



Accountable Care Organizations and the Medicare Shared Savings Program

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Summary

The provision of health care in the United States has been described as fragmented, with patients seeing multiple unrelated providers. Fragmented care has been found to be, among other things, both costly, since provider payments are not linked to performance or outcomes and services can be duplicative, and of lower quality, since providers lack financial incentives to coordinate care. Section 3022 of the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA), as amended, directs the Secretary of Health and Human Services (the “Secretary”) to implement an integrated care delivery model in Medicare, the Medicare Shared Savings Program, using Accountable Care Organizations (ACOs)—a model of integrated care formulated to reduce costs and improve quality.

ACOs are modeled on integrated delivery systems such as the Mayo Clinic, Geisinger Health System, Kaiser Permanente, and Intermountain Healthcare. While ACOs can be designed with varying features, most models put primary care physicians at the core, along with other providers, and emphasize simultaneously reducing costs and improving quality. The emphasis is on physicians rather than insurers or hospitals because physicians influence almost 90% of all personal health spending.

In the simplest case, the ACO contracts with payers to be accountable for the entire continuum of care provided to a defined population, and if the costs of care provided are less than targeted amounts, and certain quality measures are achieved, the ACO and the payer will share the savings generated. Under the Medicare Shared Saving Program, the Centers for Medicare & Medicaid Services (CMS) will contract for ACOs to assume responsibility for improving quality of care provided, coordinating care across providers, and reducing the cost of care Medicare beneficiaries receive. If cost and quality targets are met, ACOs will receive a share of any savings realized by CMS. The Congressional Budget Office scored the Medicare Shared Savings Program as reducing Medicare expenditures \$4.9 billion in the FY2013 through FY2019 period.

PPACA Section 3022 leaves many of the design features to be determined by the Secretary, and regulations governing Medicare ACOs are expected in the fall 2010. As is often the case, the regulations will be fundamental to defining the program. For instance, while PPACA suggests a fundamental role in ACOs for physicians and providers, it does not guarantee one. In addition, PPACA leaves the contracting terms and beneficiary assignment rules to the Secretary. However, for Medicare beneficiaries, the Medicare Shared Savings Program will continue to allow Medicare beneficiaries enrolled in fee-for-service Medicare to continue to select any Medicare provider.

The Medicare Shared Savings Program is slated to begin January 1, 2012. While ACOs hold out the prospect of improving care, reducing costs, and raising quality, there are still gaps in knowledge of what existing ACOs have achieved and whether they can be widely replicated. Moreover, there may be unanticipated consequences from encouraging the formation of ACOs, such as further health provider market concentration, that could adversely affect efforts to control overall health costs.

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Introduction

A noted shortcoming in the American health care system is the fragmented care available to most individuals.¹ Fragmented care, where patients see multiple unrelated providers, has been found to be, among other things, both costly, since provider payments are not linked to performance or outcomes and services can be duplicative, and of lower quality, since providers lack financial incentives to coordinate care.² Research has suggested that integrated care delivery models can reduce costs and improve quality.³ Section 3022 of the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA), as amended,⁴ directs the Secretary of Health and Human Services (the “Secretary”) to implement an integrated care delivery model in Medicare, the Medicare Shared Savings Program, using Accountable Care Organizations (ACOs)—a model of integrated care formulated to reduce costs and improve quality.⁵

While the concept of an ACO is still evolving, “Section 1: What Is an Accountable Care Organization?” describes generally what an ACO is, and “Section 2: How Are ACOs Supposed to Work?” discusses how an ACO may operate. “Section 3: Essential Provisions of § 3022 of PPACA” describes essential provisions of the Medicare Shared Savings Program created by PPACA. “Section 4: Potential Advantages and Limitations of ACOs” explores some of the arguments in favor and against ACOs, and the report concludes with a discussion of the likely impact of Medicare ACOs. The discussion in sections 1 and 2 focuses on ACOs generally and possibly offers insight into how the Secretary may implement the Medicare Shared Savings Program.⁶ Sections 3, 4, and 5 more narrowly focus on the Medicare Shared Savings Program.

Section 1: What Is an Accountable Care Organization?

While there are numerous definitions of an accountable care organization, the following captures the essential elements:

ACOs are collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, and others around the ability to receive shared-saving

¹ Alain C. Enthoven, “Integrated Delivery Systems: The Cure for Fragmentation,” *The American Journal of Managed Care*, vol. 15, no. 10 (December 2009), pp. S284-S290.

² Institute of Medicine, “Aligning Payment Policies with Quality Improvement,” in *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: The National Academies Press, 2001), pp. 181-195.

³ Laura A. Tollen, *Physician Organization in Relation to Quality and Efficiency of Care: A Synthesis of Recent Literature*, The Commonwealth Fund, Commonwealth Fund pub. no. 1121, April 2008.
http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2008/Apr/Physician%20Organization%20in%20Relation%20to%20Quality%20and%20Efficiency%20of%20Care%20%20A%20Synthesis%20of%20Recent%20Literatu/Tollen_physician_org_quality_efficiency_1121%20pdf.pdf.

⁴ Hereinafter, PPACA will refer to PPACA as amended.

⁵ Section 2706 of PPACA authorized a four-year Medicaid and CHIP pediatric ACO demonstration starting January 1, 2012. This report does not address the Pediatric ACO Demonstration.

⁶ CMS has indicated that it intends to provide more details in the fall 2010 as part of a Notice of Proposed Rulemaking.

bonuses from a payer by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients.⁷

The key elements of an ACO, highlighted in the definition, are that

- ACOs bring together and integrate, either actually or virtually, a broad range of providers across care settings;
- they emphasize primary care;
- they can achieve savings for a payer by effectively integrating care across providers;
- providers share with payers in the savings that providers generate;
- the savings are not at the expense of quality and providers are responsible for reducing costs;
- providers are responsible for improving quality and reducing costs; and
- improvements are measured across a specified population.

The emphasis is on physicians rather than insurers or hospitals since physicians “control (directly or indirectly) 87% of all personal health spending.”⁸

Rationale for Accountable Care Organizations

The rationale for ACOs emerges from the recognition that the current medical system tends to offer fragmented services across providers (an absence of coordinated care), pays for units of service rather than outcomes, and holds no one organization or individual responsible for either the quality or cost of care provided. ACOs are supposed to bring providers together under a single organization and create incentives for them to coordinate care, improve quality, and lower cost.

Although ACOs may contract with any payer (Medicare, Medicaid, or private insurer) to provide services and share in any resulting savings, the consequences for the health care delivery system are assumed to be much broader. Proponents anticipate that ACOs will change both the culture and practice patterns of providers and as these changes are institutionalized, all payers and all patients will benefit from the delivery of higher-quality, lower-cost, and better integrated services.⁹

⁷ This definition is a modified version of that developed in Aaron McKethan, Mark McClellan, Elliott Fisher et al., *Moving from Volume-Driven Medicine Toward Accountable Care*, Health Affairs, Health Affairs Blog, August 20, 2009, <http://www.healthaffairs.org/blog>.

⁸ Lawton Robert Burns and Ralph W. Muller, “Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration,” *Milbank Quarterly*, vol. 86, no. 3 (2008), p. 377, citing A. Sager and D. Socolar 2005. *Health Costs Absorb One-Quarter of Economic Growth 2000-2005*. Boston: Boston University School of Public Health.

⁹ A recent study by the Commonwealth Fund comparing the U.S. health care system to other countries found that the U.S. system underperformed in part due to poor performance managing chronic care and coordinating care—two areas directly addressed by ACOs according to proponents. Karen Davis, Cathy Schoen, and Kristof Stremikis, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update*, The Commonwealth Fund, Washington, DC, June 23, 2010, <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?page=all>.

How Will ACOs Form?

Most ACO proposals assume that *leaders* in the provider community will come together to form an ACO and the ACO will solicit other providers in the community to voluntarily join the ACO to improve the quality of care provided and share in the resulting savings.¹⁰ While this is happening to some extent, the enactment of PPACA has encouraged these efforts as various health care providers seek to position themselves relative to newly formed ACOs.

Since ACOs are perceived as having the potential to alter the influence of primary care physicians, specialist physicians, hospitals, and payers vis-à-vis one another,¹¹ providers may be motivated to participate in ACOs for a variety of reasons. These include a sincere interest in improving quality of care and reducing costs, a desire to protect their place in the market or to ensure that they have a role in any collective decisions, to share in any cost savings, and to preserve their autonomy.

Existing ACO Models and Are They Replicable

ACOs are modeled on entities seen as quality leaders in health care, such as Kaiser Permanente, the Mayo Clinic, the Cleveland Clinic, and Geisinger Health System.¹² All of these exemplars are highly integrated providers, generally with staff models where physicians are employees of the health care organization. While the above entities are non-profit, there are for-profit models, such as HealthCare Partners Medical Group, with both a staff model and affiliated independent physician association (IPA),¹³ and the for-profit Permanente Medical Group that serves Kaiser Permanente. These integrated providers are paid in a variety of ways, including fee-for-service, capitation, and pay-for-performance,¹⁴ and the method of payment does not define the ACO.

It is important to recognize that proponents of ACOs have limited experience replicating the formation and experiences of these integrated providers in more varied organizational environments (see **Table 1**). The existing models for ACOs, Mayo, Geisinger, and Intermountain, for example, may have had the benefit of physicians self-selecting into a staff model of medical care where physicians are directly employed. New efforts may involve physicians being associated with, but not employed by, the ACO or involve physicians who may not warmly welcome the presence of ACOs but perceive pressure to participate. Such factors may influence the impact of ACOs because providers may be more likely to deviate from directives when they

¹⁰ For instance, in New Hampshire, the New Hampshire Citizens Health Initiative in 2010 issued an *Accountable Care Organization Call for Proposal* “to health care leaders in the State to ascertain interest and commitment to improving the value of health care delivery systems.” <http://www.unh.edu/chi/media/documents/NH-ACO-Call-for-Proposal.pdf>.

¹¹ Arlene Weintraub, “Community Hospitals Scramble To Survive, Stay Independent,” *USA Today*, September 9, 2010, Web edition.

¹² See Atul Gawande, “The Cost Conundrum: What A Texas Town Can Teach Us About Health Care,” *The New Yorker*, June 1, 2009, and Alain C. Enthoven, “Integrated Delivery Systems: The Cure for Fragmentation,” *The American Journal of Managed Care*, vol. 15, no. 10 (December 2009), pp. S284-S290.

¹³ A staff model is one in which the physicians are employees of the medical group. An independent physician group, in this context, involves the medical group contracting with independent physicians to provide services on behalf of the group as independent contractors rather than as employees.

¹⁴ There are a variety of mechanisms used to pay for medical services, including some hybrid models. In fee-for-service, a provider generally bills uniquely for each service provided. In a capitated model, a provider is paid a single amount for assuming responsibility for some or all of the care an individual or population may require. Pay-for-performance models (P4P) seek to compensate providers for better outcomes rather than additional services.

are either not directly employed or feel compelled to participate. Similarly, concern has been expressed that existing examples of ACOs may have unique and potentially nonreplicable characteristics such as an attractive patient population—generally less poor, healthier, and more likely insured.¹⁵

Table 1. Delivery Systems That Could Become Accountable Care Organizations

Model	Characteristics
Integrated delivery systems	<ul style="list-style-type: none"> • Own hospitals, physician practices, perhaps insurance plan • Aligned financial incentives • E-health records, team-based care
Multispecialty group practices	<ul style="list-style-type: none"> • Usually own or have strong affiliation with a hospital • Contracts with multiple health plans • History of physician leadership • Mechanisms for coordinated clinical care
Physician-hospital organizations	<ul style="list-style-type: none"> • Non-employee medical staff • Function like multispecialty group practices • Reorganize care delivery for cost-effectiveness
Independent practice associations	<ul style="list-style-type: none"> • Independent physician practices that jointly contract with health plans • Active in practice redesign, quality improvement
Virtual physician organizations	<ul style="list-style-type: none"> • Small, independent physician practices, often in rural areas • Led by individual physicians, local medical foundation, or state Medicaid agency • Structure that provides leadership, infrastructure, resources to help small practices redesign and coordinate care

Source: Health Affairs, *Health Policy Brief: Accountable Care Organizations*, Bethesda, MD, July 27, 2010, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=20.

ACOs also have somewhat limited experience in (1) dense urban areas, where insureds have the ability to obtain services more easily from a non-ACO provider, and (2) large rural areas where the ACO may be a virtual entity and there may be a limited sense of shared commitment across providers spread over a large geographic area. Finally, failed similar efforts often recede into the larger health care market and are rarely cited or studied.¹⁶

¹⁵ Alex MacGillis and Rob Stein, “Is the Mayo Clinic a Model or a Mirage? Jury is Still Out,” *The Washington Post*, September 20, 2009, Web edition.

¹⁶ For instance, see Liz Freeman, “HMA to buy Cleveland Clinic,” *Naples Daily News*, January 25, 2006, Web edition and Liz Freeman, “Physicians apply for medical privileges,” *Naples Daily News*, February 27, 2006, Web edition.

Similar Organizational and Payment Efforts

While the term *accountable care organization* may have a short, recent history, related organizational and payment efforts had been undertaken or were underway at the time of PPACA's enactment. These include the following:

Organizational

Health Maintenance Organizations (HMOs). A model of health care delivery in which an organization provides comprehensive healthcare to enrollees in a specific geographic area using a network of contracted physicians, often with capitated payments, and limits referrals outside the network.¹⁷ An ACO has several features in common with an HMO but the ACO does not limit out-of-network referrals and the insured's relationship to the ACO is far more tenuous than to an HMO.

Medical Homes. "A medical home is an approach to providing primary care where the personal physician has responsibility for the ongoing care of the patient as well as providing and managing the patient's health care needs with other professionals."¹⁸ ACOs are distinguishable from the medical home model which typically emphasizes preventive and primary care or chronic care management and often excludes specialists and hospitals. ACOs typically manage the full continuum of care for its members."¹⁹ The medical home model is compatible with the ACO model and medical homes could affiliate with an ACO just like any other primary care provider or several medical homes could form the nucleus for an ACO.

Organizational and Payment

The Medicare Physician Group Practice Demonstration. "Mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554), and started in 2005, creates incentives for physician groups to coordinate the overall care delivered to Medicare patients, rewards them for improving the quality and cost efficiency of health care services, and creates a framework to collaborate with providers to the advantage of Medicare beneficiaries."²⁰ This demonstration is similar to an ACO model but the demonstration is limited to ten physician group practices.

The Medicare Health Care Quality Demonstration. Established in 2003 by the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173, MMA), this demonstration was designed "to examine the extent to which major, multi-faceted changes to traditional Medicare's health delivery and financing systems lead to improvements in the quality of care provided to Medicare beneficiaries, without increasing total program expenditures."²¹ Three demonstrations have been funded by the Centers for Medicare & Medicaid Services (CMS) and each is similar in some manner to an ACO—for instance, the Gundersen Lutheran demonstration involves shared savings.²²

Payment

Pay for Performance. "Pay-for-performance schemes provide financial incentives to health care providers to achieve specified performance/quality targets linking physician pay to the quality of care provided."²³ Unless bonuses

¹⁷ Modified definition from Stephen M. Shortell, Lawrence P. Casalino, and Elliott Fisher, *Implementing Accountable Care Organizations*, Berkeley Center on Health, Economic and Family Security, Berkeley, CA, May 2010, p. 16. http://www.law.berkeley.edu/files/chefs/Implementing_ACOs_May_2010.pdf.

¹⁸ Rural Assistance Center, *Medical Homes Frequently Asked Questions: What is a Medical Home?* http://www.raconline.org/info_guides/medicalhomes/faq.php.

¹⁹ Baker & Hostetler, "Health Law Update," June 24, 2010, <http://www.bakerlaw.com/health-law-update-june-24-2010>.

²⁰ https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf, July 21, 2010.

²¹ https://www.cms.gov/DemoProjectsEvalRpts/downloads/MMA646_IHIE_Fact_Sheet.pdf, July 21, 2010.

²² Descriptions of the three demonstrations can be found at <http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS023618&intNumPerPage=10> for

²³ Tim Doran and Catherine Fullwood, "Pay for performance: Is it the best way to improve control of hypertension?" *Current Hypertension Reports*, vol. 9, no. 5 (October 2007).

²⁴ Aaron McKethan, Mark McClellan, Elliott Fisher et al., *Moving from Volume-Driven Medicine Toward Accountable Care*, Health Affairs, Health Affairs Blog, August 20, 2009, <http://www.healthaffairs.org/blog>.

²⁵ Rand Corporation, *Overview of Bundled Payment*, Policy Options, <http://www.randcompare.org/policy-options/bundled-payment>.

²⁶ Baker & Hostetler, "Health Law Update," June 24, 2010, <http://www.bakerlaw.com/health-law-update-june-24-2010>.

are paid out of a withhold pool, they “often add to total costs by paying out incremental bonuses in exchange for meeting certain benchmarks on process measures. ACOs place a much greater emphasis on measuring and rewarding results at the level of a population of patients—not at the level of particular services or episodes that may or may not add up to higher-value care.”²⁴

Bundled Payments. “Bundled payment systems (also known as “case rates” or “episode-based payment”) provide a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings.”²⁵ ACOs differ from the bundled payment such as the Medicare End-Stage Renal Disease Bundled Payment Demonstration Project To Evaluate Integrated Care Around A Hospitalization, (MMA, § 623(e)) since ACOs seek to “promote efficiency and care on a continuing basis rather than focusing on a single medical episode.”²⁶

Which Providers Are Involved?

While there is general consensus that ACOs seek to integrate a range of providers, there has been an evolution regarding which providers need to be brought into an ACO and whether hospital participation is fundamental to ACOs. While the idealized list of participants from four often-cited ACO proposals are presented below, current thinking is that the composition of ACOs may vary geographically, reflecting local market conditions.²⁷ However, regardless of which organizations or individuals are involved, analysts have concluded that the effort needs to be provider-led.²⁸

- In an early hospital-centric model, from 2007, developed by Elliott Fisher and his colleagues,²⁹ ACOs were envisioned as a hospital medical staff model in which a hospital and its extended medical staff (those individuals who work within the hospital, those organizations which primarily refer to the hospital, and those providers for whom a majority of their patients are admitted to the hospital), form the basis of an organization responsible for system performance, improving health care quality, and reforming payment.
- In 2008, the Congressional Budget Office (CBO) described a bonus-eligible organization (BEO) model of ACO which was not hospital-centric. The BEO was envisioned to be providers or 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.³⁰

²⁷ See Kelly Devers and Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?* Robert Wood Johnson Foundation and Urban Institute, Washington, DC, October 2009, p. 3, <http://rwjf.org/files/research/acobrieffinal.pdf> and Alain C. Enthoven, “Integrated Delivery Systems: The Cure for Fragmentation,” *The American Journal of Managed Care*, vol. 15, no. 10 (December 2009), p. 289.

²⁸ As discussed in section 4 below, PPACA specifies that physicians, physician assistants, nurse practitioners, clinical nurse specialists (collectively referred to as “ACO professionals”) in either group practices or networks of individual practices; partnerships or joint ventures of ACO professionals and hospitals; hospitals employing ACO professionals; and other groups of providers of services and suppliers as the Secretary determines are eligible to participate as ACOs.

²⁹ See Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum et al., “Creating Accountable Care Organizations: The Extended Hospital Staff Model,” *Health Affairs*, vol. 26, no. 1 (January/February 2007) W44-W57. Elliott Fisher, Director of the Center for Health Policy Research at the Dartmouth Medical School, and Mark McClellan, former CMS administrator, formed the Dartmouth-Brookings Partnership and the Accountable Care Organization learning Collaborative. Dr. Fisher is generally credited with the term “accountable care organization.”

³⁰ Congressional Budget Office (CBO), *Budget Options Volume I; Health Care*, Washington, DC, December 2008, pp. 72-74, <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.

- MedPAC described an option for a hospital-centric model of an ACO in 2009 as one that “would consist of primary care physicians, specialists, and at least one hospital. It could be formed from an integrated delivery system, a physician-hospital organization, or an academic medical center.”³¹
- By 2010, the earlier Fisher proposal had been transformed from a hospital medical staff model to a non-hospital-centric model that “involves broad participation and encourages hospitals to participate” but one in which “hospital participation is not an absolute requirement.”³² In this proposal an ACO can include a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations.³³

Five ACO Delivery Models

Table 1 illustrates the various delivery systems that could form the basis for an ACO, however, there is not an archetype organization that one could name associated with each of the model types. In addition to the models listed in **Table 1**, insurers are now entering the market and evaluating the role they may play within the ACO framework. For instance, both Blue Cross Blue Shield of Massachusetts and Anthem Blue Cross have contracted as ACOs with provider groups in their service regions.³⁴ In other markets, insurers such as Cigna are working with physician groups to form ACOs.³⁵

These five models, and even entities within a model type, are likely to vary by the degree of integration, the role of hospitals, the mix of staff and non-staff physicians, and the sense of a shared commitment to the goals and aspirations of the ACO. In addition, other models may emerge as specialist physicians, who often provide primary care as well as specialty medical services, seek to maintain or improve their market position vis-à-vis other providers and payers.³⁶

There are several reasons to believe that hospitals are likely to be integral to ACOs. Given that over 30% of all health care expenditures in 2008 were hospital expenditures,³⁷ it may be difficult for an ACO to control costs without having a hospital as a participant. In addition, ACOs may

³¹ See Medicare Payment Advisory Commission, “Report to Congress: Improving Incentives in the Medicare Program,” Washington, DC, June 2009, p. 39, http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

³² Mark McClellan, Aaron N. McKethan, Julie L. Lewis et al., “A National Strategy to Put Accountable Care into Practice,” *Health Affairs*, vol. 29, no. 5 (May 2010), p. 983.

³³ An independent physician association is a group of independent physicians that contract with one or more insurers to provide medical care for a population of insureds.

³⁴ Ken Terry, “Accountable Care Organizations’ Promise Better Medicine for Lower Cost - If They Work,” *BNET The CBS Business Network*, June 11, 2010, <http://www.bnet.com/blog/healthcare-business/-8220accountable-care-organizations-8221-promise-better-medicine-for-lower-cost-8212-if-they-work/1432>.

³⁵ Leigh Page, “12 Points on Private Payor CIGNA’s Plans for ACOs,” *Becker’s Hospital Review*, September 30, 2010. <http://www.beckershospitalreview.com/hospital-physician-relationships/12-points-on-private-payor-cignas-plans-for-acos.html>.

³⁶ Despite the emphasis on primary care providers, depending on how the regulations are drafted, there is likely to be considerable interest among specialty groups to form ACOs even if they need to assume responsibility for the entire continuum of care.

³⁷ <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>, Table 2.

require a significant capital investment in their formative years, prior to earning any shared savings, and hospitals are a potential source for these funds.³⁸ For instance, ACOs are likely, at a minimum to need to (1) hire staff; (2) acquire unique health information technology, beyond the \$22 billion contained in the American Recovery and Reinvestment Act and other investments (P.L. 111-5), that can monitor performance and document improvements in quality across ACO participants; (3) retain legal counsel to contract with the Secretary to participate in the program and to recruit and contract with providers; and (4) develop and disseminate care protocols.³⁹ Again, those hospitals which are large sophisticated organizations are potentially well positioned to lead these efforts since they can exert some control over a sizable part of health care expenditures and they have capital.

Section 2: How Are ACOs Supposed to Work?

Just as there are different notions of which providers are essential to an ACO, there are different ideas of how ACOs should work. The discussion below focuses on the simplest arrangements to highlight the features of an ACO and on the several relationships that exist involving ACO and payers (Medicare, Medicaid, and private insurers), ACO and providers, and ACO and insureds (referring generally to either beneficiaries under Medicare or Medicaid or individuals covered by private insurance).

The Relationship Between the ACO and Payers

An ACO's principal function is to take responsibility for some or all of the medical care delivered to a population of patients.⁴⁰ For an ACO to *take responsibility for a defined population of patients*, it is assumed that the ACO will contract with payers on behalf of its affiliated providers⁴¹ and that the ACO will not get to pick and choose individual patients from within the defined population based on health status. For example, a payer and an ACO may agree that the ACO will take responsibility for all of the payer's insureds who received more than 50% of their primary care from a physician or group of physicians affiliated with the ACO. In this example, the ACO and payer need to agree on the following:

³⁸ The potential capital costs are sufficiently large that Miller has suggested that ACOs may require loans or front-loaded payment arrangements to deal with these investments. Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, Pittsburgh, PA, September 7, 2009, p. 35. <http://www.createhealthcarevalue.com/data/blog/HowtoCreateAccountableCareOrganizations1.pdf>.

³⁹ Some proponents anticipate that ACOs may have costs marketing to and communicating with patients of its affiliated providers. Others have suggested that ACOs be paid for demonstrating "sustained savings" (see the comments of Dr. Stuart at the September 13, 2010, MedPAC Public Meeting, <http://www.medpac.gov/transcripts/913-914MedPACfinal.pdf>, p. 72). The more regulations require ACOs to do up front (marketing or compensating insureds) or the longer any process defers bonus payments, the more difficult it may be to form ACOs.

⁴⁰ The more care the ACO is responsible for, the less likely the ACO is in the position to shift costs beyond its areas of responsibility. Hence, many ACO descriptions refer to the "entire continuum of care."

⁴¹ Kaiser Permanente, and other insurer based models, would be exceptions since the payer and ACO may be the same entity.

- the historic cost of care for this population (referred to as the “benchmark”);
- a formula to calculate anticipated changes in health care costs for this population due to such factors as increases in medical care costs, aging, or changes in health status;
- a targeted savings rate that will trigger payments to the ACO; and
- certain quality measures that the ACO will need to demonstrate have been met.

In this example, the ACO is responsible for *all* medical care, and therefore the ACO would be responsible for coordinating the entire continuum of care from primary to post-acute. To the extent that one entity is responsible for all care, responsibility is unambiguous and care can be fully coordinated.

If actual medical expenditures are less than the benchmark, adjusted for changes in costs, savings exceed the target, and quality measures are met, the ACO, and either directly or indirectly its providers, will share in the savings realized by the payer.

In its simplest form, using Medicare fee-for-service as an example, an ACO would *take responsibility for a defined population of patients*—in this example, all Medicare beneficiaries in the region who received a majority of their primary care in the prior year from providers affiliated with the ACO would be assigned to the ACO. The ACO and Medicare would agree on a benchmark amount of total medical expenditures that reflected historic patterns of spending adjusted by any forecast growth in costs over the agreement period and any other risk adjustments that the ACO and Medicare agreed to, such as age, gender, or the population’s health status. In addition, the ACO and Medicare would identify quality measures that either needed to be met or improved upon.⁴² Providers would continue to file claims with Medicare on behalf of their patients, and Medicare would pay those claims as if the ACO did not exist. If quality measures were achieved and actual Medicare expenditures were less than anticipated expenditures, by at least the targeted amount, the ACO would be eligible to share in Medicare’s saving according to some agreed formula.

In the example above, the ACO and its providers assume no risk related to either the amount that they receive for provided services or the total cost of medical services provided. That is, the ACO is not penalized in any manner if no savings are achieved and providers are paid the full Medicare fee-for-service payment regardless.

There are other payment models that payers and ACOs could adopt that could involve *risk sharing*. In order to include risk sharing in the above example, Medicare could pay providers 95% of the fee-for-service payment and set aside the difference, a 5% withhold, to be paid later, along with a proportion of the shared savings, if quality and expenditure targets were reached. The withhold and savings would be paid to physicians who elected to participate in the ACO, and their share of the savings would be governed by the ACO’s internal policies and its agreements with participating physicians. This model creates greater incentives for providers to achieve

⁴² There are competing perspectives on whether ACOs should be required to meet absolute quality objectives or demonstrate improvement relative to their own past performance. See “Negotiations Over ACO Rule Heat Up As Quality Coalition Urges Changes” *InsideHealthPolicy.com Daily News*, August 19, 2010, <http://insidehealthpolicy.com/201008192049189/Health-Daily-News/Daily-News/negotiations-over-aco-rule-heat-up-as-quality-coalition-urges-changes/menu-id-212.html>.

targeted reductions. Additional risk and incentives can be transferred to the ACO under other models, such as capitation—where a provider is paid a fixed amount per person and is responsible for the cost of all of the care required to be provided.⁴³

The ACO model explicitly couples quality and savings and generally requires providers to achieve savings while maintaining or improving quality. For instance, in the CBO's description "[ACOs] would be eligible to receive a bonus only if they met a set of quality performance measures and expenditure saving targets."⁴⁴ The linking of quality and savings in this manner may assume that as quality increases, costs decline. However, there are likely to be desirable and costly quality improvements that do not produce savings which may need to be paid for directly. While it is likely that initial quality measures may be relatively limited process-oriented measures, such as compliance with screening and preventive service guidelines, payers are likely to ratchet-up quality improvements and reporting requirements over time if they anticipate a financial return or as validated outcome measures become more readily available.⁴⁵

The Relationship Between the ACO and Providers

While there is no requirement that providers affiliate with an ACO, any relationship between an ACO and its providers more than likely will be governed by a contract that specifies the obligations of both parties and how providers share in any savings. There can be multiple ACOs in a community, and conceivably a provider could be a member of one with respect to the practice's Medicare beneficiaries and a member of another with respect to a private insurer's population of insureds.⁴⁶ Once a provider affiliates with an ACO, the provider brings all of his or her patients from the defined population (be it Medicare, Medicaid, or a private insurer) to the ACO. It is further assumed that the ACO will be composed of providers that tend to refer to one another (either admitting to the same hospital or referring to a common set of specialists).

⁴³ MedPAC has analyzed issues associated with risk sharing and the implications of varying sizes of ACOs. See Medicare Payment Advisory Commission, *Transcript of Public Meeting*, September 13, 2010, <http://www.medpac.gov/transcripts/913-914MedPACfinal.pdf>.

⁴⁴ See Congressional Budget Office (CBO), *Budget Options Volume I; Health Care*, Washington, DC, December 2008, pp. 72-74, <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>, for the CBO's calculation of shared savings.

⁴⁵ Some proponents have suggested that one area where quality can readily be monitored and improved is rehospitalizations. While not all claims associated with rehospitalizations are avoidable and there are costs to avoiding a rehospitalization, "the cost to Medicare of unplanned rehospitalizations in 2004 was \$17.4 billion." If ACOs had greater responsibility for a longer interval surrounding hospitalizations, from 4 days prior to a hospitalization to 30 days following a hospitalization, the interests of physicians and hospitals could be better aligned and the two may be better able to coordinate post-acute care and reduce the high rate of rehospitalization (19.6% within 30 days) among Medicare beneficiaries. See CRS Report R40972, *Medicare Hospital Readmissions: Issues, Policy Options and PPACA*, by Julie Stone.

⁴⁶ There is insufficient experience to know the optimal size for an ACO or the optimal number of ACOs in any region. MedPAC and others have suggested that an ACO should have more than 5,000 Medicare enrollees to reduce the random variation in year to year health care expenditures in any pool of patients that might complicate the calculation of both a baseline level of expenditures and actual expenditures. Hussey et al., ("Episode-Based Performance Measurement and Payment: Making It A Reality," *Health Affairs*, vol. 28, no. 5, p. 1406-1417) suggest that 5,000 may be appropriate to hold organizations accountable for more common conditions but larger numbers would be required to hold organizations accountable for rarer events such as heart failure. MedPAC analysis suggests that 5,000 Medicare enrollees may not be adequate to avoid mistakenly paying some ACOs for reductions in costs that occurred by chance (see David Glass and Jeff Stensland, *Medicare Shared Savings Program for ACOs*, Medicare Payment Advisory Commission, prepared for the September 13, 2010, public meeting, Washington, DC).

To generate shared savings, the ACO, working with its affiliated providers can, among other things, seek to⁴⁷

- reduce the unnecessary or duplicative use of services;
- develop or adopt existing care protocols to improve coordination of care and management of diseases, increase preventive services, and encourage early diagnosis;
- improve information flows within the ACO;
- promote lower-cost treatment options;
- benefit from economies of scale in the purchase of goods and services;
- reduce preventable emergency department visits and rehospitalizations;
- coordinate the purchase and use of expensive equipment; and
- coordinate the hiring of some specialists to optimize organizational efficiency.

Because an ACO includes a range of providers, some large and potentially influential (such as large medical groups or hospitals) and some smaller and less prominent (such as sole practitioners and small practices), some proposals envision that the ACO will be a separate and distinct legal entity with a shared decision-making structure to ensure that some providers, hospitals, or large practice groups do not dominate internal decision making. Others envision hospitals or physician groups morphing into ACOs.⁴⁸

An unresolved issue at this point is how these shared savings would be distributed to providers within the ACO after it has covered its costs and any return of capital from the organizers. For instance, how much of the savings associated with better primary care/specialist treatment are attributable to the actions of the primary care doctors as compared to the actions of the specialists? In an integrated staff model of health care organization, these potential disputes generally are muted somewhat by the employment relationship and certainty of salary, but in a virtual ACO or less integrated ACO, these divisions are likely to be more contentious. In addition, the ACO may need to decide who can affiliate with it and which cost savings efforts should be pursued. Since these types of decisions touch on earnings and livelihoods, they are also potentially contentious.

The Relationship Between the ACOs and Insureds

For proponents of ACOs, one attractive feature of the ACO model is that it does not place a new entity between providers and patients since patients continue to deal with the health care system through their regular sources of care. The provider, in turn, now has a relationship with the ACO, and the ACO has a relationship with the payer. While the ACO is accountable for the total cost of medical care consumed by those for whom it has assumed responsibility, insureds in most ACO models are not constrained by the ACO as to where they get their care (either primary care

⁴⁷ Some ACO activities may have antitrust or other legal and regulatory constraints, which are beyond the scope of this report.

⁴⁸ Section 3022(b) provides that the ACO have a “formal legal structure that would allow the organization to receive and distribute payments for shared savings.”

providers or specialists) or to which hospitals they can go. The ACO is not a closed network or gatekeeper and the insured, in most models, never affirmatively enrolls in the ACO.⁴⁹

As described above, a provider *brings* patients to an ACO when the provider affiliates. Under this model, the insured is essentially automatically enrolled in the ACO as part of the provider affiliating.⁵⁰ Since the activities of the ACO do not constrain the choices of the insured (individuals may continue to see any provider), nor do they alter the costs to the insured (there are no differential prices for in-ACO or out-of-ACO providers), the insured has no basis for selecting an ACO or for opting-in or opting-out of an ACO. Moreover, in some models, annual assignment to an ACO takes place retrospectively, based on actual patient-provider associations, so insureds are not in an ACO at the time that they receive services. The retrospective assignment of individuals to an ACO also means that a group of providers will generally not be held responsible for individuals who were not actually affiliated with the ACO because they received most of their care from other providers. In addition, retroactive assignment encourages physicians to treat all patients in a cost-effective manner since they will not know until later whether any particular patient will be assigned to their ACO.

Finally, some suggest that if there are savings to be realized, the consumer should share in these along with the insurer and providers.⁵¹ Others maintain that while the insurer and provider benefit monetarily, consumers benefit from improved quality of care and no further benefit needs to be conferred on the consumer. If consumers insists on receiving a share of savings, or ACOs want to share savings with Medicare beneficiaries, a whole host of issues emerge, including the effect of anti-kickback provisions of Medicare,⁵² as well as questions about when beneficiaries should receive payments and the size of payments necessary to align beneficiaries' interests to conform to care protocols or accept lower-cost equivalent quality services. It should be noted that while the Medicare program, through Medicare Advantage, already offers a form of *shared savings* to enrollees when plans reduce cost sharing below the 20% coinsurance generally found in traditional Medicare, the decision as to whether to enroll in Medicare Parts A or B or enroll in a Medicare managed care plan are likely to be made based on a variety of factors. However, sharing savings with Medicare beneficiaries may blur some of the distinctions between ACOs and Medicare Advantage.⁵³

⁴⁹ In the private sector, the insured is still governed by the insurance contract between the insurer and the insured, and this contract may impose constraints such as differential coinsurance depending on whether an insured sees an in-network or out-of-network provider.

⁵⁰ PPACA provides that the Secretary shall determine the process for assigning Medicare beneficiaries to an ACO and draft regulations have not been released as of the date of this report. During the public MedPAC meetings, several MedPAC commissioners have spoken in favor of giving Medicare beneficiaries the right to opt-out of participating in any Medicare ACO that their provider may choose to join.

⁵¹ Jeff Goldsmith, "The Accountable Care Organization: Not ready for Prime Time," *Health Affairs Blog*, <http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/print/>, August 17, 2009.

⁵² "Under the federal anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., 'remuneration') in return for a referral or to induce generation of business reimbursable under a federal health care program. The statute prohibits both the offer or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for, or recommending the purchase, lease, or ordering of any item or service that is reimbursable by a federal health care program." See CRS Report RS22743, *Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview*, by Jennifer Staman.

⁵³ If Medicare ACOs are required to enroll Medicare beneficiaries into an ACO (see Section 5) and in some manner potentially share savings with beneficiaries, the line between ACOs and Medicare Advantage plans may erode and (continued...)

Section 3: Essential Provisions of § 3022 of PPACA

Section 3022 of PPACA directs the Secretary to establish a Medicare Shared Savings Program by January 1, 2012. The goals of this section of the law are, in part, to promote the formation of ACOs and “encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery” (§ 3022(a)(1)).⁵⁴ The section applies only to items and services provided under Medicare Part A (hospitalization insurance) and Part B (medical insurance).⁵⁵

PPACA delegates the formulation of many of the details concerning ACOs to the Secretary, including which entities can be an ACO, what requirements will be imposed on ACOs, and what they will need to achieve prior to receiving their share of any shared savings. Section 3022(c), however, does specify:

The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided by ACO professionals.

First, the CBO, in its discussion of ACOs (referred to as BEOs prior to the passage of PPACA), estimated that within two years of implementation, 20% of fee-for-service Medicare beneficiaries would be assigned to participating primary care physicians and that 40% would be assigned by 2019.⁵⁶ Therefore, while a large number of Medicare beneficiaries are likely to participate in an ACO, the majority, for a variety of reasons, likely will not. Second, the statute directs the Secretary to determine a method to *assign* beneficiaries to ACOs. While the Secretary has the authority to determine a method that permits Medicare beneficiaries to elect to participate, participation does not otherwise appear to be voluntary. Finally, the statute is silent as to whether the assignment is prospective, with Medicare beneficiaries each year being *assigned* for the following year based on last year’s patterns of utilization, or retrospective, with Medicare beneficiaries assigned this year for the prior year based on actual patterns of utilization in the prior year. There are advantages and disadvantages to both prospective and retrospective assignment, as discussed below.

The following groups of providers of services or suppliers which have established a mechanism of shared governance are eligible to participate in the Medicare Shared Savings Program:

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists in either group practices or networks of individual practices.
- Partnerships or joint ventures of physicians, physician assistants, nurse practitioners, clinical nurse specialists and hospitals.

(...continued)

CMS may want to consider whether ACOs need to be subject to regulations similar to those applicable to Medicare Advantage plans.

⁵⁴ ACOs are not limited to Medicare and can offer their services to other payers, including Medicaid and private insurers, that may be willing to contract with them.

⁵⁵ The Affordable Health Care for America Act, H.R. 3962, would have allowed the Secretary to include Medicare Part D services, if appropriate.

⁵⁶ Note that the CBO assumed that the program would begin January 1, 2013, whereas PPACA directs the Secretary to establish the shared savings program by January 1, 2012, hence the timeframe for the CBO estimates does not align perfectly to PPACA, nor does it incorporate all of the other elements contained in PPACA.

- Hospitals employing physicians, physician assistants, nurse practitioners, clinical nurse specialists.
- Other groups of providers of services and suppliers as the Secretary determines.

The requirement that the ACO have a mechanism for shared governance may be an attempt to keep physicians, physician assistants, nurse practitioners, and clinical nurse specialists at the core of the ACO and not have it be dominated by the larger health care providers in a community. Unless addressed by the Secretary, this requirement, however, may be muted by hospitals acquiring primary care practices or health plans adopting staff models that convert physicians, physician assistants, nurse practitioners, clinical nurse specialists into employees.⁵⁷

In addition, the statute specifies that an ACO must, among other things,

- be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it;
- agree to participate in the program for not less than three-years (the “Agreement Period”);
- have a formal legal structure that would allow the organization to receive and distribute shared savings to providers of services and suppliers;
- include primary care physicians, physician assistants, nurse practitioners, clinical nurse specialists in sufficient numbers to serve assigned ACO beneficiaries;
- have at least 5,000 fee-for-service Medicare beneficiaries assigned to it;
- establish a leadership and management structure that includes clinical and administrative systems; and
- develop processes that promote evidence based medicine, patient engagement, report on quality and cost measures, and coordinate care.

Providers of services or supplies may be paid in the same manner as other Medicare providers of services or supplies but share in any savings resulting from reduced utilization. PPACA directs the Secretary to establish a *savings requirement*, the amount that the ACO has to reduce average per capita Medicare expenditures by, before the ACO can share in the savings. Actual spending is compared to a benchmark, established by the Secretary, that is based on the “most recent available 3-years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.” In addition, the benchmark is adjusted by beneficiary characteristics and the projected absolute growth in national per capita expenditures for Parts A and B services. Again, the requirements relating to quality and the exact formula for bonus payments still need to be developed by the Secretary.

Alternatively, Section 3022 of PPACA, as amended by Section 10307 of the Health Care Education and Reconciliation Act of 2010, P.L. 111-152, authorizes the Secretary, as appropriate, to use a partial capitation model for ACOs that are highly integrated and capable of bearing the

⁵⁷ Noam N. Levey, “Healthcare law has more doctors teaming up,” *Los Angeles Times*, July 28, 2010, <http://www.latimes.com/news/health/healthcare/la-na-health-doctors-20100728,0,2722731.story>.

risk.⁵⁸ In addition, Section 10307 allows the Secretary to use other payment models that improve the quality and efficiency of items or services furnished to Medicare beneficiaries. These alternative payment mechanisms, which may include payment withholding and other forms of risk-sharing, are designed to fund larger financial incentive payments that encourage greater support for ACO initiatives.

Section 4: Potential Advantages and Limitations of ACOs

Perhaps the most commonly made argument in support of ACOs begins with the premise that the current medical system offers fragmented services across providers (an absence of coordinated care), pays for units of service rather than outcomes, and holds no one organization or individual responsible for either the quality or cost of care provided. The ACO model highlights the need for change that simultaneously alters the financing and delivery of care to align incentives among providers. For instance, there is some evidence to suggest that when fees for services are reduced without altering models of delivery, providers compensate by rendering more units of services and less savings are realized.⁵⁹ Similarly, introducing new models of care, such as medical homes, requires changes in payments to encourage providers to implement these new service models. ACO proponents, in essence, say that there is a need to change both care and payments at the same time—we need to bring together Medicare providers of services and supplies, hold them accountable for the services they provide, and reward them for reducing costs and good performance.

A second argument in support of ACOs is that introducing accountability and integration in the health care system may improve access to care; increase efficiency by reducing unnecessary investment, testing, referrals, and medication; improve quality, outcomes, and patient experience; and reduce costs. For ACO proponents, the current system is not sustainable, new models of delivery are needed, and the ACO model is one that many stakeholders appear to be willing to initially embrace.

Another argument in favor of ACOs is that they have been designed to avoid at least three features of health care delivery systems that often concern the public:

- First, a perception that insurance companies are positioned between patients and their health care providers. While health plans owned by insurance companies conceivably could form the basis of an ACO, the ACO model is:

really designed to shift some of the responsibility for costs from health insurers to health care providers. Insurance plans would retain responsibility

⁵⁸ In a partial capitation model, a part of a provider's compensation is a function of a fixed-flat rate per patient and a part is based on another payment mechanism.

⁵⁹ See for example, Suzanne M. Codespote, William J. London, and John D. Shatto, Estimated Volume-and-Intensity Response to a Price Change for Physicians' Services. Memorandum to Richard S. Foster, Chief Actuary, Centers for Medicare & Medicaid Services, 1998, <http://proquest.umi.com/pqdweb?index=6&did=1970670331&SrchMode=3&sid=1&Fmt=6&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1281357481&clientId=45714&aid=1>. For a contrasting perspective, see Jack Hadley, James Reschovsky, Catherine Corey et al., "Medicare Fees and the Volume of Physicians' Services," *Inquiry*, vol. 46, no. 4 (Winter), p. 372–390.

for insurance risk—the risk that a pool of insureds will need medical care and the severity of their needs while the ACO is responsible for performance risk—the variability in the costs of treating individuals with the same level of disease severity.⁶⁰

Therefore, within the ACO model the role for insurers is not expanded; however, as noted, insurers may form ACOs.

- Second, a return to the 1980s and that era’s model of managed care and health maintenance organizations. Since many Americans prefer to remain outside of organized health plans, particularly seniors in Medicare,⁶¹ the ACO model does not require that Medicare beneficiaries actually join a health plan. Rather, since Medicare beneficiaries will be assigned by a mechanism developed by the Secretary, there is no necessary requirement that beneficiaries be informed that they are part of an ACO and in fact they may never know that they are assigned to a panel.⁶²
- Third, closed panels of providers with potentially differential pricing depending on whether a provider is in or out-of-network. Many Americans have expressed a clear preference for open panels of providers, where they can select their own doctors, without any difference in copayments, rather than closed panels with lower coinsurance when one sees an in-network provider and a higher copayment when one goes out-of-network. While physicians and other health care providers and suppliers may be aware of which providers are in-network and which providers are out-of-network, the Medicare beneficiary assigned to an ACO can pick and choose his or her providers without regard to either a network or differential cost.⁶³

ACOs have detractors and ACOs have raised concerns among policy analysts. Randall Brown of Mathematica Policy Research, for instance, has described ACOs as

much like an HMO, but without any real authority. Medicare Advantage plans (HMOs and PPOs) have generally shown themselves to be poor role models for efficiency or delivering higher quality than fee-for-service, despite the appeal of having one entity being responsible for delivery of the full range of health care services to a defined population of patients. Other forms of Medicare Advantage plans, such as private fee-for-service (PFFS) plans, are even less efficient. Furthermore, the logistics of how such a system would or could work

⁶⁰ Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, Pittsburgh, PA, September 7, 2009, <http://www.createhealthcarevalue.com/data/blog/HowtoCreateAccountableCareOrganizations1.pdf>.

⁶¹ In 2010, about 24% of Medicare beneficiaries have elected to join a Medicare Advantage plan. <http://www.kff.org/medicare/upload/2052-14.pdf>.

⁶² The House Tri-Committee’s proposal, the America’s Affordable Health Choices Act of 2009, required that beneficiaries be informed of their assignment to an ACO, whereas the Senate Finance Committee’s America’s Healthy Future Act of 2009 did not stipulate that beneficiaries be informed. See Kelly Devers and Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?* Robert Wood Johnson Foundation and Urban Institute, Washington, DC, October 2009, p. 6, <http://rwjf.org/files/research/acobriefinal.pdf>.

⁶³ While a private insurer could offer different incentives for insureds to use in-network providers, these incentives would come from the insurer and not the ACO. It may be the case that a private insurer employing an ACO to control costs and improve quality would coordinate its efforts such that the ACO network and in-network providers were similar.

anywhere, except perhaps in a small community where physicians are salaried (and therefore have no financial incentive to overuse services), are unclear. As Fisher and colleagues note, there are significant cultural, legal, and practical obstacles to this model. Saving money will require reducing hospital use and unnecessary services provided by physicians; the pie has to shrink. Battle lines will quickly form on which provider's piece will take the biggest hit, and it is unclear who will wield the actual authority in making those decisions. The failure of HMOs to achieve similar promise should be a warning sign, and how accountable health organizations will avoid the same fate is unclear.⁶⁴

While the ACO needs to implement an internal governance structure, as directed by statute, there are concerns on the part of some critics, including University of Virginia professor Jeff Goldsmith, as to whether primary care doctors and specialists practicing in varying arrangements, hospitals, and other providers truly share enough in common to coordinate care and reduce costs.⁶⁵ Goldsmith also notes that

- past efforts at forming integrated networks of providers, real or virtual, had the consequence of concentrating provider networks (either hospitals or physicians) that can effectively raise prices when negotiating with private insurers; and
- consumers have repeatedly and strongly expressed their preference for open networks rather than hospital/physician based risk bearing organizations.

A recent study by Berenson, Ginsburg, and Kemper (2010) of the California health care market, a location where ACOs are common, warns that while Medicare may benefit from the introduction of ACOs, the larger health care system could be negatively affected because the consequences of ACOs may not be limited to Medicare. They conclude, based on their study of California, that “if accountable care organizations lead to more integrated provider groups that are able to exert market power in negotiations—both by encouraging providers to join organizations and by expanding the proportion of patients for whom provider groups can negotiate rates—private insurers could wind up paying more, even if care is delivered more efficiently.”⁶⁶

A potential limitation of the Medicare Shared Savings Program is that it addresses items and services only under Medicare Parts A and B. Medicare Part D prescription drug benefits in 2010 are estimated to be slightly more than 11% of all Medicare benefits, and ACOs are not initially responsible for these expenditures as part of the Medicare Shared Saving Program. As Crosson has suggested, “it may be useful to consider models in which Part D benefits are incorporated into payment design,”⁶⁷ particularly as there may be instances where there is the appearance of cost

⁶⁴ Randall Brown, *Strategies for Reining in Medicare Spending Through Delivery System Reforms: Assessing the Evidence and Opportunities*, The Henry J. Kaiser Family Foundation, Washington, DC, September 2009, p. 5. <http://www.kff.org/medicare/upload/7984.pdf>.

⁶⁵ Jeff Goldsmith, “The Accountable Care Organization: Not ready for Prime Time,” *Health Affairs Blog*, <http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/print/>, August 17, 2009. Also note the fractious environment between the hospital and physician group at City of Hope National Medical Center has been held out as “a harbinger of things to come under health care reform.” Patrick J. McDonnell, “City of Hope’s reorganization plan creates rift with doctors group,” *Los Angeles Times*, September 22, 2010, <http://www.latimes.com/news/local/la-me-city-hope-20100922,0,5277469>.

⁶⁶ Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper, “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” *Health Affairs*, vol. 29, no. 4 (April 2010), p. 700.

⁶⁷ Francis J. Crosson, “Medicare: The Place to Start Delivery System Reform,” *Health Affairs*, Web Exclusive January 27, 2009, pp. W232-W234.

savings as a result of providers unduly relying on Part D prescription medicines over other forms of care.

Section 5: Discussion and Likely Impact of PPACA § 3022

Scope of ACOs and Likely Savings

The CBO scored the Medicare Shared Savings Program as reducing Medicare expenditures \$4.9 billion over the FY2013 through FY2019 period.⁶⁸ The CBO also estimated, in 2008 and prior to PPACA, that within two years of implementation of an ACO-type program, 20% of fee-for-service Medicare beneficiaries would be assigned to participating primary care physicians and that 40% would be assigned by 2019.⁶⁹ The CBO assumes that the savings to Medicare from BEOs would decline over time, in part because as quality improved, more ACOs would be paid their share of any resulting savings. While these projected savings are perhaps an argument in support of ACOs, the size of these savings are also a caution. ACOs have the potential to significantly change the structure of health care markets, with potential unintended consequences, and consolidation around ACOs in the publicly financed part of the health care market may increase costs in the private, non-government, part of the health care market because of consolidation among providers.

Actual Source of Potential Savings

MedPAC maintains that “the financial incentive in a large ACO for physicians to change their individual decisions affecting a single patient are likely to be small.”⁷⁰ Rather, the real savings from the ACO model are projected to come from the incentives that physicians as a group have to constrain the growth in capacity and growth in the supply of specialists while adopting care protocols and other mechanisms to reduce the growth in Medicare spending.⁷¹ For instance, providers within an ACO may decide to share an imaging machine across entities rather than having each entity purchase its own machine. Since the savings “stem from group rather than individual decisions,” ACOs will need a mechanism for collective decision making and the member organizations (physician groups and hospitals) will need to restrict their autonomy and transfer authority to the ACO in order for the ACO to enforce collective decisions. This type of coordinated decision making, across entities, may be difficult to foster.

⁶⁸ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Honorable Nancy Pelosi, Speaker, House of Representatives, March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

⁶⁹ Note that the CBO assumed that the program would begin January 1, 2013, whereas PPACA directs the Secretary to establish the shared savings program by January 1, 2012, hence the timeframe for the CBO estimates does not align perfectly to PPACA.

⁷⁰ Medicare Payment Advisory Commission, “Report to Congress: Improving Incentives in the Medicare Program,” Washington, DC, June 2009, p. 51, http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

⁷¹ Medicare Payment Advisory Commission, “Report to Congress: Improving Incentives in the Medicare Program,” Washington, DC, June 2009, pp. 49-52, http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

Limited Experience with Model

An additional concern, as noted earlier, is that the ACO model has a limited track record beyond a handful of integrated health care providers. It remains an open issue as to whether less integrated providers can come together, achieve savings, and internally govern an organization with potentially highly fractured sets of interests. For example, in the start-up phase, which could last several years, ACOs will need to generate operating capital to cover the costs of contracting, developing health information technology (HIT) monitoring and reporting systems, and building compliance programs to report to CMS. This is in addition to any costs associated with implementing care protocols or other cost-reduction or quality improvement efforts. Moreover, ACOs may have some difficulty monitoring which providers are responsible for any savings achieved and avoiding tension over which providers should be compensated and how much, when responsibility may not be clearly attributable. Finally, quality improvements do not always result in savings and some improvements in quality may prove costly.

Informing Beneficiaries

As noted earlier, some proponents and some critics have suggested that Medicare beneficiaries should be informed of their physician's participation in an ACO, and some suggest that Medicare beneficiaries should have the right to either opt-in or opt-out of their physician's ACO panel. Prior notice to a beneficiary implies that assignment to an ACO is prospective rather than retrospective. As a practical matter prospective enrollment, where Medicare beneficiaries are informed of their assignment ahead of time, may be somewhat problematic. First, it requires that CMS base the current year's enrollment on the prior year's utilization, whereas retrospective assignment would allow CMS to assign beneficiaries based on actual utilization. Second, since assignment can change from year-to-year, Medicare may have to inform beneficiaries each year of their assignment and offer to allow beneficiaries to either opt-in or opt-out of the ACO. While an opt-out option would not be dependent on Medicare beneficiaries actually responding, if there is concern about *automatic* enrollment, an opt-in strategy may be more desirable since beneficiaries would not be assigned to an ACO unless they affirmatively indicated their desire to enroll. As with many CMS communications to beneficiaries, while each is intended to inform, these communications may also give rise to potential confusion and increased call-center activity.

Potential Market Consolidation

Returning to the concerns of Berenson, Ginsburg, and Kemper (2010) and Goldsmith, the actual impact of ACOs may depend on how they potentially change local market competition and whether these disparate local interests (including primary care physicians, specialists, hospitals, payers, and other health care professionals including, but not limited to, nurse practitioners, physical therapists, home health care agencies) can work together cooperatively to achieve and share savings. One could find that ACOs offer the Medicare program savings compared to current practices, but that ACOs also raise prices for other payers as providers consolidate under the ACO structure and become potentially more formidable negotiators vis-à-vis other payers.⁷² In addition, one may find in some locations ACOs have difficulty reaching agreement regarding which individuals or entities were responsible for generating the savings, and hence should share

⁷² CMS has acknowledged potential unintended consequences in the market for health care. http://news.bna.com/hdln/HDLNWB/split_display.adp?fedfid=17792088&vname=hcenotallissues&fn=17792088&jd=a0c4d7x7v4&split=0.

in any distribution, or that the overhead and program costs of operating the ACO reduce the impact of the limited financial incentives such that some participants drift away from the ACO over time.

Finally, and building on the Berenson et al. (2010) conclusion, since hospitals are likely to be a critical component of any ACO, perhaps essential to controlling costs, hospitals may end up being the prime movers in creating ACOs and the hub around which other providers gravitate.⁷³ Hospitals may find that once they form an ACO, they have little incentive to assist other ACOs but significant incentives to bring specialists and other providers into the ACO either as staff or affiliates. In addition, in the past, when hospitals have increased their negotiating leverage vis-à-vis payers, they have used their leverage to obtain higher payment rates.⁷⁴ It is an unresolved issue, and one that is likely to play out differently in different markets, as to whether hospitals will aim to achieve savings that will need to be shared with their partners.

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⁷³ Jeff Goldsmith has suggested that the ACO legislation has prompted hospital consolidation already, http://news.bna.com/hdln/HDLNWB/split_display.adp?fedfid=17792088&vname=hcenotallissues&fn=17792088&jd=a0c4d7x7v4&split=0.

⁷⁴ Kelly J. Devers, Lawrence P. Casalino, Liza S. Rudell et al., "Hospitals' Negotiating Leverage with Health Plans: How and Why Has It Changed," *Health Services Research*, vol. 38, no. 1 (February 2003), pp. 419-446.