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## ANALYSIS &amp; COMMENTARY

# The Accountable Care Organization: Whatever Its Growing Pains, The Concept Is Too Vitally Important To Fail

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**ABSTRACT** The success of health reform efforts will depend, in part, on creating new and better ways to organize, deliver, and pay for health care. Increasingly central to this idea is the accountable care organization model proposed for Medicare and a slightly different model for commercial health care. But these new health care delivery and payment models face considerable skepticism. Can Medicare succeed with accountable care organizations if physicians can't determine whether patients are in the organization or not? Will commercial hospitals use their clout to create accountable care organizations, leaving physician practices in a weaker position? This article answers those and other criticisms of the developing accountable care organization movement. If the concept fails, the nation may face indiscriminate cuts to health care payments, with resulting reductions in access, service, and quality.

**T**here is great interest across the United States in improving the way health care is delivered, how well it performs, and how it is paid for. One strategy receiving intense focus is the accountable care organization, an evolving model of care in which physicians and hospitals accept joint responsibility for the quality and cost of care delivered to a population of patients.<sup>1</sup> This model of care is meant to make many improvements, including better coordination of care among physicians and across settings of care, leading to better quality and greater safety, more appropriate and efficient care services, and a more supportive practice environment for primary care physicians.<sup>2</sup>

The accountable care organization model is intended as an option both for Medicare and for non-Medicare, commercial health care services. However, the general model and the specific shared savings model proposed for Medicare have come under criticism. Much of the

criticism is valid and should be addressed. However, none should serve to prevent the evolution of this model, because the alternative to a fundamental restructuring of how health care is delivered and paid for in the United States is likely to be a type of indiscriminate cost cutting that will leave the nation with a damaged health care system, reduced access to care services, and declining quality of care.

## Criticism Of Medicare's Evolving Models

One commentator recently suggested that the development of accountable care organizations will bring about the end of innovation in how health care is delivered.<sup>3</sup> This outcome is unlikely. Many innovations in how health care is delivered have, in fact, come about through changes in financial incentives by payers. This is particularly true of payers that moved away from traditional fee-for-service payments, such as

Medicare's diagnosis-related group payment system for hospitals, and capitation payments from insurers to provider organizations.

Recent innovations have also occurred through self-generated financial incentives in integrated delivery systems such as accountable care organizations. Examples are lean management at the Virginia Mason Clinic in Washington and ProvenCare at the Geisinger Clinic in Pennsylvania. Additional innovation has come through the leadership of organizations such as the Institute for Healthcare Improvement. Such forces will be stimulated, not impeded, under well-designed accountable care organization models.

Critics have also argued that the development of accountable care organizations will unleash a torrent of federal regulation—especially regulation of physician practices—that would not happen otherwise.<sup>3,4</sup> There is no evidence that new regulations will be imposed, other than requirements for reporting the quality measurements essential for organizations' accountability proposed in the Shared Savings Program draft regulations (sec. II E[3]).<sup>5</sup> In fact, accountable care organizations offer the promise of the kind of self-management, internal standard setting, and capability for systematic quality improvement that for decades have characterized groups such as the Permanente Medical Groups, Mayo Clinic, the Geisinger Clinic, the Virginia Mason Clinic, and the Henry Ford Health System in Detroit.

If anything, the proper development of accountable care organizations should create an environment in which less external regulation of individual medical practices is necessary, not more. To be truly "accountable," these organizations will need to commit to public transparency of information—about care processes as well as about outcomes of care. This transparency will not only be helpful to patients and payers in selecting among providers, but it should also obviate the need for certain investigative regulatory activities.

Even many proponents of the accountable care organization model have voiced criticism about certain design elements proposed in draft federal regulations concerning the Medicare Shared Savings Program section (sec. 3022) of the Affordable Care Act, which serves as the model for accountable care organizations. Among the design elements that have prompted criticism are the proposed methodologies to "attribute"—or assign—Medicare beneficiaries to an accountable care organization based on a mix of retrospective analyses of where beneficiaries received most of their primary care services in the recent past. There is also concern about the Shared Savings Program's reliance on a fee-for-

service payment model and about the absence of a mechanism by which the accountable care organization can manage the quality or cost of services obtained by the beneficiary outside of the organization.

The proposed regulation sets forth a complex methodology for attributing beneficiaries to an accountable care organization, which has been described elsewhere.<sup>6</sup> The regulation also proposes that accountable care organizations in the Shared Savings Program be paid on a fee-for-service basis, albeit with financial rewards and penalties related to performance on quality and cost. Yet some proponents of the model believe that it will work most effectively if patients more directly become "members" of an accountable care organization and if the organization is paid prospectively for services rendered to patients through capitation, rather than fee-for-service. They believe that prospective payment creates incentives for the accountable care organization to encourage healthy behavior in its population of patients, to prevent and detect diseases early where possible, and to manage costly chronic illnesses aggressively, leading to better quality and lower cost.

Finally, the proposed regulations were unable to address controlling quality or cost of services patients receive outside of the accountable care organization. This is because the Shared Savings Program is an extension of Medicare Parts A and B, which by law allow Medicare beneficiaries to seek care services from any qualified provider, whether the provider is part of an accountable care organization or not.

The final Medicare Shared Savings Program regulations are to be released later this year, and they may address some of these concerns along with other operational and financial issues. In the meantime, other accountable care organization models are also about to come on line. In May 2011 the Center for Medicare and Medicaid Innovation announced the availability of an alternative called the Pioneer Accountable Care Organization Model, which will test both prospective attribution of patients and capitation payments.<sup>7,8</sup> As Stephen Shortell and colleagues have noted, the innovation center will have the flexibility to test even further a variety of structural and payment models, well beyond those proposed in the Shared Savings Program draft regulations or even the Pioneer program.<sup>9</sup> And in the commercial marketplace, a number of accountable care organization relationships are being formed that involve physicians, hospitals, and commercial payers.<sup>10</sup> All of these developments suggest that the scope of the accountable care organization concept remains quite broad and ripe for continued innovation.

Just months ago, some critics jokingly described accountable care organizations as akin to unicorns.<sup>11</sup> In other words, some people believe in them, but no one has ever seen one. But clearly, some of these entities now exist or are soon to be among us.

On a more serious note, still other critics contend that there are few physician groups with the organizational capabilities or capital to become a basic accountable care organization. This assessment is not correct.

In recent discussions, the American Medical Group Association estimated that more than a hundred member medical groups across the country are well positioned to be accountable care organizations, and others could become so rather quickly. Such organizations have in place multispecialty group practices, formal or informal partnerships with hospitals, well-functioning clinical information systems, established physician leadership, and, often, experience with payments other than fee-for-service.

The capital requirement to form an accountable care organization appears to be manageable for the larger groups of the sort that the American Medical Group Association identified.<sup>12</sup> Many of these organizations already have invested in clinical information systems, and federal funding exists for others to do so. Also, it is quite likely that the operational cost of clinical information systems will decline as Internet “cloud-based” services become available. Such services will offer physicians access to “virtual” clinical information online and practice support services for a monthly fee, thus obviating the need for expensive hardware and software purchases.

True, it will be more difficult to initiate and fund the creation of new accountable care organizations among smaller, disaggregated physician practices, many of which do not have clinical information systems, and most of which do not have ready access to claims information and other administrative data needed for success. But many of these costs can be mitigated through partnerships with hospitals, arrangements with insurance plans, and the development of information systems funded by and distributed within local communities.

**HEALTH INSURANCE PLANS** Even as some health insurance plans are now participating in accountable care organization-type contracts or actively creating such organizations themselves, others fear the organizations’ development and spread. A primary concern within the insurance industry is the potential for “disintermediation”—that is, the removal of the plan’s role as an intermediary between payers and physicians and hospitals, as a result of po-

tential direct payment arrangements between accountable care organizations and public or private payers. Other insurers see a potential diminution in their clinical role and financial success, as accountable care organizations take over the care management activities that many plans currently provide, and the organizations receive the monetary rewards for successful care management. Still another concern is that the organizations may use their size or reputation to force plans to pay higher prices.

However, as noted, a number of plans—for example, Blue Cross Blue Shield of Massachusetts<sup>13</sup> and some large national plans, including Aetna, Humana, and WellPoint<sup>14</sup>—are actively engaging in various accountable care organization-like arrangements with providers, perhaps because they see the movement toward this model as potentially fruitful, or at least because it may seem inevitable. Furthermore, many leaders of potential accountable care organizations have indicated that they are not really interested in carrying the full insurance risk or performing insurance-like functions. In fact, only a few are likely to have the capacity to generate the necessary capital reserves.

The accountable care organization model most likely to be successful will be a shared-risk arrangement between payers and accountable care organizations, in which the health plan continues to bear some of the financial risk but transfers some of it to the organization on an annual or ongoing basis. The reason, simply, is that such shared risk arrangements align incentives between plans and providers, generally leading to cooperative, innovative relationships between them rather than destructive, antagonistic relationships. In such arrangements, the organization can assume some of the “depth” of risk (that is, a fixed percentage of the total gain or loss) and some portions of the “breadth” of risk (that is, those elements of care that the organization accepts accountability for). These elements include primary care and specialty services, hospital services, and pharmaceutical usage, among others. Risk sharing can vary in design based on the care management and financial capabilities of the accountable care organization.

**PHYSICIANS** Some physician organizations<sup>15,16</sup> are concerned that hospitals will dominate the creation of accountable care organizations in many parts of the country, simply employ physicians, and then interfere inappropriately with the traditional professional relationship between physicians and their patients. Although these concerns are understandable, there is good reason to believe that the physician’s role will not change as predicted.

# It is in our common interest to see that accountable care organizations succeed.

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Decades of experience in well-established integrated delivery systems clearly show the essential role of physician leadership in such organizations as a component of long-term success. Physicians are generally highly intelligent, self-motivated professionals who contribute best to the success of an enterprise when they understand and believe in its mission but are also fully involved in its day-to-day operational leadership.

Hospitals setting out to develop an accountable care organization with practicing physicians in subordinate roles are at real risk of failure if they lack the asset of physician leadership. On the other hand, the accountable care organization concept has created an opportunity for physicians and hospitals to rethink their respective roles, form working partnerships, and even rethink the governance structure of health care delivery institutions.<sup>17</sup>

The proposed Shared Savings Program regulations reinforce the idea of physician-hospital partnership in their proposed required governance model (sec. II B[2]c).<sup>18</sup> In addition, payers, regulators, and those designing commercial accountable care organizations should require a similar collaborative model between physicians and hospitals as a condition of recognition and payment. This should promote a culture of mutual cooperation, which in turn will lead to a sense of shared responsibility within the provider organization.

**HOSPITALS** Many hospital administrators, including those considering forming an accountable care organization, are concerned that improved care management will result in unfilled beds and a decline in revenue. They are correct to be concerned about this if the current fee-for-service payment incentives for hospitals remain unchanged. It will be important that designers of accountable care organization payment models address this problem by creating new revenue opportunities for hospitals, related not to the volume of services but to the quality and appropriateness of services, and by allowing enough time for hospitals to adjust their business plans to reflect new realities.

**REGULATORS AND CONSUMER ADVOCATES**

Some people believe that accountable care organizations may be formed simply to concentrate provider market power and increase prices. Robert Berenson and colleagues are concerned that the organizations could develop unwarranted pricing power because of their size or reputation.<sup>19</sup>

This is a real concern, and an existing problem not limited to accountable care organizations. However, this argument should not derail the accountable care organization train and thereby preclude realizing the organizations' potential benefits described above.

The draft Shared Savings Program regulations propose antitrust guidelines for accountable care organizations (sec. II I[3,4]),<sup>20</sup> and an accompanying set of draft regulations from the Federal Trade Commission<sup>21</sup> seems to strike a reasonable balance between protecting the public from abusive pricing and not inhibiting the formation and operation of accountable care organizations. Berenson and colleagues suggest that even more protection may be needed, however, because some organizations may exert undue pricing power simply as a result of their reputation in the marketplace, without necessarily violating antitrust regulations. They suggest that perhaps all-payer rate regulation may be needed in addition to antitrust regulation.

However, such a solution would be politically unacceptable to many, as it is considered a highly regulatory solution that turns the health care sector into a kind of public utility. Thus, it may be better to turn to more market-based solutions, such as binding arbitration over prices between payers and providers, that could be tried first if needed.<sup>2</sup>

**PATIENTS** Finally, what happens if “we build it and they don’t come”?<sup>22</sup> In other words, will patients, the public, and the media reject accountable care organizations in the way that managed care was rejected in the late 1990s? The answer to that question will depend on various factors.

In part, it will depend on the political dynamics in the country, on the stance taken by the popular media, and ultimately on whether or not accountable care organizations actually deliver care that is seen by patients to be safe, high-quality, and better than what they had before. The concept envisions just this promise: accountability for quality and affordability through transparency of information about quality and patient satisfaction.

The interim challenge for the health policy community, as well as for the health care industry, is to articulate this better in the future, and in words that are easily understandable to people. A starting place might mean finding a more patient-friendly term than *accountable care organi-*

zation. An often skeptical public will need to hear language that more clearly reflects the value of accountable care organizations in improving care outcomes and the patient experience. And this message should be supported by a careful and thoughtful legal and regulatory environment.

### Conclusion

It is important to look past issues of accountable care organization structure and payment design, and even to try to ignore current political disagreements about the Affordable Care Act. We must ask a bigger question: What happens next if the accountable care organization idea fails? What lies “behind that door”?

Many share the strong belief that accountable care organizations offer the clearest path to reaching the “Three-Part Aim,” as espoused by Centers for Medicare and Medicaid Services administrator Donald Berwick (originally called the Triple Aim by the Institute for Healthcare Improvement): improved population health; high-quality care experiences; and moderation of per capita health care cost increases.<sup>23</sup> But this belief does not guarantee that accountable care organizations will succeed.

The success of the concept will require steadiness of political support, especially from Congress and the administration (particularly the Centers for Medicare and Medicaid Services), and eventually public understanding and support. The success of individual accountable care organizations will require the support of payers, the development of partnership-like behavior between physicians and hospitals, adequate up-front financial resources for nascent accountable care organizations, and enough time to allow hospitals and the least-integrated physicians to organize and catch up.

Past efforts similar to the accountable care organization concept, which incorporated integrated delivery systems and payment reform, failed during the 1990s for lack of these support-

ive conditions. This could happen again. But this time, if the concept fails, the result is unlikely to be a return to the status quo, especially in terms of the flow of payments to health care providers.

Soon, the seemingly inexorable rising rate of health care costs, combined with a still-fragile US economy, will force the issue. If accountable care organizations have proved their value in improving quality and moderating cost increases, then the future will look fairly bright, and achieving the Three-Part Aim will be feasible.

If they have not, both public and private payers will probably be forced into across-the-board reductions in payment rates to providers, because the state of the economy will require cost reductions, and there will be no other obvious course to pursue. Reductions in quality and access may follow, because if the accountable care organization model fails, payers—lacking adequate information about providers’ performance on quality and cost—will have little ability to discriminate between high performers and poor performers, so all providers may see payments reduced more or less indiscriminately.

Progress toward the Three-Part Aim will slow to a crawl, as providers scramble to survive financially by continuing simply to increase the volume of services they provide in an attempt to balance lower payment rates. In addition, the very notions of the value of integrated delivery systems and providers’ responsibility for population health and health care costs may fall into disrepute. It could take a decade or more before they resurface again, perhaps under some different name.

The nation will lose a lot if this “other door” is the one we must pass through. The accountable care organization idea must not be allowed to fail. It is in our common interest to see that accountable care organizations succeed and that they deliver the long-awaited promise of a high-value, effective, and efficient health care system for our country. ■

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## ABOUT THE AUTHOR: FRANCIS J. CROSSON



**Francis J. Crosson** is a senior fellow at the Kaiser Permanente Institute for Health Policy.

In this issue of *Health Affairs*, Jay Crosson argues that accountable care organizations represent the best of current options to improve health care and reduce costs. If efforts to form and operate them fail, policy makers may have no alternative but to resort to further across-the-board cuts in payments to providers, to the considerable

detriment of health care.

Crosson, a senior fellow at the Kaiser Permanente Institute for Health Policy and director of public policy for the Permanente Medical Group, says that his experiences in the public and private sectors have led him to conclude that accountable care organizations offer "a sound path forward for the country."

Crosson hopes that his article will further the discussions about accountable care organizations by addressing legitimate concerns and increasing "the likelihood that the model will ultimately succeed." Among legitimate issues that should be addressed are the potential problem of abusive

pricing power and the design of payment models that will encourage more providers to participate.

Crosson was previously the executive director of the Permanente Federation, the physician component of Kaiser Permanente. He was a commissioner on the Medicare Payment Advisory Commission (MedPAC), for which he served as vice chair from 2009 to 2010. He was also a member of the Council of Accountable Physician Practices, a group of thirty-four medical group leaders.

Crosson received his medical degree from the Georgetown University School of Medicine.