

Like a seasoned chef challenged to tweak her signature dish, the Centers for Medicare and Medicaid Services (CMS) have been charged with reimagining the cornerstone of the United States healthcare delivery system. The test comes at a veritable time of crisis, and with the national debt at frightening levels and uncontrollable Medicare costs spiraling out of control, the healthcare status quo is almost unanimously accepted as untenable by both providers and consumers and by all members of the political spectrum. A deeply entrenched fee-for-service regime has long favored healthcare quantity over quality, pushing providers to treat *more* rather than treat *well*.¹ All around us, the system is failing, and its very survival depends on our ability to reform it effectively and without delay. To meet this challenge, the highly anticipated accountable care organization (ACO) is the latest creation to emerge from the CMS kitchen. ACOs promise to improve the quality of healthcare and reign in its skyrocketing costs by increasing system efficiency. The expectations are tremendous, and the promises are great, but key problems with the evolving ACO design need to be resolved before the model will be ready and able to rescue US healthcare from its fragmented, strained, and inherently inefficient state of near-chaos.²

This paper argues that the conceptual foundations of the ACO model are both praiseworthy and timely but that significant flaws and limitations must be corrected before ACOs can accomplish the Herculean “three-part aim” of improved population health, high-quality care experiences for individuals, and moderation of per capita healthcare cost increases.³ If these flaws and limitations are addressed, ACOs will offer real hope for success because the idea behind the system is a brilliant one: to promote healthcare quality by improving care coordination and efficiency while simultaneously incentivizing frugality by sharing savings with providers. Because the ACO seeks to accomplish these feats without entirely abandoning the central fee-for-service paradigm, the idea is also a realistic and realizable one, a fact that is of paramount importance given the widely accepted prophecy that if the ACO concept fails, a return to the status quo would be unlikely—if not impossible—and the aftermath would be dominated by economically necessary reductions in payments to providers and consequent deteriorations in healthcare quality and access.⁴ While

promising and realistic, the crystallization of ACOs' finalized structures will undoubtedly depend on evolutionary economic processes negotiated by each of the constituent healthcare stakeholders: payers, hospitals, providers, and—ultimately—patients.^{5,6}

Because the CMS currently have three distinct and heterogeneous models proposed for potential ACOs to adopt (the main Medicare Shared Savings Program and two alternative models, the Pioneer and the Transitions programs),⁷ and because none of the models will be implemented until January 2012, discussing the structure of ACOs in general is difficult. Furthermore, additional models may be unveiled,⁸ and even the current ones allow enough flexibility for each potential ACO to distinguish itself. Therefore, the ACOs that appear over the next few years are expected to be extremely diverse in appearance.⁹ However, while the final details of the Shared Savings Program will not be released until later this year, in March the CMS published a sketch outlining this prototypical model for how Medicare ACOs in general can be expected to look. Future ACOs affiliated with private payers also are likely to draw inspiration from this key prototype. According to the 429-page federal rule, Shared Savings Program ACOs can be led by physicians in independent group practices, networks of individual practices, hospitals or academic centers and their physician employees, or partnerships between these groups and other healthcare providers.¹⁰ The core of the ACO will be primary care-oriented, and each ACO will be responsible for the care of at least 5,000 Medicare beneficiaries.¹¹ While patients will still have the freedom to choose the Medicare-affiliated healthcare provider of their choice, the Shared Savings Program dictates that each beneficiary will be “assigned” retrospectively to the ACO that provided him the majority of his primary care during a defined period of time.¹² Payers will then hold ACOs accountable for the care they provided their given patient populations during that time by assessing the quality and efficiency of their care using real-time data monitoring and standardized metrics. These measures prioritize care coordination in addition to preventative and chronic care to reduce the unnecessary use of resources, for example, by avoiding duplicate tests and preventable emergency visits and hospitalizations.¹³ Health information technology is also essential to the coordination of care envisioned by ACOs.¹⁴ While the traditional

fee-for-service payment paradigm will be retained, the fundamental and defining feature of the ACO is the shared savings concept, which represents an innovative incentive program that encourages providers to moderate the volume of services they render and thus provide more cost-effective care. If an ACO meets the standards for delivering high-quality care and manages to stay within the payer-defined spending targets determined for its assigned population, the ACO is rewarded with a portion of the Medicare savings it generates.¹⁵ However, the ACO risks financial penalties if the spending targets are not met.¹⁶

While the Medicare Shared Savings Program is undoubtedly going to be modified, there are serious problems with this prototype that simply must be corrected for ACOs to be successful. However, given that the CMS have already addressed some of these issues in the design of the Pioneer and Transitions models, there is good reason to believe that when the blueprints for ACOs are finalized they will indeed be poised for success. One of the most cited limitations of the ACO model is the sizeable initial investments potential organizations face in adapting their existing structures to comply with program requirements. Expanding primary care capacity and implementing health information technology require large upfront capital that is difficult to muster, especially for smaller physician groups.¹⁷ An obvious solution to this cash-flow problem is to move toward a system where ACOs are paid some of their shared savings upfront. The CMS are already responding to this concern, and the Pioneer model features an experimental capitation payment system to start in the third year of an ACO's operation, in which a monthly, per beneficiary sum is paid to providers for a portion (about 50%) of the services they provide.¹⁸ Although consumers in the past have rejected pure capitation systems as programs that incentivize skimping on care provision,¹⁹ tempered options like this hybrid capitation/fee-for-service system would likely make transitioning to an ACO structure more feasible and less risky for provider groups. After all, the financial risks associated with transforming an organization into an ACO are substantial, and the hesitation of many groups to make the transition is understandable, especially given the mixed results of the Physician Group Practice (PGP) Demonstration, in which most of the prototypical ACO-like participants did not even

recoup their initial investments.²⁰ Another common criticism of the proposed ACO system is that the savings the organizations can generate are meager (the CMS predict national savings from ACOs of \$510–\$960 million over three years, a sum dwarfed by the \$515.8 *billion* that Medicare spent in 2010 alone)²¹ and, moreover, that not enough of the program savings are shared with the providers. These flaws are potentially existential since, according to analysts of the PGP demonstration, an ACO making the mean initial investment of \$1.7 million would need to accomplish an extremely improbable 20% profit margin for three years in order to survive.²² The ACO system cannot be successful if providers are not willing to adopt it, and unless something is done to ameliorate the unappealing combination of high initial investments and meager payoffs, few providers will likely take the leap. The CMS, however, appear to be recognizing this fact, and the Pioneer and Transitions programs are already designed to return bigger portions of Medicare savings to providers.²³

Critics also lament the CMS’s behemoth bureaucracy, suffocating regulation, and excessive “top-down micromanagement” as incompatible with the provider autonomy required to successfully operate an ACO.²⁴ Of course, regulation is necessary for any system to work, but, for instance, the quality metrics proposed by the CMS to keep providers accountable add up to a veritable gauntlet of 65 separate measures.²⁵ This challenge is especially daunting when the proposed rules mandate that beneficiaries be *retrospectively* assigned to ACOs such that providers would not even know which patients they are responsible for until after the fact,^{26, 27} a scheme that directly undermines the very *concept* of accountability. These challenges are accompanied by the threat that ACOs may be audited and even subject to cumbersome site visits by the Department of Health and Human Services.²⁸ Furthermore, since real-time data monitoring is absolutely essential for adapting to unforeseen problems and adjusting to the dynamic needs of the populations served, CMS bureaucracy poses a potential hurdle for ACOs’ success—as it did for PGP participants when the CMS provided Medicare claims data only after problematic delays.²⁹

Careful antitrust protections must also be implemented to prevent ACOs from consolidating too much economic power and aggregating excessive market shares within regions. ACO rules must

encourage coordination of care without promoting monopolistic abuses of power. Diminished competition among providers causes patients to suffer higher prices, and unilateral market dominance suppresses the natural, evolutionary economic pressures that must exist to innovate and refine successful business practices. The Federal Trade Commission and Department of Justice are preempting this threat with a special 90-day antitrust review process for ACOs,³⁰ but the risk of progress being stifled cannot be underestimated: the success of ACOs will depend on their own continuous fine-tuning and adaptation to both natural market pressures and dynamic population needs.³¹

Antitrust concerns are just one potential threat to patient choice, a value we prioritize. A successful ACO will engage the end consumer as a discerning and active participant in his or her own healthcare and foster patient autonomy to support this end. The ACO model cannot be launched until it is attractive not only to providers and businesspeople but also to patients, and given the fundamental importance of the physician-patient relationship, physician leadership in ACOs is a critical asset when it is in sync with community participation.³² The patient is the ultimate consumer, and in the end she must like and prefer the product—the ACO—for it to succeed. Even if the patient receives enough care from an ACO to be officially “assigned” to it, the ACO cannot be judged successful if that patient is still receiving considerable care elsewhere; the ACO will instead face the difficulty of being held accountable for that patient’s health outcomes when other unaffiliated providers are also playing a significant role in caring for her. Therefore, on both the individual level of a given provider group and on the national level of the entire ACO system, organizations must provide sufficiently satisfying care that patients choose to receive all (or at least nearly all) of their care there. Otherwise, ACOs risks being left to go cold and untouched like a meal nobody wants to eat.

Serving a successful dish requires not only a reliable recipe and quality ingredients; it takes the coordination of the entire culinary team—from the chef du cuisine who writes the menu to the waiter who presents the final product to the diner. Similarly, developing and implementing an ACO

model that will work requires that it be crafted according to a meticulous and durable legislative recipe from the choicest policy ingredients that are not only inspired by the right principles but also carefully selected and precisely measured in tried and validated proportions. Apprehensions about investment and return, worries about regulation and bureaucracy, antitrust concerns, and beneficiary assignment problems must be resolved for ACOs to succeed. Furthermore, for ACOs to work—and they *must* work—they will have to involve and engage all healthcare stakeholders, including payers, hospitals, healthcare providers, and, most importantly, patients. Judging by the steps the CMS have begun to take with the Pioneer and Transitions models to address some of these concerns, there is good reason to believe that once ACOs are a reality, they will be in good shape to succeed. The stakes are high, however, and in a near future dominated by ACOs, any alternative to success will be unacceptable. Moreover, ACOs must *quickly* persuade consumers, businesses, and legislators of their value.³³ Now it is up to the CMS to add the finishing touches to the ACO blueprints to ensure the new creation is an appealing one that is not only at once enticing but also immediately convincing.

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