

Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere?

Robert A. Berenson, MD

Accountable care organizations (ACOs) have emerged over the past 2 years as the newest big thing in healthcare. Hospitals, physician organizations, community health centers, and lots of other organizations are holding strategic planning meetings to figure out how to get some of the ACO action that the Patient Protection and Affordable Care Act promises.

The specific provisions of the Affordable Care Act that people are excited about are Sections 3022 and 10307, which delineate a Medicare Shared Savings Program and include the broad requirements for organizations that as ACOs would be eligible for participation under the new payment approach. As a program, rather than a pilot or demonstration, any entity that meets the eligibility criteria gets to participate. And because it is a program, the Centers for Medicare & Medicaid Services (CMS) will issue program regulations rather than a request for proposals, with proposed regulations expected to be issued by year-end.

The impetus for establishment of ACOs, which are charged with holding down spending while meeting quality criteria, comes from the growing pressure of escalating healthcare costs on public and private insurers combined with evidence that at least some of this spending appears to not improve either quality of care or patients' experience with care. Although experts dispute the exact amount of wasted spending, it is generally thought to be substantial.¹⁻⁴

Even a small reduction in the excessive spending—more precisely, a small reduction in the rate of increase in healthcare spending—on the order of about 2 percentage points in real, per capita growth per year would essentially forestall the need for possibly more arbitrary approaches to cost containment and the specter of actual rationing of care. Accountable care organizations are thought by many to hold great promise for cost containment because, unlike the “regulatory” approaches used by many managed care plans, the ACO approach would give responsibility for containing costs to *clinicians*, who can better target waste and inefficiency if motivated to do so, rather than distant third-party public and private payers.

Further, ACOs offer the promise of decreasing the fragmentation of healthcare delivery by bringing under one

virtual roof the various medical specialists and other health professionals and institutions that need to coordinate care for the growing number of patients with multiple chronic conditions. In one recent accounting, half of Medicare beneficiaries had 5 or more chronic conditions and were responsible for 76% of Medicare spending in 2006.⁵ A Medicare patient with 5 or more chronic conditions averages 37 physician visits, sees 14 different physicians, and fills 50 prescriptions a year.^{6,7} Patients with multiple chronic conditions often receive sub-optimal care despite the fact that individual clinicians may be practicing according to their own professional standards.

In theory, the ACO would address the fragmented care that too often results from competent clinicians practicing in silos, producing different diagnoses and treatment plans, prescribing incompatible medications, and delivering redundant, costly care. Although a lot of current activity is focused on the addition of promising chronic care coordination and management programs to current healthcare delivery, the ACO—again, in theory—would take practice redesign to a broader level, producing a different business model for success and an altered culture to achieve that success with active involvement of all clinicians and other professionals across the spectrum of care that patients receive.

In practice, numerous provider organizations appear to be well positioned to meet the expectations one would have for ACOs. These include very successful physician-led, multispecialty group practices, such as Scott and White Healthcare in central Texas and Group Health of Puget Sound in Seattle; physician-hospital organizations such as Advocate Health in Chicago; hospitals with employed medical staff such as Virginia Mason in Seattle and Carilion Health System in Virginia; and independent practice associations (IPAs) and management services organizations such as Monarch Health Care in southern California and Physician Health Partners in Denver. Some already own their own health plans and can participate in Medicare through the Medicare Advantage (MA) program.

A real-world model for developing ACOs is “delegated-capitation,” which is being used by

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health maintenance organizations (HMOs) in much of California and some other markets where medical groups and IPAs (generally without the organizational inclusion of hospitals) are functioning and, subsequent to a market shakeout in the 1990s, are now doing pretty well.⁸ In fact, the ACO idea is not really new; in the 1990s, these organizations were labeled provider-sponsored organizations (PSOs), and there were great hopes for them to enter traditional Medicare. Indeed, the Balanced Budget Act of 1997 established the opportunity for direct contracting between Medicare and PSOs, without having a health plan intermediary.

The fact that only a couple of PSOs have participated in what is now called the MA program should offer caution about the prospects for ACOs.⁹ It appears that organizations capable of meeting the program criteria for risk-taking under MA rules chose either to obtain insurance licenses themselves to become full-fledged MA plans or to contract with insurance companies to serve Medicare patients. The latter activity has been spurred on in recent years by the substantial extra payments MA plans have received since 2004.¹⁰ Indeed, many would-be ACOs, such as Geisinger Health System and Kaiser Permanente, already participate in Medicare with their own MA plans. Given this experience, 2 questions need to be asked. First, why would the opportunity to become an ACO produce a different provider response than PSOs did? Second, which kinds of organizations would choose to participate in Medicare under the Shared Savings Program as ACOs?

PROBLEMS WITH THE SHARED SAVINGS PROGRAM MODEL

Proponents of the shared savings approach for ACOs believe that an incremental, nonthreatening program design is the best way to gain initial participation by diverse provider systems across the country and to nudge them in the desired direction of change, with the possibility of strengthening the program design over time to more fundamentally change the business model and culture of the ACOs. Consistent with this notion of a glide path to transformation of healthcare delivery systems, some have suggested a tiered approach that over time would implement different design features, including the use of financial risk, in ACOs based on the extent of their organizational integration and capabilities.¹¹

Unlike the PSO program, the shared savings design does offer the possibility of broad participation. However, if CMS is not careful, broad participation will likely happen because the members that make up the ACOs will not actually have to change the way they deliver care. Unless CMS chooses to put some teeth into the program through reasonably demand-

ing eligibility criteria, the Shared Savings Program expects relatively little of ACOs.

The basic statutory requirements of the program are that ACOs need to have the capacity to deliver or arrange for the continuum of care for those patients assigned to it, to have a sufficient number of primary care professionals to provide services to at least 5000 beneficiaries (achievable by as few as about 10 primary care physicians with typical practices), and to report data on cost, quality, and overall patient experience for beneficiaries in traditional Medicare.¹² Although Sections 3022 and 10307 give the Secretary discretion in using additional payment approaches, they specify in detail a shared savings payment approach whereby groups would be paid their usual Medicare fee-for-service reimbursements, with no penalties at all for higher spending, and could share in savings if the group provides care to assigned beneficiaries for less than a Medicare benchmark spending target, while passing readily achievable thresholds for patient service and quality of care.¹³

Under the legislated approach, there can be no limitation on patient choice of provider at the point of service, in contrast to the lock-in approach that many MA plans adopt. It is even possible that the Secretary could assign beneficiaries “invisibly” (without their knowledge) to an ACO on the basis of concurrent fee-for-service claims that indicate where they receive the preponderance of their primary care services, as was done in the Medicare Physician Group Practice (PGP) demonstration (discussed below). Under such an approach, it is possible that the ACO wouldn’t know which of its patients qualify it for shared savings payments.

To set the spending target, the ACO’s 3-year spending history for the beneficiaries assigned to it would be compared with a spending target that trends the historical spending forward by the projected increase in spending in Medicare Parts A and B nationally. If actual spending ends up being less than the projected spending by a certain percentage (eg, 2% in the PGP demonstration), the ACO would split the savings with Medicare (eg, 80%-20% in the PGP demonstration). The threshold and the percentage shares for the parties will be determined by CMS in forthcoming regulations.

The problem with this approach is there are no downside penalties for missing the spending targets. Given the reliance on fee-for-service, it is hard to see how a speculative bonus attained in the future would counter the direct fee-for-service rewards for providing more reimbursable services, especially for hospital-sponsored ACOs. The ACO might engage in some targeted programs to address a particular care area, but not engage in a broader approach to change the “more is better” culture that is pervasive under fee-for-service.

A further problem is that the ACO’s historic spending pattern for its assigned patients, “risk-adjusted” for health sta-

tus, is used as the base spending amount the ACO is working with. Therefore, previous practice inefficiency is baked into the calculations. Indeed, prospective ACOs even have an incentive to spend more before onset of the program to build up their 3-year historical spending base. It is no wonder that some have described the anticipated ACO program as the “lottery.” Why not take a chance on sharing in savings that might occur for reasons having little to do with new organizational efforts to alter care delivery (eg, experiencing a season without influenza)?

MODEL FOR ACCOUNTABLE CARE ORGANIZATIONS

As referred to above, the model for the ACO program, including invisible, claims-based assignment and shared savings with no risk payment approach, has been tested in the PGP demonstration project that began in 2005. In the demonstration, 10 group practices (with 1 practice actually functioning like an IPA, and most with strong hospital affiliations or ownership) were permitted to receive bonus payments if they passed quality-of-care thresholds and achieved savings on Part A and B Medicare spending compared with spending for a matched control group cared for by others in the same geographic area.

In the first 3 years of this demonstration, 5 of the 10 practices bettered the 2% savings threshold compared with the control group and so received shared savings; 3 practices were within 1% of the control target; and 2 practices had spending that exceeded the target by more than 2%, with no financial penalties.¹⁴ However, the year 2 evaluation report documented that the essential reason for the overall savings across the 10 sites of about 1% compared with the control group was from diagnosis coding changes the PGP sites initiated that produced different risk-adjustment scores for their patients.¹⁵ In effect, the coding pattern changes produced apparent savings that resulted in shared savings payments to some of the demonstration sites, but not actually fewer dollars spent. In addition, the evaluators were not able to link savings to specific interventions, and found that the formal programs the PGP sites adopted were targeted to particular small patient subpopulations, with little attempt to reorient the basic care provided to all patients.¹⁴ Another barrier to successful organizational change, according to the PGP program managers, was that individual PGP physicians were still paid based on fee-for-service-oriented productivity.¹⁴

Given that the initial CMS commitment for the PGP demonstration was only 3 years, it is not surprising that the participant organizations adopted targeted programs that did not attempt to change the fee-for-service-oriented business model they have been long accustomed to. To do

so based on a mere 3-year commitment from one of its payers—even one as significant as Medicare—would have been foolhardy.

Theoretically, a program that offers shared savings without any financial downside provides weak incentives for providers to change behavior. Empirically, the approach did not succeed in the PGP demonstration, assertions to the contrary notwithstanding.

DEVELOPING A GLIDE PATH FOR CHANGE

History tells us that meeting the requirements for being a full-fledged MA plan is not something that a diverse set of provider organizations have been willing to undertake, presumably because it represents too much change and uncertainty for most providers. A refreshed approach, whereby Medicare directly contracts with organized provider groups, reasonably avoids beneficiary lock-ins, does not require providers to assume full insurance risk, and bypasses many regulatory requirements designed to protect beneficiaries and the Medicare program. But in the process of taking this refreshed approach, the Shared Savings Program may have swung too far in the opposite direction. The question at this point is whether the ACO design, based on the not particularly successful PGP demonstration, represents *too little* change—a bridge to nowhere.

Fortuitously, although the PGP demonstration design was essentially adopted as the Shared Savings Program, there appears to be flexibility for CMS to alter the design somewhat to provide an opportunity for a better test of something between unfettered fee-for-service (with all of its perverse incentives) and full-risk contracting (with its inherent limitations on patient prerogatives and incentives for stinting on care). The Centers for Medicare & Medicaid Services has been holding “listening sessions” in which many prospective ACOs, including many experienced group practices and IPAs, are suggesting the need for making changes to the PGP model. Further, the Affordable Care Act specifically allows the Secretary to create a “partial capitation” ACO payment model or “any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this Title,” instead of the PGP-style payment approach outlined in the legislation. With this flexibility in mind, we recommend making the following program design changes:

Recommendation #1: Avoid Invisible Assignment

Many want to avoid the PGP demonstration’s passive, invisible assignment, but not require a formal, locked-in enroll-

ment by beneficiaries as under MA. There are 2 basic reasons why individuals should know up front that their care is being analyzed as part of an ACO's cost calculations.

First, although the shared savings model built on unchanged fee-for-service may provide weak incentives for change, the approach in fact does have incentives that could well affect how care is provided—both for better and for worse. Physician group ACOs without a hospital component would benefit financially under a shared savings approach by keeping patients out of the hospital. In contrast, hospital-based ACOs might not have an incentive to keep patients out of the hospital because the actual fee-for-service profits would likely be greater than the potential share of savings coming many days later. And all ACOs would have an incentive not to refer patients to other providers even when another institution might be more capable of addressing a patient's clinical situation; in this way they would maximize fee-for-service income while reducing “out of network” spending attributed to their patients.

We now have good measures of primary and secondary preventive care that ACOs could be required to meet to be eligible for bonuses; but we lack measures for “rescue” care withheld, such as for a patient who might be referred to a specialized cancer center, often at much greater cost than if the ACO provided the services itself. Patients need to know about these incentives and perhaps have an opportunity to opt out of such arrangements, while being able to continue seeing the same providers. Some process protections are likely needed as well, although probably fewer than what are required under the appeals procedures applicable to MA plans. One idea to consider is an ombudsman program to help patients navigating healthcare and making choices, perhaps by facilitating access to a non-ACO second opinion about a recommended course of treatment.

The other reason for rejecting invisible assignment is to promote a kind of social contract between beneficiaries and the ACO, outlining the parties' responsibilities to each other but not otherwise restricting patient freedom of choice—call it a “soft lock-in.” An ACO should be expected to (1) make a positive case to would-be ACO participants (ie, patients who have been seeing its clinicians) about the potential benefits that their involvement in enhanced patient care activities would provide and (2) attempt to achieve their affirmative participation.

Under an approach that uses prior-year claims to attribute patients to an ACO ahead of time and offers them the opportunity to opt out, provision also should be made for other beneficiaries to seek out care from an ACO electively without first having to spend a year or more seeing that ACO's physicians. For these individuals, the approach is like an enroll-

ment, but again, their freedom of choice of provider at the point of service would not be taken away. Finally, consideration should be given to permitting the ACO to provide some additional services that are currently prohibited as illegal inducements to care (eg, reducing cost-sharing for those without supplemental insurance, covering travel expenses) to support development of a social contract emphasizing ACOs' and patients' responsibilities to each other.

Recommendation #2: Introduce Shared Risk

Many organizations that want to be rewarded for prudent husbanding of healthcare resources while providing high-quality care are not in a position to take on full insurance risk for care provided by all providers that see their patients, as they would as a PSO under the MA program, or even to take full risk for the services they provide themselves. Because of the skewed nature of healthcare spending, in which a small number of individuals are responsible for a highly disproportionate share of spending (many as a result of random, unpredictable events that often are outside of providers' control), ACOs—especially the smaller ones without deep pockets—correctly are leery of entering into any risk arrangements. Many providers assumed risk in the 1990s and did not have the tools to manage cost control; most subsequently gladly gave up their risk arrangements and reverted back to fee-for-service.

A middle ground between full risk and fee-for-service would be to adopt risk corridors on top of risk payment so that the downside financial exposure is limited and manageable. Risk corridors would limit to some extent the profits or losses the ACOs would incur if their spending deviated beyond preset limits from the spending target. In essence, Medicare would share both savings and losses with the ACOs. These risk corridors should probably apply both to spending on individual patients and to spending in the aggregate, much as stop-loss reinsurance works. Large ACOs based in hospitals might want to purchase reinsurance themselves and assume full risk for their Medicare patients, although organizations taking full risk raise solvency and beneficiary protection issues that might require an MA-like regulatory regime. For most ACOs, Medicare would essentially become the reinsurer by having the risk corridors, in an approach similar to what was set up for Part D prescription drug plans. The payments to physicians might continue to be fee-for-service based on existing reimbursements for services rendered with reconciliation later (as under the PGP demonstration) or actual per capita payments, with the risk corridors. Such a shared-savings and shared-risk approach would simulate capitation (now often called “global” or “comprehensive” payment to avoid the stigma often associated with the term “capitation”), with the marginal incentive to avoid provision

of unneeded services clear. However, because of the risk corridors, and because the financial stakes are not as great as they are under the MA program, many organizations would likely be willing to participate. This approach would meet what should be a key objective of ACOs and the Medicare Shared Savings Program: to fundamentally change the business case for providers such that an unnecessary hospital admission, test, or invasive procedure is considered an avoidable expense rather than profitable revenue.

Recommendation #3: Decrease Variation in Spending Targets

The PGP-style payment approach contemplated for the Medicare Shared Savings Program in the legislation would accept ACOs' historical spending levels for assigned patients as the base for determining the ACO's applicable spending target, presumably to stimulate provider interest in trying the ACO approach. But this approach ignores the substantial variation in wasteful, baseline spending and also the reality that there is a somewhat negative correlation between baseline spending levels and rates of spending growth¹⁶; that is, low-spending geographic areas often exhibit higher-than-average rates of growth and vice versa. Ignoring this fact would in essence reward the previously profligate with shared savings while providing an obstacle for organizations that use resources prudently.

The Shared Savings Program approach took a step in the right direction of recognizing the baseline spending variations by calculating the national projection of Medicare spending growth in absolute dollar terms rather than a straight percentage increase; providing a dollar increase provides a marginally greater percent increase to ACOs with lower base spending than to higher spending ones. Another straightforward approach would be to vary the rates of increase used to calculate the spending target based on the level of the ACO's baseline spending. For example, ACOs with historical risk-adjusted per capita spending that exceeds the average by a certain amount would receive a reduction, perhaps 1% to 2%, in the spending target, whereas ACOs with low baseline spending might receive a comparable increase in the target. Over time, spending targets would converge, a desirable policy objective.

CONCLUSION

At this point it would be customary to conclude by making a statement such as, "ACOs offer great potential to transform the healthcare system, but the devil is in the details." Of course, that goes without saying. Here, the more relevant cliché is, "You can't make an omelet without breaking eggs." In

their understandable zeal to avoid some of the problems seen in the past with full-risk contracting in HMOs, proponents of the shared savings model have designed an approach that attempts to upset or dislocate no one, with no limitation on patient choice, no need to inform beneficiaries of their ACO assignment, no financial downside for providers, acceptance of the ACO's baseline spending pattern, and no difficult organizational and programmatic requirements for ACOs to meet. They overestimate the ability of currently used performance metrics to differentiate actual performance.

If CMS permits easy ACO entry, it is likely that many organizations will participate—and many will be unable to generate savings. As a result, another very good idea could fail in its execution. Simply put, the Shared Savings Program design is at great risk of not providing a sufficiently strong business case to convince provider organizations to change their practice cultures. However, the changes outlined above to the primary payment approach described in the Shared Savings Program statute—although likely to add complexity—could increase the possibility of success for a policy initiative that deserves a fair trial.

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Address correspondence to: Robert A. Berenson, MD, Urban Institute, 2100 M St, NW, Washington, DC 20037. E-mail: rberenson@urban.org.

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