implement the changes and see significant results, pursuing reform through a small number of either demonstration or pilot projects implies maintaining an increasingly unacceptable status quo in most of the country while waiting to see the results of these projects. Implementing more incremental Medicare reforms in other areas, such as pay-for-performance programs, while waiting for results of ACO demonstrations and pilots, would likely be counterproductive, since it would conflict with efforts by regions and commercial payers that want to implement more dramatic reforms, and it might require providers to implement changes that would have to be dismantled when the longer-run payment changes are made.

The best solution would seem to be for Medicare to encourage and participate in locally defined ACO initiatives, e.g., Medicare requirements would be waived and payment rules would be changed in order to participate in payment and delivery system reforms initiated by states or Regional Health Improvement Collaboratives in order to implement Accountable Care Organizations. If Medicare supported state and regional reforms, it would enable rapid and broad-based implementation, while also providing the opportunity to learn from different approaches taken in different states and regions.

Authorizing legislation would be needed to enable the Centers for Medicare and Medicaid Services (CMS) to grant these waivers, but it could be similar to the waiver/demonstration authorization that was enacted under Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).¹¹⁰ To assure Congress and CMS that there would be a high enough likelihood of success to justify dramatic changes in Medicare rules and payment, applications could be limited to regions where at least two other major payers (commercial insurers, Medicaid, etc.) have agreed to make the same or similar payment changes and where at least one Accountable Care Organization has stepped forward with a commitment to change care delivery if the supporting payment changes are made. (This requirement could also serve as an incentive for the other major payers to agree to participate and for providers to organize themselves into an ACO.) Ideally, CMS and the Office of Management and Budget (OMB) would define the set of specific information that regions would need to provide about expected costs, savings, etc., and they would also define a clear set of decision criteria for determining which applications would be approved. Moreover, in order to speed implementation, it would be desirable for CMS and OMB to commit to review and render a decision on complete applications within a short period of time (e.g., 90 days), although Congress would likely need to provide additional resources to CMS and OMB to permit this kind of expedited review.

*MEDICARE SHOULD
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COLLABORATIVES*

3. FIXING THE FEE-FOR-SERVICE SYSTEM

The need for a multi-year transition process to Accountable Care Organizations and the payment systems to support them implies that some form of the current fee-for-service structure will need to continue for quite some time. Consequently, efforts to repair the most serious flaws in the fee-for-service structure should still be pursued.

Although there are many problems with the fee-for-service system and the RBRVS system used by Medicare and by most payers to define payment amounts, perhaps the most serious problem relative to the creation of Accountable Care Organizations is the disparity in fees and earnings between procedural specialists and physicians such as primary care physicians that primarily use cognitive skills. Low and limited fees for primary care physicians have resulted in shortages of primary care physicians, yet as explained in Section III, primary care physicians will be critical to the success of Accountable Care Organizations.

There is growing agreement that the current process for setting fees in Medicare is badly broken. Part of the problem stems from the Relative Value Scale Update Committee (the “RUC”),¹¹¹ which advises the Center for Medicare and Medicaid Services (CMS) on the relative values used in Medicare payment rates. Although some improvements have been made, it has continued to favor specialists and proceduralists over primary care physicians in setting the relative values of different physician activities. Many agree that the RUC should be either dramatically restructured (e.g., by adding additional representatives of primary care and representatives of consumers and purchasers) or replaced entirely.¹¹²

However, the RUC is merely advisory to CMS, so even though many of the problems with the RBRVS system originate with the RUC's recommendations (or lack thereof), there is nothing that stops CMS from overriding its recommendations and changing the fee schedule. Moreover, the RUC only controls one factor in determining a physician's fee for a particular service – the Physician Work (PW) Relative Value Unit (RVU) component. CMS (and Congress) determines the other seven factors – the Practice Expense (PE) RVU, the Professional Liability Insurance (PLI) RVU, the three Geographic Practice Cost Indexes for the PW, PE, and PLI RVUs, the weights for each of these factors, and the Conversion Factor that converts the combined RVU value into an actual payment rate.¹¹³ Many of the problems with fee-for-service payment levels derive from these other factors, not just the RVU value addressed by the RUC. Consequently, a broader overhaul of the fee-setting process is needed.

In addition to improving fees for primary care across the board, it may be appropriate to provide greater increases to primary care physicians who are participating in an Accountable Care Organization. A number of payers have been doing this through enhanced payments to primary care practices serving as Medical Homes; doing so for ACOs would be a natural extension of this approach.

Ultimately, a Comprehensive Care Payment structure supporting an Accountable Care Organization would address these issues more effectively by providing greater flexibility in what kinds of primary care services are paid for and how much is paid, and by rewarding better care management and reduced hospitalizations. However, in the short run, as transitional payment systems are implemented, it will be important to make sure that primary care physicians are adequately compensated and have the time to focus on making the transitional improvements in care needed to build the Accountable Care Organization.

Once there is enough experience with alternative payment systems to create confidence that they are preferable to current fee-for-service systems, in addition to improving the fees for those providers who participate in Accountable Care Organizations, it may be desirable to make the current fee-for-service systems progressively less attractive in order to create additional incentives for providers to participate in an Accountable Care Organization. (Some have described this as “burning the boats on the shore” to discourage turning back.)

VI. CONCLUSION

Creating Accountable Care Organizations and the payment systems to support them may well have the greatest potential for both improving quality and controlling costs of any of the many health reform strategies being discussed today. After many years of unsuccessfully pursuing top-down programmatic initiatives that encourage or mandate specific changes in processes of care that are expected to improve quality or reduce costs, the concept of Accountable Care Organizations is an entirely new paradigm – giving healthcare providers the responsibility and appropriate incentives to improve outcomes and giving them the flexibility to design the most efficient and effective way to do so.

As this report makes clear, there is no single formula for a successful ACO that is known at this time; therefore different approaches should be encouraged, and some failures should be expected. Overly rigid standards about how an Accountable Care Organization should be structured could end up simply preserving the status quo in many areas of the country.

It is also clear that significant reforms to healthcare payment systems, implemented by most or all of the payers in a community (including Medicare), are a critical element of success. Modest or incremental changes alone will be insufficient to support the kinds of dramatic changes in delivery systems that are needed to achieve better healthcare value.

Despite the urgency of reform, it will be important to not expect that dramatic transformations can occur overnight. The serious cost and quality problems in our healthcare system developed over many decades, and they cannot be reversed overnight. A multi-year transition process will likely be needed, along with significant resources to support that transition.

APPENDIX

BLUE CROSS BLUE SHIELD OF MICHIGAN'S PHYSICIAN GROUP INCENTIVE PROGRAM

Starting in 2005, Blue Cross Blue Shield of Michigan (BCBSM) has offered incentives to communities of physicians to organize into Physician Organizations (PO). Rather than using pre-established criteria to define what BCBSM refers to as Organized Systems of Care, it encourages natural communities of caregivers to create POs based on their own assessment of factors such as cross-coverage and referral patterns, hospital affiliation, and geography. There is an explicit expectation that they will develop and use shared information systems and shared processes of care and that they will collectively share responsibility for aggregate, population level quality and efficiency outcomes. They are held accountable both for proactive population management and for establishing systems which reliably customize care to patients' needs at the point of service.

Two of the 80 POs in the Physician Group Incentive Program are vertically integrated, staff model health systems. The rest are POs and PHOs organized as IPAs. Many, but not all, of these were pre-existing organizations limited mostly to managed care contracting. The BCBSM partnership with them is intended to move them from federations of independent practices to inter-dependent practices and ultimately to integrated systems of care.

These 80 POs are composed of about 7,000 physicians, mostly, but not all, Primary Care Physicians. Their size ranges from 30 to 1,200 physicians. BCBSM measures performance at the population level by PO. The POs are responsible for assessment and improvement efforts at the office practice and individual physician level. BCBSM provides relevant data to support such accountability, but the frame of reference and measurement for the health plan is at the population level. This applies both to measuring physician performance and to how the incentive program views members. This means that incentives are paid for the net result of providers' performance on a population level, not for the quality and efficiency of an individual member's care.

POs participate in specific "Initiatives," each with potential incentive dollars, for quality (using a range of preventive and chronic illness measures) and efficiency. Initiatives are focused on specific areas of care with opportunities for improvement, such as ambulatory care sensitive condition admission rates, rates of use of Emergency Departments, generic drug dispensing rates, high-tech imaging rates, and low tech imaging rates. BCBSM is working on others such as re-hospitalization rates, cancer care quality and efficiency, anticoagulation services management, overall cost and quality of cardiac care, and identification and management of chronic kidney disease.

POs also earn substantial incentive dollars for developing and implementing core capabilities (information systems, care processes) of the Patient Centered Medical Home (PCMH) model. More than half of the incentive pool payments are allocated to support infrastructure development. The PCMH model guides this incentive program. BCBSM recognizes that no practices have fully functioning, medical home-based practice capabilities, so it is aggressively priming the pump rather than trying to find PCMH-based practices and pay them extra for care management, hoping it all turns out well.

In the fiscal year starting in July 2009, there will be over \$64,000,000 in the incentive pool available to reward POs for their efforts to build PCMH capability and for the cost and quality outcomes they achieve.

As part of the PCMH program, physicians in the PGIIP program are able to bill for services provided to patients with chronic illness who have established treatment goals when provided by ancillary providers (e.g., a nurse, social worker, diabetes educator, etc.) under the direction of a physician. There are two specific "T-codes" BCBSM uses for this purpose, one for face-to-face contacts with a patient and one for telephonic contacts. This allows the health plan to provide financial support to practices which have taken on responsibility for longitudinal care management and self-management support, without changing the benefit structure.

In July 2009, BCBSM began a PCMH Designation Program in which about 1,200 physicians were designated as working in PCMH-based practices, based on having demonstrated substantial progress in implementing PCMH capabilities and in achieving good results on quality and efficiency measures. The information about these designations is available to BCBSM members. These physicians receive a 10% increase in their office visit E&M (evaluation and manage-

ment) fees. The number of designated physicians is expected to substantially increase over the next two years as physician practices make use of incentives to transform systems of care.

Taken together, the incentive dollars, the T-code payments, and the PCMH Designation program provide substantial support for physicians devoted to transforming their practices in keeping with the PCMH concepts. This approach also represents an explicit strategy aimed at re-framing relationships among physicians, and between physicians and the health plan, and re-focusing physicians' efforts toward the development of highly functioning systems of care which reliably provide high quality, efficient care to a defined patient population. Without having to eliminate the FFS payment system (and radically restructure benefits and claims systems), BCBSM is using this incentive program to re-direct a meaningful proportion of professional payment and considerable physician effort toward practice transformation and population level performance and away from volume-based practice.

Michigan BC/BS Physician Group Incentive Program

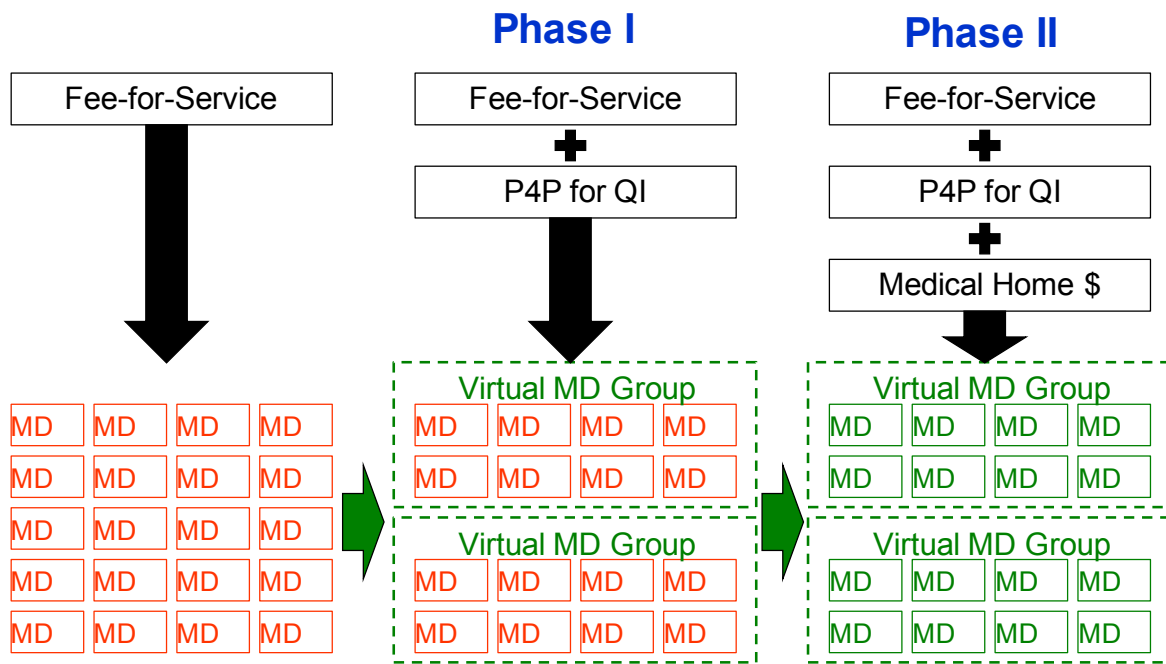


FIGURE 13

In parallel to the PGIP program, BCBSM has a hospital incentive program. The Michigan Hospital Association has agreed in principle that hospitals should take responsibility for population-level performance regarding cost/use and quality. BCBSM is developing methods for establishing denominators for hospitals for the purpose of measuring population-level performance on key measures such as ED use, ambulatory care sensitive condition admission rates, readmission rates, discretionary procedure use rates, and overall population payment trends for hospital care. Incorporating these measures into the hospital incentive program will effectively align many incentives between the POs and the hospital community. These efforts are moving more slowly than the work on the physician side.

BCBSM recognizes the theoretical appeal of having organized systems of care which include partnerships between physician organizations and hospitals and have that in mind as part of a long term vision. But it isn't waiting for that to be feasible before implementing these incentive alignment strategies.

ENDNOTES

1. Medicare Payment Advisory Commission. Chapter 2: Accountable Care Organizations. In: Report to the Congress: Improving Incentives in the Medicare Program. Washington (DC): MedPAC; 2009 Jun.
2. Fisher ES, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: the extended hospital medical staff. *Health Aff (Millwood)*. 2007 Jan-Feb;26(1):w44-57, and Fisher ES, McClellan MB, Bertko J, Lieberman SM, Lee JJ, Lewis JL, et al. Fostering Accountable Health Care: Moving Forward In Medicare. *Health Aff (Millwood)*. 2009 Jan 27.
3. Shortell SM, Casalino LP. Health care reform requires accountable care systems. *JAMA*. 2008 Jul 2;300(1):95-7.
4. Fisher, McClellan, et al, op cit.
5. Pittsburgh Regional Health Initiative. Accountable Care Networks: Transitions for Small Practices and Community Hospitals. Pittsburgh (PA): Pittsburgh Regional Health Initiative; 2009 August. Available from: <http://www.prhi.org/docs/Accountable%20Care%20Networks.pdf> .
6. Congressional Budget Office. Option 37: Allow Physicians to Form Bonus-Eligible Organizations and Receive Performance-Based Payments. In: Budget Options, Volume I: Health Care. Washington (DC): Congressional Budget Office; 2008 December.
7. Information on the Blue Cross Blue Shield of Michigan's Physician Group Incentive Program is available in the Appendix and at http://www.bcbsm.com/provider/value_partnerships/pgip/index.shtml .
8. Shortell and Casalino, op cit.
9. See, for example, Abelson R. Policy Experts Call Fear of Medical Rationing Unfounded. *New York: New York Times*; 2009 August 25. p. A12.
10. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.
11. See, for example, Murray M, Berwick DM. Advanced access: reducing waiting and delays in primary care. *JAMA*. 2003 Feb 26;289(8):1035-40; Wagner EH, Grothaus LC, Sandhu N, Galvin MS, McGregor M, Artz K, et al. Chronic care clinics for diabetes in primary care: a system-wide randomized trial. *Diabetes Care*. 2001 Apr;24(4):695-700; Wade TJ, Mansour ME, Guo JJ, Huentelman T, Line K, Keller KN. Access and utilization patterns of school-based health centers at urban and rural elementary and middle schools. *Public Health Rep*. 2008 Nov-Dec;123(6):739-50; and Bennett GG, Herring SJ, Puleo E, Stein EK, Emmons KM, Gillman MW. Web-based Weight Loss in Primary Care: A Randomized Controlled Trial. *Obesity*; 2009.
12. See, for example, O'Connor AM, Llewellyn-Thomas HA, Barry Flood A. Modifying Unwarranted Variations in Health Care: Shared Decision Making Using Patient Decision Aids. *Health Aff (Millwood)*. 2004;63(1), and Bottles K, Vinz C. Decision-Support Alternative to Prior Authorization for Ordering High-Tech Diagnostic Imaging Scans [PowerPoint Presentation]. Institute for Clinical Systems Improvement; 2009.
13. See, for example, Fischer MA, Avorn J. Economic implications of evidence-based prescribing for hypertension: can better care cost less? *JAMA*. 2004 Apr 21;291(15):1850-6.
14. See, for example, Bourbeau J, Julien M, Maltais F, Rouleau M, Beupre A, Begin R, et al. Reduction of hospital utilization in patients with chronic obstructive pulmonary disease: a disease-specific self-management intervention. *Arch Intern Med*. 2003 Mar 10;163(5):585-91; Cordisco ME, Benjaminovitz A, Hammond K, Mancini D. Use of telemonitoring to decrease the rate of hospitalization in patients with severe congestive heart failure. *Am J Cardiol*. 1999 Oct 1;84(7):860-2, A8; and Gadoury MA, Schwartzman K, Rouleau M, Maltais F, Julien M, Beupre A, et al. Self-management reduces both short- and long-term hospitalisation in COPD. *Eur Respir J*. 2005 Nov;26(5):853-7.
15. See, for example, Toussaint J. Writing the new playbook for U.S. health care: lessons from Wisconsin. *Health Aff (Millwood)*. 2009 Sept-Oct;28(5):1343-50.
16. Edmonds C, Hallman GL. CardioVascular Care Providers. A pioneer in bundled services, shared risk, and single payment. *Tex Heart Inst J*. 1995;22(1):72-6; Johnson LL, Becker RL. An alternative health-care reimbursement system--application of arthroscopy and financial warranty: results of a 2-year pilot study. *Arthroscopy*. 1994 Aug;10(4):462-70; discussion 71-2; and Cromwell J, Dayhoff DA, Thoumaian AH. Cost savings and physician responses to global bundled payments for Medicare heart bypass surgery. *Health Care Financ Rev*. 1997 Fall;19(1):41-57.

17. See, for example, Sakala C, Corry M. Evidence-Based Maternity Care: What It Is and What It Can Achieve. New York: Milbank Memorial Fund; 2008; Fisch JM, English D, Pedaline S, Brooks K, Simhan HN. Labor induction process improvement: a patient quality-of-care initiative. *Obstet Gynecol.* 2009 Apr;113(4):797-803; Toussaint, op cit.; and Baicker K, Buckles KS, Chandra A. Geographic variation in the appropriate use of cesarean delivery. *Health Aff (Millwood).* 2006 Sep-Oct;25(5):w355-67.
18. See, for example, Shannon RP, Patel B, Cummins D, Shannon AH, Ganguli G, Lu Y. Economics of central line--associated bloodstream infections. *Am J Med Qual.* 2006 Nov-Dec;21(6 Suppl):7S-16S, and Pronovost P. Interventions to decrease catheter-related bloodstream infections in the ICU: the Keystone Intensive Care Unit Project. *Am J Infect Control.* 2008 Dec;36(10):S171 e1-5.
19. See, for example, Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med.* 2006 Sep 25;166(17):1822-8, and Jack BW, Chetty VK, Anthony D, Greenwald JL, Sanchez GM, Johnson AE, et al. A Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. *Ann Intern Med.* 2009 February 3, 2009;150(3):178-87.
20. See, for example, Sweeney L, Halpert A, Waranoff J. Patient-Centered Management of Complex Patients Can Reduce Costs Without Shortening Life. *Am J Manag Care.* 2007;13:84-92.
21. Sakala C, Corry M. Evidence-Based Maternity Care: What It Is and What It Can Achieve. New York: Milbank Memorial Fund; 2008.
22. See, for example, Institute of Medicine. *Prenatal Care: Reaching Mothers, Reaching Infants.* Washington (DC): National Academy Press; 1988.
23. Some differences in costs of providers derive from desirable services or functions they perform which are not otherwise paid for. For example, teaching hospitals incur additional costs beyond the direct cost of care for patients, and it would be undesirable to direct patients away from them solely because of their costs of teaching. Ideally, such costs should be paid for through separate mechanisms that would enable “apples-to-apples” comparisons of the costs of procedures between teaching and non-teaching hospitals. See Section IV-G.
24. Other authors have labeled the two types of risk “probability risk” and “technical risk.” See Emery D, *Customer-Directed Healthcare Reform with Episode Pricing.* Mason (OH): Thomson; 2006.
25. Miller, HD. *From Volume to Value: Better Ways to Pay for Health Care.* *Health Aff (Millwood).* 2009 Sept-Oct;28(5):1418-28.
26. Schoenbaum SC. Physicians and prepaid group practices. *Health Aff (Millwood).* 2004 Jan-Jun;Suppl Web Exclusives:W4-76-8.
27. Network for Regional Healthcare Improvement. *From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs.* Pittsburgh (PA): Network for Regional Healthcare Improvement; 2008. Available from: <http://www.nrhi.org/downloads/NRHI2008PaymentReformRecommendations.pdf>.
28. Medicare Payment Advisory Commission, op cit.
29. Shortell and Casalino, op cit.
30. Fisher, Staiger, et al., op cit.
31. Congressional Budget Office, op cit.
32. Sepulveda MJ, Bodenheimer T, Grundy P. Primary care: can it solve employers' health care dilemma? *Health Aff (Millwood).* 2008 Jan-Feb;27(1):151-8.
33. Although a specialized provider organization could take accountability for the cost and quality of care for a narrowly defined population (e.g., people with a specific chronic disease), it seems desirable to reserve the term Accountable Care Organization for organizations that intend to manage the care of as broad a population as possible.
34. See, for example, Bohmer RM, Lee TH. The shifting mission of health care delivery organizations. *N Engl J Med.* 2009 Aug 6;361(6):551-3.
35. Kautter, J, Pope G, et al. *Physician Group Practice Demonstration Bonus Methodology Specifications.* Waltham (MA): RTI International. 2004 December 20. Available at: http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Payment.pdf.
36. Practices do not need to develop these guidelines themselves; for example, the Institute for Clinical Systems Improvement (www.icsi.org) has developed evidence-based guidelines for the appropriate treatment of many kinds of conditions, and it provides assistance to physicians in implementing them.

37. Greene RA, Beckman HB, Mahoney T. Beyond the efficiency index: finding a better way to reduce overuse and increase efficiency in physician care. *Health Aff (Millwood)*. 2008 Jul-Aug;27(4):w250-9.
38. Ortiz, DD. Using a Simple Patient Registry to Improve Your Chronic Disease Care. *Family Practice Management*. 2006 April, pp. 47-52.
39. Wright A, McGlinchey EA, Poon EG, Jenter CA, Bates DW, Simon SR. Ability to generate patient registries among practices with and without electronic health records. *J Med Internet Res*. 2009;11(3):e31.
40. In many cases, these types of patient support and care management services are currently provided by health insurance plans or independent disease management companies, rather than by physician practices. However, recent research suggests that in order to be effective, the services need to be closely linked with a patient's primary care physician or practice. If primary care practices organize themselves to efficiently provide these services, they could be supported using the resources currently spent on less effective services delivered through health plans and disease management companies, thereby improving results without increasing costs.
41. Rosenthal MB. Doughnut-hole economics. *Health Aff (Millwood)*. 2004 Nov-Dec;23(6):129-35.
42. See for example, Mahoney JJ. Reducing patient drug acquisition costs can lower diabetes health claims. *Am J Manag Care*. 2005 Aug;11(5 Suppl):S170-6.
43. Bodenheimer T, Lo B, Casalino L. Primary care physicians should be coordinators, not gatekeepers. *JAMA*. 1999 Jun 2;281(21):2045-9.
44. See, for example, the reports from the California Cooperative Healthcare Reporting Initiative (<http://www.cchri.org>); the Quality Measurement Analysis Portal (<http://www.lhcqf.org/project-overview.html>) developed by the Louisiana Health Care Quality Forum; the Maine Doctor Ratings (<http://www.mhmc.info/>) developed by the Maine Health Management Coalition; the Clinical Quality in Primary Care Reports (<http://www.mhqp.org/quality/clinical/cqMASumm.asp?nav=032400>) developed by Massachusetts Health Quality Partners; Minnesota Health Scores (<http://www.mnhealthscores.org>) developed by Minnesota Community Measurement; the Community Checkup Reports (<http://www.wacommunitycheckup.org/>) developed by the Puget Sound Health Alliance; the Save Lives Save Dollars Health Care Performance Report (http://www.gdahc.org/GDAHc_site/index.html) developed by the Greater Detroit Area Health Council; and the Performance and Progress Reports developed by the Wisconsin Collaborative for Healthcare Quality (<http://www.wchq.org/reporting/>).
45. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. 2007 March. Available at: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf.
46. Congressional Budget Office. Option 39: Pay for a Medical "Home" for Chronically Ill Beneficiaries in Fee-for-Service Medicare. In: Budget Options, Volume I: Health Care. Washington (DC): Congressional Budget Office; 2008 December.
47. The NCQA standards are available at: <http://www.ncqa.org/tabid/631/Default.aspx>.
48. Nutting PA, Miller WL, Crabtree BF, Jaen CR, Stewart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Ann Fam Med*. 2009 May-Jun;7(3):254-60, and Network for Regional Healthcare Improvement. Pay for Innovation or Pay for Standardization? How to Best Support the "Medical Home." Pittsburgh (PA): Network for Regional Healthcare Improvement. 2009. Available at: <http://www.nrhi.org/reports.html>.
49. Moore GL, Wasson JH. The Ideal Medical Practice Model: Maximizing Efficiency, Quality, and the Doctor-Patient Relationship. *Family Practice Management*. 2007 Sept, pp. 20-24.
50. Crosson FJ. The delivery system matters. *Health Aff (Millwood)*. 2005 Nov-Dec;24(6):1543-8, and Nutting, Miller, et al., op cit.
51. Blue Cross Blue Shield of Michigan has been pursuing this approach through its Physician Group Incentive Program, which is described in more detail in the Appendix.
52. Examples of IPAs composed of primarily or exclusively small primary care practices that are managing risk-based contracts include Physician Health Partners (<http://www.phpmcs.com>) and Primary Physician Partners, LLC in Denver, Colorado; Mesa County IPA Doctors in Grand Junction, Colorado (<http://www.mcpiipa.org/>); JSA Medical Group in St. Petersburg, Florida (<http://www.jsahealthcare.com>); Physicians of Southwest Washington in Olympia, Washington (www.pswipa.com). See, for example, Nichols LM, Weinberg M, Barnes J. Grand Junction Colorado: a health community that works. Washington (DC): New America Foundation; 2009.
53. Fisher, McClellan, et al., op cit.

54. Fisher, Staiger, et al., op cit.
55. Valderas JM, Starfield B, Forrest CB, Sibbald B, Roland M. Ambulatory care provided by office-based specialists in the United States. *Ann Fam Med.* 2009 Mar-Apr;7(2):104-11.
56. Forrest CB, Majeed A, Weiner JP, Carroll K, Bindman AB. Comparison of specialty referral rates in the United Kingdom and the United States: retrospective cohort analysis. *BMJ.* 2002 Aug 17;325(7360):370-1.
57. For example, the Institute for Clinical Systems Improvement in Minnesota developed a new payment method to support the ability for psychiatrists to consult with primary practices about how to care for patients with depression. See the “DIAMOND Initiative,” http://www.icsi.org/health_care_redesign_/diamond_35953/.
58. Casalino LP, Pham H, Bazzoli G. Growth of single-specialty medical groups. *Health Aff (Millwood).* 2004 Mar-Apr;23(2):82-90.
59. Casalino LP, November EA, Berenson RA, Pham HH. Hospital-physician relations: two tracks and the decline of the voluntary medical staff model. *Health Aff (Millwood).* 2008 Sep-Oct;27(5):1305-14.
60. National Health Expenditure Data, 2006-2007.
61. McKinsey Global Institute. Accounting for the cost of health care in the United States. McKinsey & Company. 2007 Jan.
62. Miller HD. Methodology on adverse events. *Health Aff (Millwood).* 2007 Jan-Feb;26(1):293; author reply -4.
63. Tompkins CP, Altman SH, Eilat E. The precarious pricing system for hospital services. *Health Aff (Millwood).* 2006 Jan-Feb;25(1):45-56.
64. Berenson RA, Ginsburg PB, May JH. Hospital-physicians relations: cooperation, competition, or separation? *Health Aff (Millwood).* 2007 Jan-Feb;26(1):w31-43, and Casalino, November, et al., op cit.
65. Luft HS. *Total Cure: The Antidote to the Health Care Crisis.* Cambridge (MA): Harvard University Press; 2008.
66. See, for example, Bazzoli GJ, Dynan L, Burns LR, Yap C. Two decades of organizational change in health care: what have we learned? *Med Care Res Rev.* 2004 Sep;61(3):247-331.
67. See, for example, Toussaint, op cit.
68. Bazzoli, Dynan, et al., op cit.
69. Minnesota is exploring the concept of “Accountable Care Communities,” which would ask an entire community to take accountability for the health of its population by encouraging exercise, facilitating access to healthy foods, etc. in addition to delivering efficient, effective healthcare services and public health programs.
70. The different levels are not intended to imply, for example, that Level 1 ACOs *cannot* address the cost-savings opportunities associated with Level 2 ACOs, or that Level 2 ACOs *cannot* address the cost-savings opportunities associated with Level 3 ACOs, etc., but merely to indicate that the expectations as to the nature and magnitude of cost-savings for each type of organizational structure should be different.
71. Miller, HD. *From Volume to Value: Better Ways to Pay for Health Care.* op cit.
72. Rosenthal MB. Beyond pay for performance--emerging models of provider-payment reform. *N Engl J Med.* 2008 Sep 18;359(12):1197-200.
73. Many physician groups have continued to practice voluntarily under capitation unless it was no longer feasible in their local community. See, for example, Super N. From capitation to fee-for-service in Cincinnati: a physician group responds to a changing marketplace. *Health Aff (Millwood).* 2006 Jan-Feb;25(1):219-25.
74. Centers for Medicare and Medicaid Services. Physician Group Practice Demonstration. 2009 Aug. Available at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf.
75. The payer would not count the \$100,000 incurred by the ACO in the savings calculation because those costs would not be paid for under the fee-for-service system.
76. Miller, HD. *From Volume to Value: Better Ways to Pay for Health Care.* op cit. The commonly used unit for such payments is “PMPM,” i.e., per member per month. However, this terminology has two undesirable connotations: (1) the payment is the same for each patient, rather than varying based on the patient’s conditions, and (2) care is only planned for a month at a time, rather than over a longer period (e.g., at least a year).
77. See, for example, Hughes JS, Averill RF, Eisenhandler J, Goldfield NI, Muldoon J, Neff JM, et al. Clinical Risk Groups (CRGs): a classification system for risk-adjusted capitation-based payment and health care management. *Med Care.* 2004 Jan;42(1):81-90.

78. An important area where risk/severity-adjustment systems need to be improved for payment purposes is avoiding penalties for providers who help their patients improve their health status. For example, if a provider takes on a new patient who is obese, the provider should be paid more than for a new patient who is not obese, since the obese patient will have more health problems on average. But if the provider successfully helps the obese patient to lose weight, it would be inappropriate to penalize the provider by reducing the payment to the same level as for the patient who was not obese to begin with.
79. More information on the Patient Choice program is available at <http://www.patientchoicehealthcare.com>.
80. Blue Cross Blue Shield of Massachusetts, The alternative QUALITY contract. Boston (MA): BCBSM; 2008 Nov. Available from http://quality.bluecrossma.com/press/aqc_white_paper_11_19_08.pdf.
81. See, for example, Gosfield AG, "Getting the team paid: how Medicare physician payment policies impede quality", *Health Law Handbook*, Eagen, MN: West; 2009 §2:17, p. 72.
82. Mechanic RE, Altman SH. Payment reform options: episode payment is a good place to start. *Health Aff (Millwood)*. 2009 Mar-Apr;28(2):w262-71.
83. de Brantes F, D'Andrea G, Rosenthal MB. Should health care come with a warranty? *Health Aff (Millwood)*. 2009 Jul-Aug;28(4):w678-87. Geisinger Health System's "ProvenCare" program provides what is effectively a warranty for care: Casale AS, Paulus RA, Selna MJ, Doll MC, Bothe AE, Jr., McKinley KE, et al. "ProvenCareSM": a provider-driven pay-for-performance program for acute episodic cardiac surgical care. *Ann Surg*. 2007 Oct;246(4):613-21; discussion 21-3.
84. de Brantes FS, Rastogi A. Evidence-Informed Case Rates: Paying for Safer, More Reliable Care. New York: The Commonwealth Fund June 2008.
85. A variant of this approach is proposed in Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med*. 2007 Mar;22(3):410-5.
86. Information on Blue Cross Blue Shield of Michigan's Physician Group Incentive Program is available in the Appendix and at http://www.bcbsm.com/provider/value_partnerships/pgip/index.shtml.
87. Murray, R. Setting hospital rates to control costs and boost quality: the Maryland experience. *Health Aff (Millwood)*. 2009;28(5):1395-1405.
88. PROMETHEUS Payment has been striving to create Evidence-Informed Case Rates that are based in part on the estimated costs of delivering care consistent with evidence-based guidelines. See the information available at <http://www.prometheuspayment.org/>.
89. Capps C, Dranove D. Hospital consolidation and negotiated PPO prices. *Health Aff (Millwood)*. 2004 Mar-Apr;23(2):175-81.
90. Ginsburg PB, Thorpe KE. Can all-payer rate setting and the competitive strategy coexist? *Health Aff (Millwood)*. 1992 Summer;11(2):73-86.
91. For more information on the Minnesota Medical Education and Research Costs (MERC) Fund, see: <http://www.health.state.mn.us/divs/hpsc/hep/merc/index.html>.
92. Miller, HD. From Volume to Value: Better Ways to Pay for Health Care. op cit.
93. More information on Regional Health Improvement Collaboratives is available at <http://www.nrhi.org>.
94. See the U.S. Department of Health and Human Services Hospital Compare website at <http://www.hospitalcompare.hhs.gov>.
95. See, for example, the Patient Assessment Survey reports from the California Cooperative Healthcare Reporting Initiative (http://www.cchri.org/programs/programs_pas.html) and the Patient Experiences in Primary Care reports from Massachusetts Health Quality Partners (<http://www.mhqp.org/quality/pes/pesMASumm.asp?nav=031600>).
96. For example, under the Medicare Physician Group Practice Demonstration project, the participating groups do not find out exactly which patients they are being held accountable for until more than a year after the care has (or has not) been delivered. See Kautter, Pope, et al., op cit.
97. Altman SH, Tompkins CP, Eilat E, Glavin MP. Escalating health care spending: is it desirable or inevitable? *Health Aff (Millwood)*. 2003 Jan-Jun;Suppl Web Exclusives:W3-1-14.

98. Miller, HD. From Volume to Value: Better Ways to Pay for Health Care. op cit.; Center for Healthcare Quality and Payment Reform. Setting Payment Levels. Pittsburgh (PA): Center for Healthcare Quality and Payment Reform. 2009. Available at: <http://www.chqpr.org/downloads/SettingthePaymentLevel.pdf>.
99. See, for example, Sloan FA, Shadle JH. Is there empirical evidence for "Defensive Medicine"? A reassessment. *J Health Econ*. 2009 Mar;28(2):481-91.
100. See, for example, Peters PG Jr. Resuscitating hospital enterprise liability. *University of Missouri School of Law: Missouri Law Review* 2008; 73:369.
101. Health CEOs for Health Reform. Realigning U.S. health care incentives to better serve patients and taxpayers. Washington (DC): New America Foundation; 2009 June 12. Available at: <http://www.newamerica.net/files/DeliverySystemWhitePaper.pdf>.
102. See, for example, Wilensky GR, Wolter N, Fischer MM. Gain sharing: a good concept getting a bad name? *Health Aff (Millwood)*. 2007 Jan-Feb;26(1):w58-67.
103. Capps, Dranove, op cit.
104. Greaney TL. Whither antitrust? The uncertain future of competition law in health care. *Health Aff (Millwood)*. 2002 Mar-Apr;21(2):185-96; Capps, Dranove, op cit.
105. Several Regional Health Improvement Collaboratives are convening Payment Reform Summits to build consensus among stakeholders in their communities about the appropriate changes needed in healthcare payment systems. See, for example, information on the Oregon Payment Reform Summit at <http://www.ochcp.org/default.asp?id=93>.
106. Lynn J, Straube BM, Bell KM, Jencks SF, Kambic RT. Using population segmentation to provide better health care for all: the "Bridges to Health" model. *Milbank Q*. 2007 Jun;85(2):185-208; discussion 9-12.
107. See, for example, Tompkins CP, Higgins AR, Ritter GA. Measuring outcomes and efficiency in Medicare value-based purchasing. *Health Aff (Millwood)*. 2009 Mar-Apr;28(2):w251-61.
108. Lurie N, Somers SA, Fremont A, Angeles J, Murphy EK, Hamblin A. Challenges to using a business case for addressing health disparities. *Health Aff (Millwood)*. 2008 Mar-Apr;27(2):334-8.
109. National Health Policy Forum. The Basics: Medicare Demonstrations. Washington (DC): George Washington University. 2008 July 30.
110. Section 646 (Medicare health care quality demonstration programs), Public Law 108-173, enacted December 8, 2003. Two demonstrations have been approved under Section 646 to begin in 2009, one organized by the Indiana Health Information Exchange and one by North Carolina Community Networks. For more information see: http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MMA646_FactSheet.pdf.
111. For more information on the RUC, see <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/the-rvs-update-committee.shtml>.
112. See, for example, Sandy LG, Bodenheimer T, Pawlson LG, Starfield B. The political economy of U.S. primary care. *Health Aff (Millwood)*. 2009 Jul-Aug;28(4):1136-45, and Lee PV, Lansky D. Making space for disruption: putting patients at the center of health care. *Health Aff (Millwood)*. 2008 Sep-Oct;27(5):1345-8.
113. For a more detailed explanation, see Medicare Payment Advisory Commission. Physician Services Payment System. Washington (DC): MedPAC; 2008 Oct. Available at: http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_Physician.pdf.



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