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Achieving Accountable Care: Are We on the Right Path?

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The new Medicare Shared Savings Program has the potential to promote the delivery of "accountable health care" that achieves the aims of better health, better care, and lower costs. How well it fulfills that potential will depend in large part on the ability of federal officials to ensure the program remains responsive to the needs of health care organizations, payers, and patients.

The Centers for Medicare and Medicaid Services (CMS) recently released a "Notice for Proposed Rule Making" regarding the new Medicare Shared Savings Program for accountable care organizations—groups of health care providers that agree to take collective responsibility for the quality and costs of treatment for a population of patients. The Shared Savings Program, which was created by the Affordable Care Act and is slated to begin in 2012, represents an important step in reorienting our health care payment and delivery systems toward a focus on high-value, accountable care.

The Commonwealth Fund's Commission on a High Performance Health System recently released 10 recommendations to help ensure the success and spread of accountable care organizations, or ACOs. Using the framework provided by the Commission's recommendations, we identify issues for CMS to consider in finalizing the federal rule.[1]

What Are the Characteristics of a Successful Shared Savings Program?

1. A strong primary care foundation.

All high-performing health care systems have a strong primary care foundation, an essential component of accessible, well-coordinated care—especially for individuals with chronic health conditions. That's why the Commission on a High Performance Health System recommends that CMS ensure that all ACOs have a

[1] This commentary reflects the opinions of the authors and not necessarily those of the Commission on a High Performance Health System, The Commonwealth Fund, or the Fund's board of directors.

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primary care foundation built on the patient-centered medical home, which emphasizes timely access to care and is the core of a system that delivers evidence-based, coordinated care.

In the proposed rule, CMS addresses this issue implicitly through performance measurement and functional requirements in line with the goals of a medical home. For example, many patient experience and care coordination measures for assessing ACO performance are proposed as standards for high-value care. In terms of functional requirements, ACOs will need to demonstrate many of the features of medical homes, such as processes to provide evidence-based care, patient engagement, coordination between primary and specialty care, and internal reporting of information about quality and costs. The general approach of allowing ACOs flexibility in determining how to meet the goals of evidence-based, coordinated care is consistent with the Commission's recommendations.

2. Accountability for quality of care, patient care experiences, population outcomes, and total costs.

Because performance measurement is critical for holding providers accountable for the quality of care they deliver, the Commission recommends that any shared savings payments should be contingent upon meeting high performance standards. In order to ensure that ACOs are meeting the aims of better health, better care, and lower costs, all ACOs should report on quality, outcomes, patient care experiences, and costs.

CMS proposes a fairly extensive list of performance measures that covers the full spectrum of care and addresses the three aims, and further proposes that the amount of shared savings payments be based on these measures. Similar to the strategy used in hospital and physician reporting, CMS is requiring that ACOs report on quality only in the first year. In subsequent years, performance will be taken into consideration in determining payment, with the first-year results used to establish performance standards. The scoring system in the proposed rule sets a minimum threshold for receiving shared savings payments at the 30th percentile of fee-for-service or Medicare Advantage plan performance, above which ACOs will receive higher payments. To strengthen the incentive to improve performance, CMS should move as quickly as possible to adopt higher standards of performance.

3. Informed and engaged patients.

How to engage patients effectively in new models of care is an important design issue for ACOs. The Commission recommends that patients be notified when their providers belong to an ACO, and providers should specify what that means in terms of their own expected roles and responsibilities and those of patients. Patients should always retain the right to visit the provider of their choice, including those not participating in the ACO. At the same time, CMS should develop and test different approaches to providing positive incentives to encourage patients to designate an ACO as their principal source of care.

In the proposed rule, CMS focuses very strongly on patient-centered care. For example, at least one beneficiary must be on the governing board, patients must receive notification that their provider is in an ACO, and ACOs must describe specific processes by which patients and their caretakers will be able to participate in their health care choices. ACOs will also be required to collect patient-reported information on care experiences and incorporate it into their individualized care plans.

4. A commitment to serving the community.

The Commission recommends that CMS make an explicit commitment to serving the community, including low-income and uninsured patients, an integral part of qualifying as an ACO. A high performance health system means that providers must be accountable not only for the patients who walk through their doors but for the community as well.

CMS requires each ACO to demonstrate that it evaluates the health needs of its population, which includes taking into account diversity. Furthermore, ACOs must identify high-risk individuals and develop

individualized care plans for targeted patient populations. Although ACOs are encouraged to include community stakeholder representatives on the governing board, CMS should continue to search for other ways to ensure that the community is fully involved and that all segments of the population have access to accountable care. Finally, federal officials should focus on the health of the community in assessing the success of the ACO program.

5. Criteria for entry in the Shared Savings Program and continued participation that emphasize accountability and performance.

The Commission recommends that criteria for becoming an ACO should include, at a minimum, the availability of primary care and the capacity to ensure access across the continuum of care, and that continued participation in the Shared Savings Program should focus on performance and accountability rather than structural characteristics. While organizations should be required to show promise in attaining those goals, entry criteria and assessment ought to focus on performance more than the means of achieving it.

For the most part, the proposed rule allows ACOs flexibility in the types of tools they can use to meet functional and performance standards. There is also substantial flexibility in the types of organizations and configurations of providers that can participate. Although there are limitations on the types of providers that can independently apply to be an ACO, any type of Medicare provider can participate in the program by partnering with an ACO. CMS should always work to ensure that the goals of the program are consistently and clearly stated.

6. Alignment of payers to provide appropriate and consistent incentives.

The Commission recommends that CMS should work with private and other public payers to align payment incentives and performance metrics so that consistent signals are sent throughout the health system that better health, better care, and lower costs are valued above all else. This alignment will also help reduce administrative burden for health care providers, and leverage efforts to increase quality and control costs.

The proposed rule is fairly silent with regard to multipayer alignment. Moving forward, CMS should seek greater alignment of core measures with other payer initiatives. Several of the pilots initiated by the new Center for Medicare and Medicaid Innovation indicate that CMS recognizes the value of multipayer alignment, and some of the major ACO initiatives currently in place involve private payers in arrangements with provider organizations.

7. Payment that reinforces and rewards high performance.

The Commission recommends designing the process for calculating shared savings payments in a way that ensures ACOs are rewarded for actual improvements in performance, and that payments are not generated simply by random fluctuations in year-to-year costs. In addition, rewards for performance should be delivered in as timely a manner as possible to reinforce that performance. The Commission also recommends that CMS and other participating payers consider providing upfront support to ACOs under certain circumstances—to help offset the infrastructure investment expense required to redesign care processes and institute a team approach to care.

CMS proposes to use empirically based minimum savings thresholds to ensure that providers are rewarded for intended improvements in care. To improve the business case for undertaking improvements in health care delivery, more consideration should be given to setting an appropriate balance between protecting the Shared Savings Program from making payments based on cost fluctuations unrelated to performance and recognizing and rewarding performance. CMS does make some adjustments to help smaller ACOs—which may experience greater difficulties in revamping their infrastructure to coordinate and manage care better—achieve shared savings, and it even offers the opportunity for ACOs that include safety-net providers, as well as smaller ACOs, to attain higher shared savings amounts. Nevertheless, there

will be a delay of at least several months between the end of the performance period and the time that shared savings are disbursed (or losses are shared). CMS should continue to investigate ways to reduce the delays in payments.

8. Innovative payment methods and organizational models.

The Commission recommends that CMS be prepared to incorporate payment models that are suitable for different organizational configurations in different circumstances, as appropriate.

CMS has proposed an approach that allows ACOs the option in the first two years to receive a higher share of any savings they achieve if they agree to take responsibility for a share of any excess spending. This two-sided approach will apply to all ACOs in the third year. CMS, through its Innovation Center, should consider alternative payment models in the Shared Savings Program that also incentivize higher-value health care, including bundled payments and risk-adjusted global fees.

9. Balanced physician compensation incentives.

The Commission recommends that ACOs receiving payment for direct care, as well as shared savings, have incentives to deliver evidence-based care while ensuring that appropriate care is not withheld.

Although the proposed rule is silent with regard to physician compensation, CMS incorporated a robust measure set in the proposed rule, with any shared savings payments to be contingent on meeting quality standards. CMS also plans to monitor ACOs for actions that may inhibit patients from seeking care, particularly outside of the ACO network. This includes a proposal to require ACOs to submit a description of how it will use the shared savings to meet the goals of the program.

10. Timely monitoring, data feedback, and technical support for improvement.

CMS can significantly improve the ability of ACOs to improve patient care by providing timely access to data across the full continuum of health care services. The Commission recommends the development of

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standardized reports on pertinent ACO-specific population quality, cost, and utilization trend data that can be delivered in a timely manner to ACOs throughout the performance period. The Commission also recommends that technical support be made available by CMS and other payers to help ACOs identify and adopt successful practices. In addition, CMS should work with other payers to develop robust information exchanges and ensure transparency of information while minimizing administrative complexity.

The amount of data CMS proposes to share with ACOs will greatly improve the ability of these organizations to undertake innovations leading to higher-value care. ACOs will have aggregated data reports on their patient populations at the beginning of the first performance period and then on a quarterly basis, and there will also be a limited amount of beneficiary identifiable data available for budgeting purposes as well as for targeting resources to improve care. The data will also include Part D information, which will be particularly helpful for managing patient care, even thought Part D spending is not included in shared savings determinations.

It will be critical for CMS to work with ACOs both to make sure that the reports include all the information they need to succeed and to help them get the most out of this information—for example, by figuring out ways to make the data available in a more timely fashion. Provisions in the proposed rule are limited in detailing how CMS will facilitate access for ACOs to the technical support they may need. In addition, there is no mention of working with other payers to alleviate administrative burdens and resolve data transparency issues. This may be something that CMS needs to work on outside the ACO regulations.

Conclusion

The Notice for Proposed Rule Making represents an important step forward, but there are ways to improve the Medicare Shared Savings Program's chances for success. CMS has been proactive in soliciting input from all stakeholders in finalizing the rules for the program, and the suggestions contained here are offered in that spirit. The role of the Center for Medicare and Medicaid Innovation will be crucial in developing new models of payment and delivery that can be incorporated in the program as it evolves. In addition, the involvement of multiple payers is critical in accomplishing the goals of the program and achieving a high performance health system. Finally, CMS should implement the Shared Savings Program with creativity and flexibility—protecting against unnecessary Medicare expenditures while simultaneously ensuring that sufficient opportunities for rewards are available to organizations that truly achieve high performance.

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