ISSUE BRIEF

Accountable Care Organizations

March 2009

Reforming Provider Payment

Moving Toward Accountability for Quality and Value

Introduction

The ongoing debate over health care reform in the United States has expanded from targeted concerns about the millions of Americans without health insurance to broader consideration of gaps in quality, rising health care costs, and the structure of a system that is failing to address either problem. Dramatic variations in healthcare spending that bear little correlation to quality indicate that our current system neither rewards nor encourages higher-value care.

For example, we spend three times more per Medicare beneficiary in certain geographic regions than in others – and yet the quality and outcomes of care are no better. In addition, many preventive services are underused, and adherence to proven-effective therapies for many chronic diseases is low. Medical errors and other safety problems remain too common, accounting for many thousands of deaths and billions of dollars in health care costs. All of these gaps in care are reinforced by Medicare's current payment systems, which tend to promote high-volume and high-intensity care regardless of quality, and do not support innovative approaches to coordinating care or preventing avoidable complications or services.

The Need for a New Payment Model and Principles for Payment Reform

Increasing awareness of these problems has resulted in a growing array of public- and private-sector initiatives to promote efforts by providers to improve care and to foster greater accountability for both quality and cost. While there is ongoing debate over the specific form that such approaches should take and how to implement them around the country, these efforts are marked by growing consensus on several guiding principles for reform.

First, there is increasing agreement on the need for local accountability for quality and cost across the continuum of care. The consistent provision of high-quality care – particularly for those with serious and chronic conditions – will require the coordination and engagement of multiple health care professionals across different institutional settings and specialties. The health care system must not only facilitate, but also encourage such coordination.

Second, a successful approach to achieving greater accountability must be viable across the diverse practice types and organizational settings that characterize the U.S. health care system and should be sufficiently flexible to allow for variation in the strategies that local health systems use to improve care.

Third, successful reform will require a shift in the payment system from one that rewards volume and intensity to one that promotes value (improved care at lower cost), encourages collaboration and shared responsibility among providers, and ensures that payers – both public and private – offer a consistent set of incentives to providers.

Finally, with increased accountability on the part of providers must come greater transparency for consumers. Measures of overall quality, cost, and other aspects of performance relevant to consumers will facilitate informed choices of both providers and services and increase consumers' confidence in the care they are receiving as their providers face different incentives.

Many of the payment reforms that have been proposed or are already in use – for example, bundled payments, disease management, and pay for performance – represent meaningful steps toward greater accountability. The next step is accountability for care that leads to better outcomes and lower costs at the person level, with support for the infrastructure required to provide high-quality, coordinated care.

The Accountable Care Organization Model

The Accountable Care Organization (ACO) model establishes a spending benchmark based on expected spending. If an ACO can improve quality while slowing spending growth, it receives shared savings from the payers. This model is well-aligned with many existing reforms, such as the medical-home model and bundled payments, and also offers additional support (and accountability) to the provider organization to enable them to deliver more efficient, coordinated care. This approach has been implemented in programs like Medicare's Physician Group Practice (PGP) Demonstration, which has shown significant improvements in quality and savings for large group practices.

Because the groups receive a share of the savings beyond a threshold level, steps like care coordination services, wellness programs, and other approaches that achieve better outcomes with less overall resource use result in greater reimbursement to the providers. These steps thus "pay off" and are sustainable in a way that they are not under current reimbursement systems. In addition, the shared savings approach provides an incentive for ACOs to avoid expansions of health care capacity that are an important driver of both regional differences in spending and variations in spending growth, and that do not improve health.

The ACO approach also builds on current reform efforts that focus on one key group of providers, as in the medical-home model, or on a discrete episode of care, as in bundled payments. On their own, these initiatives may help strengthen primary care and improve care coordination, but they do not address the problem of supply-driven cost growth highlighted by the Dartmouth group. If adopted within a framework of overall accountability for cost and quality as is envisioned in the ACO model, both the medical home and bundled payment reforms would have added incentives to support not only better quality, but also lower overall spending growth (see Table 1).

By shifting the emphasis from volume and intensity of services to incentives for efficiency and quality, ACOs provide new support for higher-value care without radically disrupting existing payments and practices. The ACO model builds on current provider referral patterns and offers shared savings payments, or bonuses, to providers on the basis of quality and cost. A wide variety of provider collaborations can become ACOs assuming that they are willing to be held accountable for overall patient care and operate within a particular payment and performance measurement framework. Examples include existing integrated delivery systems, physician networks such as independent practice associations, physician-hospital organizations, hospitals that have their own primary-care physician networks, and multispecialty group practices. Alternatively, primary-care groups or other organizations that provide basic care could contract with specialized groups that provide high-quality referral services with fewer costly complications.

Table 1

Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient "lock-in" and may be viewed as too risky by many providers/ patients
Strengthens primary care directly or indirectly	Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers "upfront" payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination	Yes– Strong incentive to coordinate and take other steps to reduce overall costs	Yes– Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita cost
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires "lock-in" of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure and do not require patient "lock-in" outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned

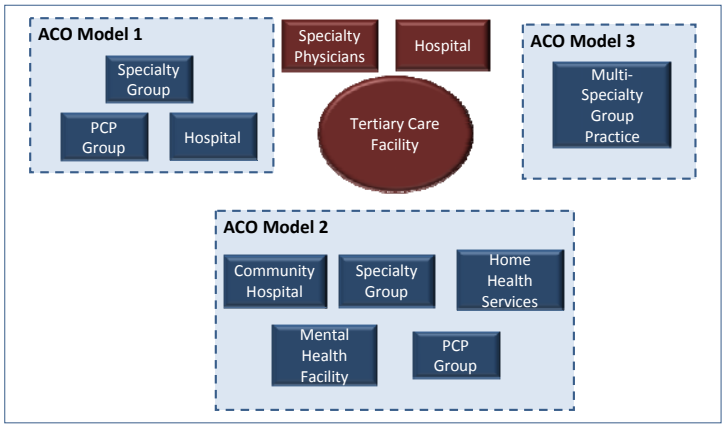
Regardless of specific organizational form, the ACO model has three key features:

1. **Local Accountability.** ACO entities will be comprised of local delivery collaborations that can effectively manage the full continuum of patients' care, from preventive services to hospital-based and nursing-home care. Their patient populations are comprised of those who receive most of their primary care from the primary-care physicians associated with the ACO (see Figure 1). (As noted above, ACOs may include a range of specialists, hospitals, and other providers, or may contract or collaborate with them in other ways.)

Figure 1

ACOs Can Be Configured in Different Ways

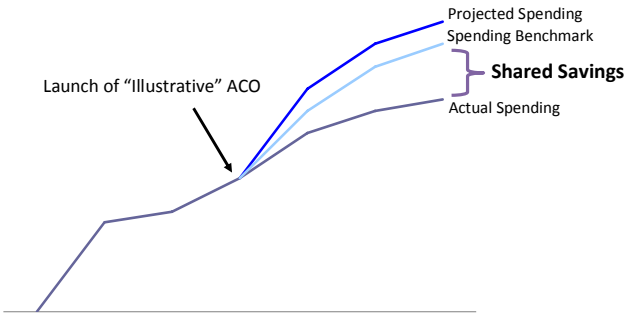
(Some care will likely be delivered outside of the ACO)



2. **Shared Savings.** ACO-specific expenditure benchmarks will be based on historical trends and adjusted for patient mix. Contingent on meeting designated quality thresholds, ACOs with expenditures below their particular benchmark will be eligible for shared savings payments, which can be distributed among the providers within the ACO. These shared savings allow for investments – in health IT or medical homes, for example – that can in turn improve care and slow cost growth (see Figure 2).

Figure 2

Shared Savings Derived from Spending Below Benchmarks That Are Based on Historical Spending Patterns



3. **Performance Measurement.** Valid measurement of the quality of care provided through ACOs will be essential to both ensuring that cost savings are not the result of limiting necessary care and promoting higher-quality care. Such measurement should include meaningful outcome and patient-experience data.

Laying the Foundation for Successful Implementation

While the ACO framework holds promise for improving quality, cost, and overall efficiency, it does create some important implementation issues. It is worth highlighting some factors that can improve the likelihood of success.

Engagement of a broad range of key local stakeholders, such as payers, purchasers, providers, and patients alike, can provide momentum for ACOs. A demonstrated history of successful innovation and reform with respect to health IT adoption and clinical innovations, for example, may also be a good foundation for further ACO reforms.

Having a structural foundation in place at the outset will also facilitate the transition to an ACO. Key factors include patient populations that are sufficient in size to permit reliable assessment of expenditures and quality performance relative to benchmarks, in order to calculate shared savings. Additional key elements include some degree of integration – either formal or virtual (i.e., for the purposes of the ACO) – within the delivery system and the capacity for collecting and reporting on the performance of participating providers.

Finally, having an agreement and process in place for distributing shared savings will be critical in terms of presenting an attractive proposition to providers – that is, a real opportunity to generate additional payments in return for improved care – and rewards genuine improvements in efficiency.

Key Design Components

While consideration of the more technical aspects of implementation are beyond the scope of this overview, a brief description of several key design questions highlights the decisions that will need to be made at the ACO level through negotiations with participating payers:

- **Organization of the ACO.** The form and management of the ACO need to be well-defined. ACO "leaders" who will drive improvements in care and efficiency must be identified from the start.

- **Scope of the ACO.** The specific providers involved in ACOs are likely to include primary-care physicians and may also include selected specialists as well as hospitals and other providers. Such decisions about the scope of providers to be included will clearly shape many of the technical aspects of the ACO, referral patterns, and other behavioral changes induced by the ACO itself.

- **Spending and quality benchmarks.** Spending benchmarks must be projected with sufficient accuracy based on historical data (or other comparison groups) and savings thresholds to provide confidence that overall savings will be achieved. Sufficient measures of quality to provide evidence of improvement are also essential.

- **Distribution of shared savings.** Elements of the distribution of savings that will be subject to negotiation include the percentage split between providers and payers, for example 80/20 or 50/50, and the specific agreement governing how the savings will be distributed among the ACO providers.

Looking Ahead: The Promise of ACOs

The ACO model is receiving significant attention among policymakers and leaders in the health care community, not only because of the unsustainable path on which the country now finds itself, but also because it directly focuses on what must be a key goal of the health care system: higher value. The model offers a promising approach for achieving this goal without requiring radical change in either the payment system or current referral patterns. Rather, fee-for-service remains in place, and most physicians already practice within natural referral networks around one or a few hospitals. By promoting more strategic and effective integration and care coordination, the ACO model holds substantial promise as a reform that offers a potential win-win for providers, payers, and patients alike.

For a more technical discussion of the ACO model, including budget implications, see:

- CBO, *Budget Options, Volume I: Health Care* (December 2008), pp. 72-74 (Option 37, "Bonus Eligible Organizations").

- Fisher, Elliott, Mark McClellan, John Bertko, Steven Lieberman, Julie Lee, Julie Lewis, and Jonathan Skinner. "Fostering Accountable Health Care: Moving Forward in Medicare." *Health Affairs* Web Exclusive, January 27, 2009: w219-w231.