D espite the uncertainty and controversy it has generated, the Patient Protection and Affordable Care Act (ACA) has sown the seeds for a major reorganization of the U.S. health care delivery system. In almost every region of the country, hospitals and physicians are forming (or talking about forming) accountable care organizations (ACOs) and entering into other arrangements designed to integrate care, manage chronic conditions, and enable evidence-based practices. Critical to the achievement of these ends are the regulations and guidance soon to be issued by the Centers for Medicare and Medicaid Services (CMS) and the Federal Trade Commission (FTC). One of the most important judgments these agencies will be called on to make entails determining how best to ensure that ACOs foster, not hinder, competition in health care markets.

Although not precisely defined by the new law or the theorists who proposed the concept, ACOs are best understood as affiliations of health care providers that are held jointly accountable for achieving improvements in the quality of care and reductions in spending. ACOs may take a variety of organizational forms, including integrated delivery systems, primary care or multispecialty medical groups, hospital-based systems, and even contractual or virtual networks of physicians, such as independent practice associations. In designing an organizational framework, providers and regulators will have to contend with trade-offs involving such factors as control and governance of the organization, the extent of integration among providers, allocation of risk and rewards, and exclusivity of membership.

It appears likely that the regulations will allow for considerable variation in the form of ACO that providers adopt but will nudge them toward greater integration and more interdependent relationships. And well they should. Economic analyses of the current state of U.S. health care markets suggest that they are plagued by both fragmentation and concentration. ACOs offer a much-needed vehicle for integrating health care delivery and reducing the well-documented shortcomings of the system that are attributable to payment and organizational features that reward high volume rather than low cost or high quality.

At the same time, ACOs do little to address the problem of...
market concentration. Indeed, the ACO phenomenon may well encourage some mergers, joint ventures, and alliances that will exacerbate this considerable problem. Anecdotal evidence suggests that health care reform legislation has already prompted a number of mergers among health care providers. Furthermore, a substantial body of economic evidence indicates that market concentration has been a major factor spurring escalation in the cost of health insurance. Studies show that hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another. Similarly, a recent empirical study by the attorney general of Massachusetts linked that state’s inflation in health insurance premiums to “provider leverage” — the ability of dominant hospitals and specialty physician practices to obtain high levels of reimbursement that were not attributable to differences in quality, case mix, or demographic factors. Dominant providers have used their market power for more than seeking higher reimbursements. As reported by Blue Shield of California, there have been instances in which they have also restricted the ability of employers and health plans to obtain and use cost and quality data that would enable them to shop more effectively.

Certification of ACOs for participation in the ACA’s Shared Savings Program for Medicare beneficiaries therefore poses a challenge for regulators. Because most Medicare ACOs are likely to serve private insurers as well, those that exacerbate or entrench provider dominance are likely to raise costs in the private sector, including the commercial and self-insured markets, and may also adversely affect competition among Medicare Advantage plans. The delicate task facing the agencies (the CMS in its role as ACO gatekeeper and the FTC as enforcer of antitrust law) will be to strike a balance that encourages the efficient integration of providers while preventing the formation of anticompetitive monopolies or oligopolies.

Although it is impossible to unscramble consummated mergers facilitated by lax enforcement of antitrust laws or to reverse several dubious federal court decisions made during the past decade, the CMS, working with the FTC (which has announced that it will closely monitor the formation and operation of ACOs under the Shared Savings Program), can take a number of steps to reduce the risk of anti-competitive effects. First, the agencies must be acutely sensitive to the risks posed by “overinclusive” ACOs — those composed of an unduly large proportion of the hospitals or physicians in their markets. To the extent feasible, the CMS should not certify ACOs that are likely to inhibit the development of competing ACOs or that will otherwise impede competition in the private insurance market. In most regions of the country, this approach would constrain large hospitals from forming ACOs with rival hospitals and from locking up key specialty physician groups with exclusive contracts.

Second, the CMS should insist that ACOs provide transparent and accessible cost and quality information regarding their hospitals and physicians. Allowing private plans and their customers to monitor, share, and publicize such data can improve competition even when providers possess market power. In addition, the CMS should restrict ACOs from adopting “most favored nation” clauses in their contracts with insurers. As illustrated by a case recently filed by the Justice Department, dominant hospitals and dominant insurers making use of such contracts can undermine their rivals’ ability to compete.

Finally, in places where the creation of competitive ACOs is simply not feasible because of previous merger activity among providers, the CMS and state insurance regulators may have to take more draconian measures, such as directly capping premium increases, when providers’ costs exceed benchmarks established in competitive markets.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Center for Health Law Studies, Saint Louis University School of Law, St. Louis.

This article (10.1056/NEJMp1013404) was published on December 22, 2010, at NEJM.org.

Is the accountable care organization (ACO) a suitable model for academic medical centers to follow in their efforts to control the cost of caring for patients while delivering superior, coordinated care?

To explore this question, I talked with 37 senior faculty members and administrators at academic medical centers, governmental agencies, and research institutes and compared what they told me with my own experience as an academic division chief of cardiology and a chair of a department of medicine. These conversations revealed major organizational and cultural challenges confronting academic medical centers that attempt to adopt the ACO model.

The Affordable Care Act (ACA) describes ACOs as “groups of providers of services and suppliers meeting criteria specified by the Secretary [of health and human services] who work together to manage and coordinate care for Medicare fee-for-service beneﬁciaries.” Under a Medicare program created by the ACA, “ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings.” ACOs, which currently exist primarily as demonstration projects, will become part of the Medicare system on January 1, 2012. If successful, they will reduce utilization and costs while providing the best acute and, particularly, long-term care for patients.

The ACO concept is predicated on the primacy of primary care, with doctors, nurse practitioners, nurses, and other health care providers working together to supply the most efficient, successful, and economical care for their patients. The concept presumes that the professionals and hospitals (in ACOs that include both) will work together closely — ideally, as single governing units. The electronic medical record, integrating inpatient and outpatient information, and other relevant uses of information technology are seen as basic tools in this work. ACOs will share with the federal government any financial savings the organizations produce.

Establishing ACOs at academic medical centers will be challenging, and creating appropriate governance for these organizations will present problems to many. The most workable organizational model links the members of faculty practices with university hospitals and clinics in unified management, either legally (as at the
University of Pennsylvania) or virtually (as at Johns Hopkins Medicine). Such linkages should not pose organizational problems at hospitals in which the practice plan and the hospital administration are led by a senior official who is responsible to an independent board of trustees but not to a university official (e.g., Massachusetts General Hospital and Brigham and Women's Hospital in Boston).

However, many academic medical centers are not structured in that way. Instead, the dean, who is often responsible for the practice plan, reports to a senior university official, whereas the hospital's chief executive officer (CEO) reports to an independent board of trustees, as is the case at the University of Maryland, where I work. Conflict among deans, among chairs of clinical departments, and between directors of practices and directors of hospitals, particularly over the distribution of resources, can be endemic in institutions structured in this manner. Without an official who can resolve differences and to whom the dean and the CEO both report, this division of authority can interfere with an institution's ability to make the changes necessary to form a successful ACO.

The traditional method of training students, house staff, and clinical fellows is expensive and inefficient. Since junior trainees are particularly inexperienced, they take longer to work up their patients, and they order more tests than an experienced physician might think necessary. House officers and students, eager to answer correctly any question posed by their attending physician during morning rounds, order whatever tests and procedures are necessary to rule out every relevant diagnosis and treat every possible disease.

The supervision and teaching of trainees, whether in the hospital or in an outpatient clinic, take time, and time costs money. Reducing the cost of training will require fundamental changes in the way this mission is pursued.

To be successful, an ACO will require a high degree of collaboration among the leaders of clinical departments. Such cooperation will be difficult to achieve at many academic medical centers. Chairs tend to be jealous of their prerogatives and are not naturally inclined to transfer the administration of their clinical services to a central authority whose aims may not coincide with their own. The effectiveness of ACOs will depend on the centralization of the administration of medical care, whereas clinical departments in medical schools operate on a decentralized model. At least currently, department chairs have few incentives to change from their traditional method of operating. Without such coordination, it will be difficult for academic medical centers to reduce the costs of practicing medicine — one of the principal aims of ACOs.

Full-time clinical faculty members at research-intensive medical schools often have priorities other than delivering the most cost-effective clinical care. For many, taking care of patients is a part-time activity that is sometimes seen as taking faculty members away from directing a research laboratory, designing and evaluating the data for a clinical research project, or writing a grant.

A degree of standardization of clinical care is also necessary in order to realize the savings for which ACOs are designed. Such standardization is not characteristic of the work of many clinical faculty members, who may have their own ways of diagnosing and treating patients who have similar diseases. Furthermore, doctors must accustom themselves to working with teams of auxiliary personnel to optimize their patients' care, particularly for chronic conditions.

In addition, to succeed in controlling the cost of the medical care they provide, ACOs need large primary care programs. It is the specialists, not the primary care providers, who dominate academic medical centers and order the expensive tests that increase hospital charges. Moreover, many patients are referred to academic centers for single-encounter diagnosis and treatment of one particular medical problem and not for long-term care, which is a key focus of ACOs. The requirement for robust primary care programs will present a problem for many, perhaps most, academic medical centers that propose to become ACOs. Centers that do not have large primary care programs staffed by full-time faculty or that decide not to develop such units will need to form alliances with off-campus groups of primary care providers, many of whom may be self-employed — an undertaking with which many centers will be unfamiliar.

Establishing successful ACOs at academic medical centers will require changing several aspects of the traditional culture at medical schools. Leaders at such centers will need to convert their organizations from a hierarchical structure to one that is more horizontal and collaborative.
they be able to do so? Given the challenges, several leaders with whom I spoke doubt that ACOs can readily be established at academic medical centers.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the University of Maryland School of Medicine, Baltimore.

This article (10.1056/NEJMp1013221) was published on February 2, 2011, at NEJM.org.


Copyright © 2011 Massachusetts Medical Society.
A Cautious Path Forward on Accountable Care Organizations

Barak D. Richman, JD, PhD
Kevin A. Schulman, MD

SPURRING THE CREATION OF ACCOUNTABLE CARE ORGANIZATIONS (ACOs) was a signature initiative in the Patient Protection and Affordable Care Act of 2010 (PPACA). To achieve potential efficiencies by having health care delivery coordinated by multiple health care entities (eg, hospitals, physician groups, clinics, health care systems), the act invites such entities to integrate in ACOs and instructs the Medicare program to share with an ACO any cost savings it can demonstrate. Observers are expressing concern, however, that newly established ACOs are joining health care organizations that otherwise would compete with each other, thus creating networks with dangerous market power. It appears that the main purpose of health care entities in forming ACOs may not be to achieve cost savings to be shared with Medicare but to strengthen negotiating power over purchasers in the private sector. This may be the latest chapter in the steady accumulation of market power by hospitals, health care systems, and physician groups, a sequel to the waves of mergers in the 1990s when health care entities sought to counter market pressure from managed care organizations. The possibility that ACOs might further concentrate health care markets brings new urgency to understanding why these monopolies are pernicious and to considering how government can ensure that ACOs pursue efficiency rather than market power.

Market Power and Health Insurance

Although the point is not generally appreciated, monopoly power possessed by health care entities is more fiscally burdensome to consumers than monopolies in other markets. Ordinarily, a monopolist’s pricing freedom is constrained by consumers’ unwillingness to pay more than they can afford or believe the product is worth. However, health insurance in the United States hides the true price of health services from patients and thus weakens the usual constraints on monopolists’ ability to raise prices. Consequently, prices most consumers would not pay (and monopolists would not charge) in the absence of insurance are paid through higher health insurance premiums for all Americans.

For legal, regulatory, and other reasons, health insurers in the United States cannot refuse to pay the high prices imposed by health care organizations, even when the price exceeds the likely value of the service to the patient. Instead, insurers are expected to cover any desired service deemed “medically necessary” by professional standards, whatever the cost. Health insurance, therefore, enables monopolists of health services to charge more than the textbook “monopoly price,” earn more than the typical “monopoly profit,” and capture more consumer dollars than monopolists in other industries.

Policy makers have been slow to recognize the dangers of market power in health care. In what has properly been called a failure of antitrust policy, policy makers did little to stem the accumulation of health care market power throughout the 1980s and 1990s. But the implications have been huge. For example, hospital mergers have led to estimated price increases of 40% in local markets. Dominant providers of insured services pose a severe challenge to health care affordability for individuals and for the nation as a whole.

ACOs in Theory and Practice

Still a roughly defined policy concept, ACOs are in theory an attractive solution to problems stemming from the complexity and fragmentation of the health care delivery system. Together with good information systems and compensation arrangements, vertical integration of complementary health care entities can achieve important efficiencies by reducing medical errors, obviating duplicative services and facilities, and coordinating elements needed to deliver high-quality, patient-centered care.

However, the PPACA invites not just vertical integration of complementary elements but also horizontal integration of competitors. Organizers of ACOs are forging collaborations among entire markets of physicians and hospitals, entities that would otherwise compete with each other. Given the extraordinary threat to economic welfare that health sector monopolies pose with health insurance in the picture, horizontal consolidation in the form of ACOs could pervert a good policy idea for bad ends.

Author Affiliations: School of Law (Dr Richman) and Health Sector Management Program, Fuqua School of Business (Drs Richman and Schulman), and Duke Clinical Research Institute and Department of Medicine, School of Medicine (Dr Schulman), Duke University, Durham, North Carolina.

Corresponding Author: Kevin A. Schulman, MD, Duke Clinical Research Institute, PO Box 17969, Durham, NC 27715 (kevin.schulman@duke.edu).

©2011 American Medical Association. All rights reserved.
Antitrust and Regulatory Solutions

Despite past failures, antitrust law remains a vital tool in keeping health care markets competitive. The PPACA does not protect ACOs from antitrust laws, and because health insurance confers enormous pricing freedom on dominant health care organizations, the formation of ACOs requires heightened, not relaxed, antitrust attention. In particular, antitrust enforcers and courts should be skeptical of efficiency claims and, as a matter of law, should focus their attention only on potential efficiencies and competitive effects in private markets, ignoring the arguable benefits of ACOs to Medicare.

Although conventional antitrust analysis allows efficiency claims to be weighed against harms from increased market concentration, the distorting effects of health insurance in narrowly defined monopolized markets make health care a special case. Thus, although ACOs should be allowed to integrate health care organizations vertically, significant horizontal combinations should not be countenanced unless the affected submarkets feature an ample number of effective competitors. Because of the large number of markets and the seriousness of the potential threat to economic welfare, regulators—either antitrust authorities or Medicare itself—should impose a preapproval process, with the burden of proof on ACO proponents, to prevent the formation of ACOs that dangerously concentrate health care markets.

Given its commitment to performance measurement, Medicare should additionally require ACOs to meet normative or national standards of efficiency in serving both private and Medicare patients. Because such a test would measure performance in terms of risk-adjusted per capita costs—implicitly incorporating both price and service use—an ACO would have difficulty passing the test if it were exploiting its monopoly power in the private sector. Medicare might also condition its sharing of savings with an ACO on the latter’s demonstration that its prices to private payers have not increased because of its acquisition of market power; an ACO found to be abusing its power could be threatened with dissolution.

States also can play an important role in countering the market power of health care organizations. Some states might choose to institute rate caps, a policy that met success in a few states in the 1970s and early 1980s, or to adopt an all-payer rate-setting program. Although price regulation might be palatable only if other efforts fail to curb the market power of health care organizations, policy makers should remember that the health care monopoly problem exists today largely because horizontal mergers were permitted to create large health care systems that failed to produce their promised efficiencies. Current health care prices reflect the costs of these monopolies without many benefits from integration.

Conclusion

Innovative delivery systems must be part of the solution to cost and quality problems. Real benefits can flow from connectivity among health care organizations as well as between health care entities and patients, reducing low-value services, managing chronic diseases, and enhancing prevention. However, organizations that achieve these goals can take many forms. There are compelling reasons to experiment with organizational forms, as envisioned in the PPACA, and to encourage competition among the most promising ones. For example, rather than emphasize hospital-centered ACOs that rely on “bricks-and-mortar” vertical integration, which is arguably obsolete due to advances in information technology, a clearer path in this era of ambulatory care would be to build ACOs around multispeciality physician practices or independent physician associations that do not include most of the physicians in a geographic market. Such arrangements could lower overhead costs while improving quality without exacerbating the health care monopoly problem.

Whatever the approach, the overriding policy goal must be to achieve improvements in care while challenging, rather than playing into the hands of, health care organizations that seek to exploit market dominance. Properly regulated ACOs can be effective instruments for solving the underappreciated problem of monopoly in health care markets and health care delivery.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Richman reported receiving consulting income from Blue Cross Blue Shield of Rhode Island. Dr Schulman reported receiving consulting income from Blue Cross Blue Shield of North Carolina. Dr Schulman has made available online a detailed listing of disclosures (http://www.dcri.duke.edu/about-us/conflict-of-interest/).

Additional Contributions: Clark C. Havighurst, JD, Duke University, and Robert A. Berenson, MD, Urban Institute, contributed to writing the manuscript. Neither received financial compensation. Damon M. Seils, MA, Duke University, provided editorial assistance and assisted with manuscript preparation. Mr Seils did not receive compensation for his assistance apart from his employment at the institution where the work was conducted.

REFERENCES

Berwick Indicates CMS Still Plans To Mix Private Payers, Medicare In ACOs

Posted: February 1, 2011

CMS Administrator Donald Berwick indicated Tuesday that CMS still plans to let accountable care organizations include Medicare beneficiaries and patients with private insurance. Specifically, he said the CMS innovation center will make room for the "vanguards" of accountable care organizations so CMS can test ACO models that go beyond what is called for under the ACO program.

Sources say CMS had been planning to announce a demonstration program late last year to assign Medicare and possibly Medicaid beneficiaries to existing clinically integrated entities in the private insurance market (see story). That announcement was delayed, they said, leaving them to wonder whether CMS had backed off the plan -- but Berwick seemed to say at a Brookings Institution conference that the plan is still in the works.

CMS is talking to private payers about public-private partnerships and about how clinically integrated organizations can align what they are doing for patients with private insurance with the goals of ACOs, Berwick told reporters after his presentation. (The Federal Trade Commission has warned that broad-based ACOs involving private payers could raise antitrust concerns, but the FTC has been working out those matters with CMS.)

Berwick said the proposed rule on the ACO program should be published soon, but when asked by Inside Health Policy whether a demonstration would be announced before the proposed rule, Berwick said only that the innovation center would move "quickly" on ACO demonstrations. The health reform law created an ACO program, which is permanent and separate from the temporary demonstrations that the innovation center approves. However, CMS could approve ACO demonstrations that would later be wrapped into the ACO program, sources say.

Inside Health Policy also asked whether patients should know whether they are in ACOs and whether such an approach is compatible with retrospectively attributing patients to ACOs. Berwick responded that ACOs should be transparent. Debra Ness of the National Partnership for Women & Families said true transparency requires prospective assignment. Ness has met with CMS and innovation center officials and said they are striving toward a "patient-centric" approach, but she does not know whether that will translate specifically into CMS adopting prospective assignment.

Berwick highlighted the difficult choices CMS must make for the ACO program. At the top of the list was whether to use a "two-sided risk model" that would penalize ACOs for not hitting targets on savings and quality of care. The health reform law created a CMS program that pays bonuses to ACOs that keep costs under target thresholds and deliver care that meet quality standards. The Medicare Payment Advisory Commission recently recommended that CMS avoid adopting the bonus-only payment model and also fine ACOs that don't keep costs down.

Mark McClellan, who was CMS administrator under President George W. Bush and now works at Brookings, said it might be best for CMS to use the one-sided approach in the beginning, then move to a model that penalizes ACOs for not hitting cost and quality targets. There are two options under the two-sided approach, he said: the symmetric shared savings model and partial-capitation models that can be used to replace a portion of fee-for-service payments. In the symmetric model, the amount of the bonus and penalty are the same. In a capitation payment model, providers would be paid a fee for each beneficiary at regular intervals. A portion of provider revenue would continue to come from fee-for-service payments, and a portion would come from periodic, flat payments, which would be tied to bonuses or penalties.
Berwick also said protecting beneficiaries is a challenge. CMS wants to discourage ACOs from "cherry picking" healthy patients and not caring for sicker patients. Berwick said CMS is grappling with privacy and data sharing policies. -- John Wilkinson (jwilkinson@iwnnews.com)

Related News: Inside Health Reform Medicare Edit tags

Related News: Inside Health Reform Medicare

Web Design by Blue Water Media
Chamber Of Commerce Raises Concerns With CMS About Potential ACO Cost-Shifting

Posted: February 16, 2011

The U.S. Chamber of Commerce recently sent a private letter to CMS Administrator Donald Berwick raising concerns that providers will shift costs onto private insurers and employers insurance as an unintended result of Accountable Care Organizations (ACO), a central piece of delivery system reform in the health care law and regulations for which could come out by the end of this month.

A Chamber health policy official confirmed to Inside Health Policy that the pro-business lobby sent the letter to the agency the week of Jan. 31, but would not release the document, which the Chamber said is standard procedure. The Chamber has outwardly supported repeal of health reform and focused on some of its particular provisions - such as the unpopular 1099 reporting requirement for businesses - but it has, until now, not made public statements on the issue of ACOs and their potential impacts on the private insurance market and employers.

Katie Mahoney, the Chamber's director of health care regulations, said the Chamber is "cautiously optimistic" that the ACO model will improve quality in the health care system, but the regulations need to be carefully created to correct any perverse incentives created by the fee-for-service methodology. Mahoney said the letter raises issues about potential cost shifting by providers that decide to form an ACO to get shared savings. To compensate for the lower Medicare reimbursement rates they receive, Mahoney said, providers in ACOs could end up shifting costs to private payers and employers by increasing the amounts they charge.

"We believe that the principles behind the ACO concept are laudable and just are hopeful that the regulations will consider this potential problem," Mahoney said.

Mahoney said that the aforementioned issue was of greater concern, but the Chamber also expressed worries about potentially "excessively burdensome regulations." Mahoney said if it becomes too difficult and challenging for providers to work with the Medicare Shared Savings Program and reimbursements in Medicare are too low, providers may be inclined to serve only private payer patients, exacerbating the access problems facing some Medicare beneficiaries.

Karen Ignagni, president and CEO of America's Health Insurance Plans, told Inside Health Policy that employers increasingly are focusing their attention now onto cost-sharing problems in ACOs, one of AHIP's biggest priorities this year. The insurance lobby, in December comments to CMS on a Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program, also said it is critical that CMS avoid creating incentives for ACOs to achieve savings in federal programs by increasing costs in the private market.

To avoid this, AHIP wrote, CMS should establish specific commercial rate metrics for participating ACOs that are tied to an objective benchmark; require participating ACOs to report on those metrics before and during their participation in the program; and tie any shared savings that participants receive to savings obtained in Medicare and the commercial sector.

Potential ACO Implementation challenges have been noted by several industry groups and health policy experts. In an October 2009 analysis of ACOs by the Urban Institute's Kelly Devors and Robert Berenson, the two noted that an ACO program designed for traditional Medicare beneficiaries, particularly a mandated program based on analysis of Medicare claims data as some proposals call for, might not serve private employers' or health plans' interests very well. Berenson is also a member of the Medicare Payment Advisory Commission.
"Perhaps even more serious, purchasers and plans are concerned that sanctioning the collaboration of most of the physicians with each other, perhaps also with one or more hospitals in a geographic area, would increase providers’ market power and result in substantially increased provider prices gained through negotiated contracts, costing the payers much more than if the providers remained in their fragmented silos. In short, newly empowered ACOs might be well positioned to reduce spending and spending growth for Medicare, but not for commercial insurers and self-funded employers; providers might be able to demand higher payments from private payers even as their own costs go down,” Devers and Berenson wrote. - Rachone Dixit

Related News:  Edit tags
How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations

ABSTRACT The Patient Protection and Affordable Care Act establishes a national voluntary program for accountable care organizations (ACOs) by January 2012 under the auspices of the Centers for Medicare and Medicaid Services (CMS). The act also creates a Center for Medicare and Medicaid Innovation in the CMS. We propose that the CMS allow flexibility and tiers in ACOs based on their specific circumstances, such as the degree to which they are or are not fully integrated systems. Further, we propose that the CMS assume responsibility for ACO provisions and develop an ordered system for learning how to create and sustain ACOs. Key steps would include setting specific performance goals, developing skills and tools that facilitate change, establishing measurement and accountability mechanisms, and supporting leadership development.

The Patient Protection and Affordable Care Act of 2010 directs the Centers for Medicare and Medicaid Services (CMS) to create a national voluntary program for accountable care organizations (ACOs) by January 2012. ACOs are provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the groups’ clinicians. The organizations also provide data to be used in assessing their performance on cost and quality criteria.

Combined with payment reform, ACOs are seen as one way to reduce the rate of increase in health care costs over time, while also improving the coordination and quality of care for patients. Bending the cost curve will be necessary if the expansion of health insurance coverage to an estimated thirty-two million Americans is to be affordable over time.

Provisions In The Reform Law

The health reform act instructs the CMS on the capabilities that ACOs must display to participate in the federal program. These include a sufficient number of primary care professionals to provide services to at least 5,000 beneficiaries and the ability to report data on cost, quality, and overall patient care experience for Medicare fee-for-service beneficiaries. Participating groups must also agree to enroll in the CMS program for at least three years and exhibit a legal structure that permits them to receive payments for shared savings from the CMS and distribute a portion of the payments. The shared savings would be generated when the group provides care to beneficiaries for less than a Medicare benchmark cost while meeting criteria for patient service and quality of care.

We recommend that the CMS’s new Center for Medicare and Medicaid Innovation be charged with stimulating and overseeing the development of ACOs. The Innovation Center should communicate the potential advantages of ACOs to all parties, carefully align new payment incentives with the capabilities outlined in the provisions of the health reform law, and develop a learning system to support the formation and sustainability of the organizations.
Why Pursue ACOs?
Accountable care organizations have potential advantages for patients, physicians and other clinicians, hospitals, and payers—particularly in regard to providing more cost-effective care to a growing number of chronically ill Americans. Many people with chronic illnesses have multiple conditions and see as many as seven or eight physicians, in different locations. The multiple physicians and visits result in uncoordinated care that is reflected in preventable hospital admissions and readmissions, poor adherence to medication regimens, and inadequate follow-up care.

**Financial Incentives** ACOs can address these issues by creating and responding to financial incentives that provide rewards for keeping people well. They can also bring clinicians together into teams that take responsibility for all of patients’ care across the spectrum of medical conditions and facilities. They provide a foundation for implementing electronic health records and electronic visits—for instance, through e-mail and telephone appointments—to improve care management processes and encourage patients to be involved in their own care. The organizations also use performance measures that provide external accountability to payers and the public, and internal metrics to facilitate improved care.

**Physician Shortages** Although ACOs are not themselves a complete solution to the acute shortage of primary care clinicians across the country, they may help alleviate the shortage by allowing primary care practices to care for larger numbers of patients more efficiently through team-based practice. In addition, the combination of a more positive work environment and payment incentives may help attract more medical and nursing school graduates into primary care.

**Bundled Payment** The typical hospital business model today is based on generating net income from the inpatient margin—in other words, total payments for inpatient care minus the costs of inpatient treatment. However, as the CMS moves toward bundled payment—a single payment to hospitals and physicians jointly for a given condition or procedure—as well as toward capitation—a set payment per member per month—the business model will necessarily change. It will be based on the total margin generated by providing overall care to the patient across the care continuum, not just when he or she is an inpatient.

Thus, incentives will be created for hospitals to work closely with physicians to achieve shared savings, subject to meeting quality and service criteria. Currently, 70 percent of hospital leaders believe that their institution could be a part of an accountable care organization within the next five years.

**Less Fragmentation** Many insurers contract with networks of small physician practices, which results in fragmented relationships among primary care physicians, specialist physicians, other clinicians, and hospitals. The result is costly and often ineffective care that puts upward pressure on premiums to the insurer and on costs to employers. If ACOs can reduce some of the fragmentation and provide a platform for the delivery of more-integrated care, insurers and employers should benefit directly.

Given these potential advantages, the key policy issue for the CMS becomes how to structure and implement the ACO concept so as to maximize its advantages. This will require the CMS to encourage the development of flexible models and payment approaches for ACOs that can be adapted to fit local communities and market conditions. It will also require the creation of a system in which all parties can learn from others’ experiences.

**Accountable Care Models**

Accountable care organizations will be largely based on physician practices that, in turn, may be organized as patient-centered medical homes. Many ACOs will also include hospitals, home health agencies, nursing homes, and perhaps other delivery organizations. There are at least five different types of practice arrangements that could serve as ACOs. These are the integrated or organized delivery system, multispecialty group practices, physician-hospital organizations, independent practice associations, and “virtual” physician organizations, all described below.

**Integrated Delivery Systems**
Integrated delivery systems involve a common ownership of hospitals, physician practices, and—in some cases—an insurance plan. Some examples are Kaiser Permanente, Group Health Cooperative of Puget Sound, and Geisinger Health System. These systems typically have aligned financial incentives, electronic health records, team-based care, and resources to support cost-effective care.

**Multispecialty Group Practices**
Multispecialty group practices usually own or have a strong affiliation with a hospital. Examples of this type of arrangement include Mayo Clinic and Cleveland Clinic. They usually do not own a health plan but, rather, have contracts with multiple health plans in their areas. Most have a long history of physician leadership and highly developed mechanisms for providing...
We recommend that the CMS consider creating three tiers of ACO qualification criteria.

**Physician-Hospital Organizations** These organizations are a subset of the hospital’s medical staff. One example is Advocate Health in Chicago. Most were formed in the 1990s in response to managed care pressures to negotiate with health plans. Some function like multispecialty group practices, focusing on reorganizing the delivery of care to achieve more cost-effective coordination. Although they may be less well suited than integrated delivery systems or multispecialty practices to qualify as ACOs, many could structure themselves to meet the criteria for that type of organization.

**Independent Practice Associations** Independent practice associations consist of individual physician practices that came together largely for purposes of contracting with health plans. Over time, however, many of these have evolved into more-organized networks of practices that are actively engaged in practice redesign, quality improvement initiatives, and implementation of electronic health records. One example is Hill Physicians Group, in Northern California. Such organizations could qualify as ACOs, and that might encourage other independent practice associations to evolve similarly, given sufficiently strong financial incentives and technical assistance.

**Virtual Physician Organizations** Finally, a number of small, independent physician practices, many located in rural areas, can organize to become “virtual” physician organizations, such as Community Care of North Carolina. This process can be led by individual physicians in rural areas or by a local medical foundation, state Medicaid agency, or similar organization that can provide the leadership, infrastructure, and resources to help small practices develop disease registries; implement electronic health records; share information; and provide better-coordinated, cost-effective care. These virtual networks could qualify as ACOs and serve as models for other groups of small practices.

**Qualification Tiers**

Physicians can choose one or more of the above models, depending on what best fits their needs and local circumstances. But because there are so many options, the payment systems that the CMS creates for ACOs should evolve with the models chosen. Specifically, the more-integrated forms of accountable care, such as integrated delivery systems and multispecialty group practices, are capable of assuming the greatest risk. This would make them natural candidates for capitation or bundled payments, in which providers assume a relatively greater share of risk.

In contrast, less structurally integrated forms of ACOs, such as virtual physician organizations and more loosely organized independent practice associations, are best suited—at least initially—to low degrees of risk. For them, a form of limited, partial capitation for selected illnesses may be most appropriate.

Thus, rather than requiring that all practices interested in becoming accountable care organizations meet all of the requirements contained in the health reform law to the same degree, we recommend that the CMS consider creating three tiers of qualification criteria, as outlined below. Potential ACOs could submit a three-year plan to the CMS for qualifying for ACO status at any one of the three tiers.

The tiering approach is attractive from both a policy and a practice perspective. It would allow physician practices to start at a low level, with fewer capabilities. Practices could advance to higher levels (offering greater rewards) over time as they become able to meet stricter criteria.

**Tier 1** The accountable care organization at this tier might bear little financial risk but would be eligible to receive shared savings and bonuses if it meets quality benchmarks and reduces per beneficiary spending below an agreed-upon target. It could receive most of its payments on a fee-for-service basis.

Tier 1 requirements might include establishing a legal practice entity with a designated governance and management structure. The organization could be required to indicate the specific nature of the ownership or contractual relationships among physicians, hospitals, and its other units. Organizations in this tier might also be required to have a sufficient number of primary care physicians to care for a defined population of patients of sufficient size to reliably report performance results.

The CMS could also require the capability to report a basic set of performance measures based on at least administrative data. Initially, virtual physician organizations and loosely organized independent practice associations would find Tier 1 criteria the most appropriate and
achievable.

**Tier 2** Organizations at this tier might be eligible to receive a greater proportion of savings if they achieve spending rates below a specified target, but they would also be at risk for spending above the target. They could be paid more through partial capitation and selected bundled payments. These ACOs would be required to meet the same governance and contractual criteria as organizations in Tier 1.

Groups in Tier 2 would also be required to report more comprehensive data on performance measures that include patient experience and clinical performance for a variety of conditions, such as asthma, diabetes, and congestive heart failure. They would also have to meet specific standards for financial reporting, including revenue and expense projections and the maintenance of minimum cash reserves. Groups interested in the physician-hospital organization model might find Tier 2 eligibility criteria attractive.

**Tier 3** Accountable care organizations at this level would be reimbursed through full capitation or extensive partial capitation and bundled payments. They would be eligible for the highest level of reward but also exposed to the greatest amount of risk. In addition to the criteria for the other tiers, qualifying criteria for Tier 3 might include public reporting of comprehensive data on performance measures drawn from electronic health records, including patient reports of health-related outcomes and quality of life.

Tier 3 organizations might also be required to meet additional, more stringent, standards for financial reporting and cash reserves. Integrated delivery systems and multispecialty group practices would be most likely to qualify as Tier 3 groups.

**Implementing A Learning System**

Given the need to adapt different models of accountable care organizations to local market circumstances, and to match the risks and rewards to the different models, policy makers need to create a system of learning from experiments with ACOs. This system would help promote more rapid diffusion of successful models and achievements across the country.

Previous research and experience suggest four cornerstones for the learning system: a focus on goals and objectives that motivate efforts to change; skills and tools that facilitate change, including the implementation of electronic health records, care management processes, methods of continuous quality improvement, and the effective use of teams; measurement of and accountability for performance; and strong leadership. The CMS’s new Center for Medicare and Medicaid Innovation, working with the CMS Quality Improvement Organizations and private-sector organizations such as the Institute for Healthcare Improvement and the National Center for Healthcare Leadership, is the best vehicle for developing such a learning system.

**Strategic-Focused Goals and Objectives**

To facilitate delivery system transformation and focus attention on desired health outcomes, payment systems need to change. Payment based on outcomes achieved, rather than on volume of services provided, will be the motivation for providers to focus their attention on improving the underlying systems of care. The change will motivate them to ask such questions as: Why do I have so many diabetic patients whose blood sugar levels are over 9 percent? Why do I have to spend so much unproductive time with some patients and not have enough time for others? What are my patients doing between visits? Why are my patient experience scores in the lowest quartile of my group?

**Skills and Tools** In addition to having a motivation to learn, providers need the skills and tools to address the questions raised. These include, in particular, the use of evidence-based care management processes, the adoption of continuous quality improvement techniques, the ability to develop effective teams, and the implementation of electronic health records and registries. Much has been written about each of these skills and tools, but they need to be considered as an integrated set of competencies required to effectively respond to the new payment incentives for providing better-coordinated, cost-effective care.

For example, recent research on the use of health information technology (IT) extension centers to help physicians adopt electronic health records suggests that the adoption by itself has only a limited impact. Instead, it is important to link the centers’ assistance to an overall approach to practice redesign, and to developing team-based and evidence-based use...
of care management processes. Particular attention should be given to implementing electronic health records that can transfer relevant information to different kinds of providers within accountable care organizations and to external organizations as needed.

**MEASUREMENT AND ACCOUNTABILITY** Key to learning is receiving accurate feedback on one’s performance in a timely fashion. Thus, electronic health records must facilitate not only patient diagnosis and treatment but also the ability to aggregate data across patients. These data can form the basis of feedback reports for both individual clinicians and a practice at large, enabling providers to assess deviations from desired performance goals and to take corrective action.

The recommendations of the Institute of Medicine Performance Measurement Report and the work of the National Quality Forum and the Agency for Healthcare Research and Quality (AHRQ) constitute a portfolio of measures available for use. As performance measures improve over time, they can be grouped into three categories. The first is measures with known reliability, validity, and feasibility that are now ready for “prime time.” The second is performance measures that are almost ready but that require further testing, particularly to determine which kinds of practice settings can provide the needed data. The third is measures that are promising but whose reliability, validity, and feasibility still need verification.

**LEadership** Clinical and managerial leadership will be needed to implement accountable care organizations. Integrated delivery systems, multispecialty group practices, physician-hospital organizations, and independent practice associations have benefited greatly from the leadership of key people over the years. Leaders are needed to motivate and set an example for others to follow in creating ACOs. Leaders have an important part to play in developing the skills and tools to respond to the new payment incentives and the necessary systems to measure performance and accountability. Validated competencies of effective leadership can be used. The CMS should set aside specific funds for the development of leadership competencies within new ACOs.

**Discussion**

Considerable technical assistance will be needed to implement the learning system for the development of ACOs. This will be particularly true for loosely organized independent practice associations and virtual physician networks, which currently lack the size and resources to become ACOs.

**A PORTFOLIO APPROACH** We recommend that a variety of organizations offer technical assistance. The CMS Quality Improvement Organizations are one source. Most of them have considerable experience and expertise in quality improvement and process redesign, the implementation of electronic health records, and the promotion of care management processes. Private-sector organizations such as the Institute for Healthcare Improvement can also play key roles.

Local and statewide foundations and regional collaboratives can also be important sources of assistance. These include the Pittsburgh Regional Health Initiative, the Twin Cities Integrated Clinical Services Institute (ICSI), and California’s Integrated Healthcare Association.

An additional approach would be to develop a network of more-mature health care delivery organizations around the country. These organizations could serve as mentors to less-mature delivery organizations, to provide assistance in developing the learning system. One such mentor might be the Council of Accountable Physician Practices, which is a subsidiary of the American Group Practice Association and comprises some of the country’s leading multispecialty group practices.

The CMS might give these mentoring organizations a bonus payment for providing technical assistance to selected organizations across the country for a defined period of time. The mentors would teach best practices in care management processes, practice redesign, development of effective teams, implementation of electronic health records, and other related skills.

The payment to the mentoring organization might be structured so that 50 percent of its bonus payment would be paid up front, with the remainder paid only if the recipient organization successfully implemented these best practices, meeting predetermined criteria for success. Examples could include implementing a patient reminder follow-up system for medication adherence for diabetic patients, a transitional care program from hospitals to primary care sites, and a patient self-management program.

**SYSTEMATIC EVALUATION AND FEEDBACK** To accelerate learning from and improvement of the ACO model and to help all ACOs learn from each other’s experiences, their implementation should be systematically and comprehensively evaluated. The use of standard measures of cost and quality performance would provide one important source of data. But additional data will be needed on how electronic health records, care...
management processes, quality improvement initiatives, and leadership training programs are implemented.

Data will also be needed about the local context within which each ACO operates, including the size of the market, the concentration of payers, and related factors. Only through such a comprehensive assessment will we be able to learn rapidly from the successes and failures and maximize the probability that the program as a whole will succeed.

**CONCLUSION** The CMS should emphasize innovations in both payment and practice models, which must evolve within the context of the learning system. There are many challenges to the development and implementation of accountable care organizations beyond those discussed, such as legal and regulatory barriers. But the CMS’s actions can dramatically increase the chances of success for these organizations. As discussed, actions by the CMS should include recognizing the need for different models of ACOs adapted to local circumstances, having different levels of qualification appropriately matched with different payment models, and developing an associated system for learning.

The authors thank Emerald Montgomery for her assistance in the preparation of this paper.

### NOTES

8. Other examples are Virginia Mason Clinic, Marshfield Clinic, Billings Clinic, and Scott and White Clinic.
9. Other examples are Middlesex Hospital, in Connecticut, and Tri-State Child Health Services Inc., affiliated with Cincinnati Children’s Hospital Medical Center.
10. Other examples are Atrius Health, in Massachusetts; and HealthCare Partners and Monarch, in Southern California.
11. Other examples are Grand Junction, in Colorado; and the North Dakota Cooperative Network.
INTEREST IN ACCOUNTABLE CARE ORGANIZATIONS (ACOS) has increased dramatically with the passage of the Affordable Care Act, which establishes ACOS as a new payment model under Medicare and fosters pilot programs to extend the model to private payers and Medicaid. Proponents hope that ACOS will allow physicians, hospitals, and other clinicians and health care organizations to work more effectively together to both improve quality and slow spending growth. Skeptics are concerned that ACOS will focus narrowly on their bottom line and either stint on needed care or use the leverage they achieve through local integration to demand unreasonable prices from payers.

Whether ACOS achieve their ambitious promise remains far from certain. It is likely that the success of ACOS (and the many other payment-reform initiatives included in the Affordable Care Act) will depend in large part on whether the Centers for Medicare & Medicaid Services, private payers, physicians, and health system leaders can work together to establish a tightly linked performance measurement and evaluation framework that not only ensures accountability to patients and payers, but also supports rapid learning, timely correction of policy and organizational missteps, and broad dissemination of successful organizational and practice innovations. Because ACOS are likely to be one of the first major payment reform initiatives to be put in place, the measurement framework established for ACOS could also provide a foundation for evaluating other reforms.

Improving Performance Measurement
The limitations of current approaches to performance measurement are well recognized. Measures too often assess individual clinicians and silos of care, focus largely on processes of questionable importance, are imposed as an add-on to current work, and require burdensome chart reviews and auditing or reliance on out-of-date administrative claims data. Poor performance is seen as a consequence of individual failure, rather than flawed systems. The result is a performance measurement system that often provides little useful information to patients or clinicians, reinforces the fragmentation that pervades the US health care system, and reinforces physicians’ perception that measurement is a threat.

Advances in the science of improvement and progress in health information technology have led to an emerging national consensus that new, more promising approaches to performance measurement are within reach. Measurement of key processes and outcomes must be an integral part of the care process to support both improvement and accountability, reduce the burden of measurement, and improve accuracy and reliability. Explicit aims for improvement are essential; major stakeholders have agreed on the following: improving population health, engaging patients in making decisions and managing their care, improving safety and care coordination, guaranteeing compassionate and appropriate end-of-life care, and eliminating waste. Moreover, experts agree that achieving these aims will not be possible without longitudinal approaches to measurement that capture patient-reported health outcomes, the degree to which care was aligned with patients’ well-informed preferences, and total costs of care.

This is an ambitious vision of comprehensive, meaningful measures embedded within interconnected electronic health records that support clinicians’ efforts to improve across the full continuum of care while ensuring accountability to payers, patients, and policy makers.

Getting There From Here
The challenge facing policy makers is therefore how to simultaneously ensure that the implementation of ACOS and other payment reforms provides an adequate level of accountability for participating clinicians and health systems constrained by current measurement approaches, while helping all to advance rapidly toward the more advanced measures and measurement systems envisioned.

One approach would be to build on the notion of different levels of ACOS based on different payment models (shared savings with no risk, symmetrical shared savings with some risk for excess costs, and partial capitation), which would require differing levels of organizational structure and accreditation. The same principle of differing levels ofmeasurement extends to other payment reforms as well.

Author Affiliations: Dartmouth Institute for Health Policy and Clinical Practice, Hanover, New Hampshire (Dr Fisher); and Division of Health Policy and Management, School of Public Health, University of California, Berkeley (Dr Shortell).

Corresponding Author: Stephen M. Shortell, PhD, MPH, MBA, School of Public Health, University of California, 417E University Hall, Berkeley, CA 94720 (shortell@berkeley.edu).
measurement capacity could be used to support more rapid development and implementation of advanced approaches to performance measurement.

For example, level 1 ACOs, those without electronic health records or well-established patient registries, could rely in the near term on the meaningful measures that can be ascertained from claims data (eg, cancer screening, diabetes testing). These ACOs might be expected to progress rapidly to report on a more advanced set of measures, such as selected health outcomes (eg, blood pressure control), patient-reported care experience measures (eg, after hours access), and total costs of care. The Alternative Quality Contract developed by Blue Cross Blue Shield of Massachusetts is currently using such a set of measures for its ACO-like global payment program. Level 2 ACOs (those with site-specific electronic health records and registries) might be expected to add more advanced measures (eg, patient-reported health outcomes for selected conditions). Level 3 ACOs (those with comprehensive electronic health records across all sites of care) could be required to test and implement measurement systems that support practice improvement and accountability in such difficult areas as informed patient choice and health outcomes for a broad array of conditions.

All ACOs should be expected to participate in performance measurement to the extent of their capabilities, rather than relying on a lowest common denominator approach. Higher-level ACOs would not only be held to higher standards of accountability but would also contribute to advancing the field of performance measurement by developing and testing the new measures and measurement approaches that are needed. All ACOs would be expected to move to more advanced measures as quickly as possible.

Learning From Experience

A rapidly advancing performance measurement infrastructure could also help accelerate learning and reduce the risk of unintended harms. It is important to know not simply whether an ACO worked (improved care, reduced costs) but also how it worked. For example, what aspects of the ACO (eg, organizational structure, leadership, care processes) and of the local environment (eg, market structure, state health policies) contributed to its success? Because private payers are increasingly concerned about the market consolidation stimulated by the growth in ACOs, it will be important to evaluate the influence of ACOs on the quality and costs of care for the non-Medicare population.

It may also be worth considering the adoption of a common evaluation framework across the variety of delivery system and payment reform initiatives called for under the Affordable Care Act. The history of demonstration programs within Centers for Medicare & Medicaid Services is largely one of designing highly specific evaluation approaches and ensuring that there is no overlap among the clinicians, practices, health systems, or regions participating in the demonstrations. This is not likely to be possible or even desirable as reform proceeds. It is important to know not only whether bundled payments work but also whether they are more or less effective when combined with other reforms, such as ACOs or medical home programs. If the overarching aims of reform are shared, a common measurement infrastructure and framework will offer important advantages in allowing the effects of diverse innovations to be evaluated and compared on a level playing field.

Conclusion

The notion of accountable care has broad appeal. But only a robust, comprehensive, and transparent performance measurement system can reassure the public, physicians, hospitals, others who deliver care, and payers that ACOs are worthy of the name.

Financial Disclosures: Dr Fisher reported that he co-directs the Brookings-Dartmouth Accountable Care Organization Learning Network that provides technical support and education about policy and implementation issues related to ACOs. The Commonwealth Fund provided support through a grant to develop a measurement framework for the Brookings-Dartmouth accountable care organization pilots.

Role of the Sponsor: The sponsor had no role in the preparation, review, or approval of the manuscript.

Additional Contributions: Mark McClellan, MD, PhD, Larry Casalino, MD, PhD, Joachim Roski, PhD, MPH, and Eugene Nelson, DSc, MPH, have been important contributors to our thinking on this topic but were not financially compensated for their work.

REFERENCES

ABSTRACT Under the Affordable Care Act, the new Center for Medicare and Medicaid Innovation will guide a number of experimental programs in health care payment and delivery. Among the most ambitious of the reform models is the accountable care organization (ACO), which will offer providers economic rewards if they can reduce Medicare’s cost growth in their communities. However, the dismal history of provider-led attempts to manage costs suggests that this program is unlikely to accomplish its objectives. What’s more, if ACOs foster more market concentration among providers, they have the potential to shift costs onto private insurers. This paper proposes a more flexible payment model for providers and private insurers that would divide health care services into three categories: long-term, low-intensity primary care; unscheduled care, including unscheduled emergency services; and major clinical interventions that usually involve hospitalization or organized outpatient care. Each category of care would be paid for differently, with each containing different elements of financial risk for the providers. Health plans would then be encouraged to provide logistical and analytic support to providers in managing health costs in these categories.

Slowing the growth of health care spending will require changing how health insurers and providers contract with one another. Medicare payment innovations encouraged by the Affordable Care Act of 2010 aim to shift Medicare’s emphasis away from fee-for-service to some form of bundled payment for each episode of illness, or some kind of capitation—fixed payments per member per month, regardless of the amount of services provided—for defined populations of patients. How private health insurers respond to this shift will greatly influence not only the affordability of coverage for people not eligible for Medicare, but also the future of health insurance itself.

In the United States today, private health plans typically pay for their enrollees’ health care through fee-for-service physician payments and either per diem or per case hospital payments. As is well known, this approach offers providers powerful financial incentives to increase the volume of services they deliver. Cutting payments to providers simply encourages them to deliver even more services to compensate for lost income.

Historically, health plans used their market leverage to limit rate increases by negotiating contracts with individual providers that limited providers’ unit cost increases. But in many markets, this mechanism has become less effective in constraining costs, as hospitals have merged and
specialty physicians have consolidated into large, single-specialty group practices—thus increasing their own market share and becoming more able to resist plans’ demands.

As a result, insurers have reinstituted venerable methods of controlling use that some had abandoned in recent years—for example, requiring prior authorization for expensive services such as hospital admissions and advanced imaging procedures. More recently, some insurers have begun to work directly with patients to counsel them in managing their health risks, completely bypassing providers.1

These efforts raise two important questions: Can providers and insurers work together more constructively to manage future health costs, and how can that kind of cooperation best be developed? A “modular” approach to payment, described below, is one possible solution.

Problems With Accountable Care Organizations

Some policy advocates believe that the way to stabilize health care costs is to engage providers in a form of population-based cost management—that is, to compel providers to constrain costs across the population of an entire community. The principal embodiment of this idea is the accountable care organization (ACO). The concept originated at the Dartmouth Institute for Health Policy and Clinical Practice and has been articulated by Dartmouth’s Elliott Fisher, Mark McClellan of the Brookings Institution, and others. The idea was incorporated into the Affordable Care Act as the Medicare Shared Savings Program, to be implemented—beginning in 2012—not as a pilot or demonstration project but as an optional method for providers to be paid under the program.

Fisher and his colleagues originally envisioned the accountable care organization as an alternative payment methodology that would reward provider organizations for reducing Medicare spending growth in individual hospital service areas. Hospitals and their “extended medical staffs”—physicians practicing in the same geographic area served by a hospital—would be given a gainsharing incentive to reduce the growth rate in per capita Medicare spending for that geographic area.2 Physicians and hospitals would get a share of the savings if they could reduce aggregate Medicare spending to a level below a targeted growth rate.

As objections to the original formulation have surfaced, the ACO concept has evolved into an amorphous cluster of possible collaborative models. These models involve many different types of providers in addition to hospitals—such as independent practice associations, multispecialty medical groups, and ad hoc organizations of hospitals and physicians—and varying degrees of possible provider risk assumption.3

Hospitals Still Central

Despite the lengthening of the list of possible participants, hospitals are likely to dominate the ACO contracting process for two reasons. First, the largest avoidable Medicare costs are hospital related. And second, in many communities, the hospital is the only organized care delivery entity capable of executing the model.

The realization of this fact is having direct consequences on the private insurance market, even before Medicare implements its ACO program. Many hospital executives view it as essential that hospitals become “prime contractors” in the ACO model. Further, the executives believe that unless they “align physicians’ incentives” with those of the hospital, they will not be able to create and manage successful accountable care organizations. However, for many hospital administrators, alignment is a code word for “physicians work for me and will do what I say.”

In the 1990s hospitals rushed to merge and acquire physician practices to create “integrated health systems”—which proponents of the Clinton administration’s health reforms anticipated would contract with insurers—and many incurred catastrophic economic losses in doing so. Another wave of hospital mergers is now taking place, as is an acceleration of hospitals’ acquisition of physician practices.4 According to a recent Medical Group Management Association survey, almost two-thirds of the physicians who signed employment contracts in 2009, as well as half of the physicians who were just entering practice after training, worked for hospitals.5 Multiple studies have shown that hospital-led market consolidation increases the overall cost of the US health care system.6

It also appears that hospitals are experiencing larger economic losses on the practices they are acquiring now than hospitals did in the wave of acquisitions in the 1990s. This is because hospitals have been buying the practices of more high-earning specialists, such as cardiologists and general surgeons, and are guaranteeing salaries for these physicians that are considerably in excess of what the hospitals are collecting for the physicians’ services. Furthermore, most hospitals are still managing these newly salaried physicians as collections of geographically separate physician practices. It will take many years before these hospitals’ clinical services are well enough organized to manage population-level health costs, as the ACO model contemplates.

Hospitals wishing to become accountable care organizations will have to make sizable invest-
Accountable Care Organizations

The economic conflict between physicians and hospitals over highly profitable ambulatory services has left a powerful residue of mistrust between hospital managers and physicians. An essential ingredient of effective managed care is trust among the participants, including among physicians themselves. Sadly, that trust is absent in many health care markets.

The track record of provider-led managed care efforts has not been encouraging, either. During the 1980s and 1990s, hundreds of hospitals and hospital-physician organizations tried to contract with insurers on the basis of capitation or to create their own health plans. Most of these efforts had inadequate resources and weak governance; lacked the clinical discipline and technology capacity to control the use of services or contain expenses; and failed completely. There were a few notable exceptions—such as Geisinger Health System, in Pennsylvania; Intermountain Health Care, in Utah; Aultcare, in Ohio; and the provider system now known as Sanford Health, in South Dakota.

Mistrust: The economic conflict between physicians and hospitals over highly profitable ambulatory services has left a powerful residue of mistrust between hospital managers and physicians. An essential ingredient of effective managed care is trust among the participants, including among physicians themselves. Sadly, that trust is absent in many health care markets.

The track record of provider-led managed care efforts has not been encouraging, either. During the 1980s and 1990s, hundreds of hospitals and hospital-physician organizations tried to contract with insurers on the basis of capitation or to create their own health plans. Most of these efforts had inadequate resources and weak governance; lacked the clinical discipline and technology capacity to control the use of services or contain expenses; and failed completely. There were a few notable exceptions—such as Geisinger Health System, in Pennsylvania; Intermountain Health Care, in Utah; Aultcare, in Ohio; and the provider system now known as Sanford Health, in South Dakota.

Infrastructures: There are serious infrastructure constraints on the model of the accountable care organization that directly affect the hospital’s ability to bridge the gap between the in-hospital and nonhospital physicians. Although many hospitals and health care systems have automated their own hospital medical records, and a small minority have automated physicians’ clinical ordering in the hospital, the vast majority of physicians still do not have...
the sort of electronic health record systems that Geisinger and other established group practices use to help manage nonhospital care across their patient populations.11

The incentives contained in the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 were designed to remedy this problem by accelerating physicians’ adoption of electronic health records. But it remains to be seen how much of this technological gap can be bridged, and how soon. It typically takes health systems five to ten years of operating experience before they can use information technology to change how care is actually delivered.

**WEAK INCENTIVES AND INCOME REDISTRIBUTION**

Although the ACO model seeks to blunt the “do more to make more” incentives of fee-for-service payment, the modest rewards that the model offers for cost restraint are unlikely to catalyze major change. This is because the rewards for an accountable care organization—a share of the savings if the providers succeed in lowering the rate at which Medicare costs escalate in their communities—are grafted on top of a payment system that still rewards individuals for increasing the volume of clinical services. That is, ACO participants will continue to be paid fee-for-service.

The sacrifices required to make the accountable care organization work are not randomly distributed within physician communities. High-earning specialists—particularly surgeons and the providers who rely heavily on revenue generated through the use of advanced imaging procedures—have far more compelling incentives to keep their volumes (and incomes) up than do primary care physicians, psychiatrists, or diagnosticians who use less-sophisticated technology.

The ability to redistribute incomes within physician communities—a challenge that doomed many provider-sponsored managed care efforts in the past—will not exist in the many markets where the high earners have consolidated into single-specialty groups precisely to resist such efforts (personal communication from Nathan Kaufman, Kaufman Strategic Advisors, July 9, 2010). These single-specialty groups—which accountable care organizations will find as hard to absorb as gravel in the digestive tract—generally did not exist when the first wave of independent practice associations, provider-sponsored organizations, and other risk-sharing enterprises were created.

**LACK OF PATIENT INVOLVEMENT**

Another key defect of the ACO model is the lack of any requirement for active patient involvement in joining the organization. Historically, managed care relied on voluntary enrollment by subscribers. The incentives for subscribers—employees and Medicare Advantage beneficiaries—to enroll in managed care plans included reduced patient cost sharing, more-comprehensive services, and less-complicated billing. In exchange for these rewards, managed care subscribers accepted some limits on access to services and to specific providers.

Although regulations to implement the Medicare shared savings program of the Affordable Care Act have not yet been issued, it is likely that patients will not be required to join or enroll in an accountable care organization. Rather, they and their care will be “attributed” to particular organizations—probably based on the affiliation of their primary care physicians—for the purposes of evaluating whether or not the organization achieves performance metrics in terms of cost and quality improvement. The patients’ aggregate Medicare expenses will be measured after the fact as the basis for calculating the organization’s gainsharing reward. This is sometimes called “shadow” capitation. The precise mechanism for patients’ assignment to an organization will not be certain until the federal government issues the relevant regulations some time in 2011. But because patients will probably have no incentive to stay in the organization, they may also lack incentives to cooperate with strategies to reduce costs. What’s more, an organization’s patient population may fluctuate considerably from year to year. This uncertainty will further hamper the participating providers’ efforts to manage costs.

**A BRIDGE TOO FAR**

Private health insurers need a strategy that is real, not speculative, to hold providers accountable for cost on behalf of their subscriber populations. Because many providers lack actuarial and insurance capacity, clinical data, and infrastructure, they are unlikely to be able to manage population health costs successfully, through either “shadow” capitation for a community, as described above, or real capitation for an enrolled population.

In the meantime, the likelihood that physician markets will be consolidated through hospitals’ acquisition of practices will force private insurance costs higher through cost shifting. Such a trend could negate any possible savings through accountable care for Medicare—even if the strategy did manage to contain Medicare’s own spending. It is conceivable that we could have the worst of both worlds: a Medicare policy failure that drives private-sector costs higher.

If health insurers are to survive this transition to less inflationary payment models, they must find a way to make providers more accountable
for costs without incurring the risk of further provider market concentration. Private insurers need an alternative approach to population-based payment that recognizes the diversity of providers’ circumstances and degree of integration, yet encourages them to take manageable risks. The ideal contracting model would also preserve a role for patient choice and encourage competition among provider entities—two features that are absent from the ACO model.

**Flexible Contracting: An Alternative Approach**

Private insurers should pursue a “modular” contracting strategy that breaks the costs of health services into the three categories described below and that does a better job of limiting providers’ contractual risk to the changes they need to make to improve the quality of care and reduce its cost.

There are three general categories of health services (Exhibit 1). The first is primary medical care: low-intensity longitudinal care, delivered by primary physicians. The second—unscheduled care—consists of episodic diagnostic services, delivered by office-based physicians, and unscheduled emergency services, which chiefly take place in hospitals. The third is specialty care: major clinical interventions—such as in cancer care—that usually involve hospitalization or organized outpatient services, in which multiple specialists participate.

These three types of service warrant three different payment approaches. As described below, each would contain different elements of financial risk for the providers. Insurers could use them separately or combine them into a unified approach with organizations of providers that offered all three types of services. Some providers might wish to participate in all three forms of contracting, while others might prefer to remain with their current health plan contracting model.

Instead of holding providers accountable for a population’s health costs over a full year, as the ACO model does, this more flexible approach would link providers’ risk to more easily quantifiable and manageable elements of health costs, such as the cost of primary care services, or the cost of caring for specific complex conditions such as cancer. The approach would also focus more directly on changing providers’ behavior within each category of care to improve communication with patients and families and to reorganize how physicians and their support teams manage patient care itself.

In addition, providers’ administrative costs could be sharply lowered if health plans standardized their contracting methods for all three types of health services across insurers. In that case, providers would not have to replicate the current costly “every payer for itself” payment interface, in which each insurer imposes its own unique business rules for managing payments.

**PRIMARY HEALTH CARE THROUGH A MEDICAL HOME**

Primary care in the United States is in crisis. An entire generation of primary care physicians will retire in the next fifteen years, and—unless major changes are made in the health care delivery system—they will not be replaced by an equal number of younger primary care physicians.12 During this same period, almost the entire baby-boom generation will enroll in Medicare, beginning in 2011. With the declining number of providers and the growing number of patients, Medicare, too, will face a crisis.

Primary care is no longer economically viable, because fee-based payments for primary care services have not grown as quickly as practice costs.
expenses. To cope with this gap, primary care physicians have been forced to see more patients and increase their “ancillary service” income by more frequent use of laboratory testing and imaging. These adaptations have reduced the amount of time that primary care physicians can spend on each visit with a patient and have increased the risk of testing motivated more by financial reasons than by medical ones.

There is great excitement in the field about an enhanced primary care model that incorporates clinical information technology; more continuous, low-intensity contact with patients, such as through telephone calls and e-mail and text messages; and medical management and support services provided by advanced practice nurses and nurse educators. This model is called the patient-centered medical home.13

**Medical Home Elements:** The patient-centered medical home is physician led, but it incorporates embedded care management—protocols and guidelines for how specific clinical risks should be managed—as well as allied health care professionals who collaborate to maintain continuity of care for patients. There is evidence that more-effective primary care focused on the patient’s specific health risks—such as diabetes, high blood pressure, and asthma—can reduce medical expenses downstream, and that this model deserves a higher level of payment than traditional fees because it offers a wider range of services.14

**Billing and Payment:** Primary physicians in this model make money not by maximizing the number of office visits or tests but by expanding their patient populations through the use of improved communication and coordination of care. Services in this model should be paid for through subscriptions: Patients would enroll in the medical home, and physicians would be paid a risk-adjusted amount per enrolled patient per month.15 Each physician should be able to have enough patients so that their subscription payments would cover the practice’s expenses and give the physician a decent income.

If a physician’s patient-centered medical home practice is large enough, he or she could eliminate the clerical and administrative costs involved in today’s fee-for-service billing. Equally, insurers could eliminate claims management costs because they would no longer have to account for each service that each patient received in order to calculate the physician’s payment. Patients would be encouraged to enroll in a medical home by eliminating their copayments, which would further reduce administrative complexity for both providers and health plans.

**Chronic Disease:** Insurers should consider experimenting with a chronic disease variant of the medical home: one that focuses primarily on managing specific types of serious clinical conditions, such as mental illness, diabetes, or congestive heart failure.16 Chronic conditions of this sort are not generally episodic, but continuous. Embedded care management could materially reduce the chance that these diseases would progress to more acute stages by anticipating complications requiring hospitalization and helping patients and their families manage their conditions more effectively.

In this variant, the medical home model should not offer the primary care physician incentives to reduce the considerable costs of caring for patients with serious chronic conditions because he or she typically has little or no control over the major institutional costs, such as for skilled nursing care or rehabilitation, incurred by seriously ill patients.

**Subscription Approach:** The subscription payment approach for the general medical home would not be full capitation, as physicians would not be held accountable for downstream costs they cannot control, such as the cost of hospitalization. Nor should physicians be accountable for pharmaceutical expenses, which would continue to be managed through insurers’ pharmacy benefit management programs. Although physicians do write prescriptions, they have no control over the cost of the drugs, whether the prescriptions will be filled, or patients’ compliance with the drug regimen.

The subscription approach would also not be a gatekeeper model, in which the primary care physician is required to approve payment for specialty services or hospitalizations. The gatekeeper model has a history of increasing both administrative complexity and ill will, antagonizing patients by raising barriers to their access to specialists. Nor did it promote optimal collaboration between primary physicians and their specialist colleagues.

Rather, the medical home is intended to support the primary care physician by capturing and assimilating information from all of a patient’s encounters with the health care system. Federally qualified community health centers—which received substantial new funding to expand their service offerings under the Affordable Care Act—should be able to participate in health insurers’ medical home programs, because they already have many of the administrative supports and allied health professionals needed to execute this model.

To maximize opportunities for individual primary care physicians and those practicing in small groups to participate in this model, it is vital to keep medical home payments and incentives simple, and to impose as few record-keep-
ing requirements as possible. It would be ideal to include in an electronic health record all of a patient’s contacts with physicians. Private insurers can play a crucial role in fostering this care model—which will save them money—if they support it generously through higher payment rates for medical home subscriptions.

**Accountable Care Organizations**

**UN SCHEDULED CARE** Unscheduled medical services make up the least predictable component of medical costs. Putting providers at risk for these costs is inappropriate because most of them lack the information and decision support to manage the risk. Primary physicians often have no idea that their patients are in a hospital emergency department or have sought diagnostic advice from other providers, because in most communities there are no mechanisms for capturing and relaying to primary physicians information about their patients’ health care use. Patients also frequently bypass their primary physicians for treatment of sensitive health issues like sexually transmitted diseases, mental illness, and other conditions that they do not want to be a part of their medical records. In a tripartite payment model, these unscheduled services would continue to be paid for essentially as they are today: fee-for-service, with cost sharing for patients.

Cost sharing should be high enough so that the patient does not seek an unnecessary visit or intervention, but not so high as to raise a financial barrier to necessary care. Insurers would continue applying pressure to reduce costs through negotiating contracts with provider networks and through utilization review and quality assurance.

As suggested above, an effective medical home should provide a viable alternative to many non-urgent emergency visits, as well as a channel to enable patients to avoid some diagnostic visits. This is because medical homes provide consultation on demand through e-mail or phone calls, instead of requiring that patients address all of their medical needs through an office visit. Real-time communication with the medical home could also give a patient or family member a “reality check” on the need for an emergency visit—for example, by calling a nurse at the medical home first, to determine if the visit is really necessary.

Although this component of the model demands little from providers, some providers of diagnostic services, such as advanced imaging, may be eligible for higher unit payments if they assumed responsibility for screening out diagnostic orders that were not clinically appropriate. Similarly, providers might consider how they could refer “unattached” patients with non-urgent problems from emergency facilities to medical homes, to increase patients’ use of the homes and improve their future medical management.

**Specialty Care** The most expensive component of health costs is the clinical response to complex conditions—for example, cardiac care, cancer treatment, surgical care, and high-risk obstetric and neonatal care. For clinical interventions of this type, whether they are elective or not, providers should receive a single, severity-adjusted payment when a diagnosis has been made and a clinical approach chosen. This method would reduce billing complexity. It would also increase providers’ economic risk in dealing with complex conditions. But at the same time, it would encourage—and indeed demand—a precise division of clinical responsibilities framed by clinical protocols and care pathways for each of the conditions.

Costs incurred in treating patients that exceeded the fixed payment would be absorbed by the contracting providers, while any savings in actual cost below the fixed amount would be retained as an economic incentive. Because it focuses on specific groups of clinical conditions, this payment model would be much more tightly linked to actual care redesign and improved coordination of care.

> **A NEW CARE MODEL** Specialty care is best provided by groups of specialists working together as a team and using a well-defined model of care. This approach reduces both costs and patient risk. Such collaboration is the basis of the care models at advanced cancer treatment centers such as the Memorial Sloan-Kettering and the M.D. Anderson Cancer Centers, as well as in multispecialty organizations such as Mayo Clinic and Cleveland Clinic.

Many hospitals and health care systems, and some physician groups, have already created multidisciplinary “service lines” or “centers of excellence” such as cardiac or cancer services, centered on specific conditions or specific populations of patients. Even though some of these innovations have occurred primarily for marketing purposes, the clinical infrastructure is already in place in many institutions to support
a separate payment approach for this type of care. This contracting model would create private insurance “customers” for these centers. The clinical enterprises could be called “Specialty Care Marts.”

A single, severity-adjusted payment for specialty care would encompass all preintervention workups; the intervention itself, such as surgery or chemotherapy; charges from the facility and physicians; and postintervention costs during a defined time period—perhaps thirty to ninety days. This approach is conceptually similar to that used in the current Medicare Acute Care Episode Demonstration, but it could cover a longer time for each episode and would apply to privately insured patients, rather than those with Medicare. Previous experiments with care bundling under Medicare, such as the Centers of Excellence demonstrations of a decade or more ago, appeared both to save money and to improve clinical quality.

▸ Specialty Care Marts: Specialty Care Marts could be sponsored by a hospital, health care system, physician group, independent practice association, or some combination of organizations. The sponsor would be responsible for collecting and disbursing the payments for services and would distribute any payment in excess of expenses as a bonus. Ideally, multiple Care Marts would be available to patients in a given geographic area, fostering price and service competition.

Specialty Care Marts would attract patients by offering at least partial forgiveness of their deductibles, as the Medicare Acute Care Episode Demonstration projects do. Some sort of enrollment would be required to ensure that all parties understand that the patient has, in fact, selected a particular Specialty Care Mart to provide his or her care. To counteract providers’ tendency to increase the volume of services they provide by giving care that is only marginally appropriate, individual providers would be required to adhere to and enforce appropriateness guidelines as a condition of participation.

To qualify as a Care Mart, a provider would have to document that it provided, or could contract with another organization to provide, the full range of services required to resolve the patient’s diagnosed complaint. To have their deductibles forgiven, patients would be required to receive all of their care for the covered condition from the chosen Care Mart.

▸ Insurers’ Role: In addition to paying Specialty Care Marts, health insurers could provide them with management services. These could include radiology and pharmacy benefit management services; actuarial consulting, including assistance with risk adjustment; marketing; enrollment and eligibility verification; and other administrative support services. Insurers could use predictive modeling software to identify people in their insurance pools who are potential candidates for clinical intervention. Insurers could also offer providers their network contract discounts for the postacute care—such as rehabilitation and home health care—provided within the Care Mart’s contracted time frame. This would reduce the administrative complexity required to sponsor and support a Care Mart.

Insurers would remain free to pay for specialty services on a fee basis in markets with limited or no access to Specialty Care Marts for a particular service, and would continue paying under present methods for specialty services for providers or patients unwilling to use a Care Mart.

Fewer Barriers to Adoption

This modular approach to payment does not require as much provider integration or infrastructure spending as global capitation does in order for providers to participate. It encourages delivery system reorganization for both low-intensity or primary care and high-intensity or specialty care, as well as better-coordinated medical practice, without catalyzing a further concentration of ownership of hospitals and physician practices. Both the patient-centered medical home and the Specialty Care Marts would reduce administrative expenses for providers and insurers by consolidating and simplifying the payment process.

This modular approach to payments would replace the fee-for-service system, instead of overlaying it—as the accountable care organization model does—for providers who elect to participate. And, most important, it would give patients and their families a greater choice of providers and would foster competition among primary care providers and specialists.

Instead of delegating to providers the responsibility for managing population health costs that they cannot control, this approach relies on three diverse contracting methods—comprehensive, risk-focused payments for primary care; cost sharing for unscheduled episodic and emergency care; and bundled payments for acute interventions—to address three different types of clinical problems without necessarily linking them together. Both low-intensity and high-intensity clinical care would rely on using specified clinical pathways, unified payments, and improved coordination of care as the principal ways of saving money. The goal should be better management of care at both ends of the spectrum, to reduce the volume of fee-based care in the middle.
Insurers’ Options Under Health Reform

Under health reform, insurers have lost considerable flexibility in the ways they can cope with rising medical expenses. They can no longer rely on many of their traditional medical underwriting strategies, such as exclusions of preexisting conditions.

The temptation will be for insurers to rely exclusively upon current cost control mechanisms to manage subscribers’ medical expenses—for example, by negotiating lower prices on services from health care providers, or imposing external use controls such as prior authorization for hospitalization.

This would be a mistake, because it would risk damaging what should be collaborative relationships with providers to improve their care management processes and clinical outcomes. Improving the way in which risk is shared between private health insurers and providers can encourage the changes in care management and coordination needed to make the health care system economically sustainable.

The payment approach proposed here would be modest, targeted, and flexible enough to accommodate both differences in readiness for health reform across US regions, and in the capacity of physicians and hospitals to reorganize care in the best interests of patients.

The author thanks David Klein, Peter Kongstvedt, and Robert Berenson for their helpful comments on this article.

NOTES

1 Pratt MK. Humana Inc.: keeping a watchful eye on patients. Computerworld. 2006 Sep 18.
15 In most medical home demonstrations, a blended payment approach is employed, including a monthly per capita “care coordination” payment, regular fees for patient visits, and a performance-based bonus contingent on achieving certain quality and efficiency measures. This approach imposes additional administrative costs on the practice beyond those required to support a more comprehensive care model. Merrell K, Berenson RA. Structuring payment for medical homes. Health Aff (Millwood). 2010;29(5):852–8.
Accountable Care Organizations:
The End of Innovation in Medicine?

By Scott Gottlieb, M.D.

The Obama administration is pinning its hopes for controlling Medicare costs on accountable care organizations (ACOs)—a system in which groups of doctors are given responsibility for a large population of patients, with a share of the doctors’ reimbursement dependent on their ability to reduce spending and improve clinical outcomes. The Department of Health and Human Services is expected to release regulations governing the framework for ACOs by the end of February. ACOs are supposed to offer incentives for doctors to improve the coordination of care. While this idea is not inherently wrong, the Obama team relies heavily on hospitals to develop these new organizations. Yet historically, most of the significant innovation in health care delivery has developed in for-profit companies, often started by entrepreneurs, and has aimed to move patient care away from costly hospital settings and into less expensive outpatient settings. But entrepreneurs are now exiting the health care services space because the Obama plan tilts the marketplace so heavily against their endeavors. The Obama team is forced to rely on hospitals as much by default as by design, but many hospitals are unlikely to succeed at running ACOs.

Writing in summer 2010 for the prestigious medical journal Annals of Internal Medicine, Obama’s former health care czar Nancy-Ann DeParle joined two of her White House colleagues in arguing that “the economic forces put in motion by [the Obama health care plan] are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups.”

In the provocative but little-noticed article, DeParle said doctors who “accept the challenge will be rewarded in the future payment system” by changes likely to occur in how doctors are compensated under Medicare. In other words, doctors who consent to these new arrangements will see their incomes rise. “Physicians who embrace these changes and opportunities,” DeParle writes, “are likely to deliver the greatest benefits to their patients, the health system, and themselves.”

Key points in this Outlook:

- The Obama administration envisions accountable care organizations (ACOs) as the drivers of health care innovation, but such innovation has historically come from entrepreneurs in the private sector.
- ACOs offer financial incentives to cut costs, but this means restricting patient choice and limiting the use of some expensive care.
- The ACO concept is not new. Similar ideas have been tried before, but they failed because they were unable to control costs or manage medical risk.
DeParle’s counsel was a nod to the Obama administration’s support for ACOs and the sizable changes the Obama team foresees in the way medical care is organized and delivered as a result of them. The ACO concept has quickly become Washington’s most fashionable vehicle for pursuing cost savings in the Medicare program. Obama’s recently enacted health care legislation, the Patient Protection and Affordable Care Act (PPACA), puts the concept at the center of efforts to change how Medicare patients are managed. The ACOs are supposed to be implemented starting in 2012—not as a pilot or demonstration program, but as an alternative payment system for providers accepting reimbursement under Medicare. The Obama team is placing a bet that ACOs can improve medical outcomes while reducing costs to the government.²

But the president’s team also envisions that hospitals will be at the center of these ACOs. The regulatory effort to tilt ACOs into the hands of hospitals stems from the administration’s impulse to tightly manage how these organizations operate and the president’s instinct to try to centrally plan aspects of how medical care is delivered. As large, geographically distributed, and mostly unionized institutions, hospitals provide the easiest scaffold for the technocratic tinkering of the administration’s health policy team.

Hospitals are accessible, relatively pliable, and already have a business incentive to roll up the providers in their local markets and form these integrated care organizations. As health policy scholar Jeff Goldsmith notes in a recent issue of Health Affairs, “despite the lengthening of the list of possible participants, hospitals are likely to dominate the ACO contracting process for two reasons. First, the largest avoidable Medicare costs are hospital related. And second, in many communities, the hospital is the only organized care delivery entity capable of executing the model.”³

By building geographic monopolies, hospitals are in a better position to exact favorable contracts with insurers and local, self-insured businesses. Therefore, hospitals see plenty of financial advantages in becoming ACOs. The Obama team—out of a desire to control the ACOs—provides hospitals with the opportunity to dominate this new construct.

But hospitals are the wrong vehicles to entrust with driving innovation. According to one prominent Wall Street research firm, “hospitals will have to take on an increasing amount of risk going forward as future regulations are likely to place more accountability of patient care on them. In our opinion, this is a risk going forward given hospitals have traditionally been slow to evolve in new operating environments. We would expect for-profit hospitals to fare much better than their less sophisticated non-profit competitors.”⁴

Indeed, most of the significant changes in how health care is delivered have been motivated by private companies—led by entrepreneurs and often backed by venture capital. Their business models were typically aimed at moving patients out of hospitals, not into them. But ACOs, like other inventions in the new health care law, try to achieve reform by changing how market power is distributed in the system, rather than creating incentives for innovation in how health care is delivered. The legislation makes a leap of faith that once ACOs consolidate enough local-market dominance, they will have the incentive, capital, and wherewithal to introduce meaningful changes in how medical care is coordinated.

Most of the significant changes in how health care is delivered have been motivated by private companies—led by entrepreneurs and often backed by venture capital.

There is a rich history of private businesses that introduced successful and enduring reforms in how medical care is delivered, but these entrepreneurs—and the investors who backed their previous ventures—are not placing many new bets. The Medicare program and the Obama health plan are targeting many of these private businesses with new costs and regulations, so private investors are exiting the health services sector. The number of capital investments in health care services ventures in 2010 was fewer than half the median number of annual deals since 2000.⁵ The result is that hospitals are one of the last entities with capital to fund the formation of ACOs.

There will be a handful of regions where large, integrated medical practices have the sophistication and capital to form their own ACOs. The large medical groups found in Texas, California, and Florida might meet the minimum requirements. But most parts of the country do not have the necessary concentration of physician-owned
organizations for provider-led ACOs. Hospitals will therefore end up forming the majority of ACOs, but their incentive will always be to fill hospital beds, not manage patients at lower-cost delivery settings. Even when competitive pressures have previously forced hospitals to reduce stays for some acute procedures, they have compensated by driving the adoption of elective procedures that fill empty beds. Witness the explosion in procedures such as bariatric surgery or the increasing number of orthopedic joint replacements in younger patients.

**Origin of the Accountable Care Organization**

An ACO is basically a large group of providers who practice as part of a single entity. The organization takes overall responsibility for the care of each patient and the associated costs. An ACO can be a large multispecialty group of doctors or—more likely—a hospital that owns or contracts with many of the local doctor practices in its geographic region. Under the PPACA, an ACO will take “accountability” for a local population of Medicare patients. Patients, in turn, get most of their care from providers working inside the ACO’s network.

To encourage efficiency and cost cutting, the doctors practicing inside an ACO can share in any cost savings they achieve. The idea is to give doctors a financial incentive to reduce utilization of expensive services and work more closely as part of coordinated teams. An ACO needs to be large enough that the savings it generates are a result of improving the quality of care being delivered, not of fluctuations in membership levels or the clinical events that occur from year to year. To these ends, proponents say an ACO should care for at least five thousand Medicare beneficiaries or fifteen thousand beneficiaries with private insurance.6

The ACO concept is attributed to Elliot Fisher, M.D., the architect of the Dartmouth Atlas Project, a program that has documented the seeming variation in the cost of medical care and outcomes across the United States.7 The theory behind ACOs has its origins in the work of the Dartmouth Atlas and its conclusion that Medicare spending can be reduced while also improving clinical outcomes. The term ACO itself is said to have grown out of an exchange Fisher had with Chairman Glenn Hackbarth at a November 2006 meeting of the Medicare Payment Advisory Committee (MedPAC). Fisher’s findings on the variation in medical outcomes and their inverse correlation to health spending became the intellectual foundation for Obama’s vision of “bending the cost curve” and his proposals for cuts to Medicare that he says will simultaneously improve medical care.

In many ways, the ACO concept builds on the 1990s approach to “capitation,” in which health maintenance organizations (HMOs) gave doctors a lump sum of money to care for a large group of patients. The arrangement put a financial onus on providers to cut costs and pursue efficiencies. It lowered spending for a time but ultimately proved unpopular with patients, who believed that it gave doctors financial incentives to ration care. Eventually, it led to a backlash against managed care and the introduction of the Patients’ Bill of Rights.8 It is envisioned that the ACOs will occupy a middle ground between doctors who are paid on a fee-for-service basis and managed-care plans that are paid under capitated arrangements.9

In a June 2009 report, MedPAC explored the concept of mandatory ACOs. Under such a model, doctors and Medicare patients would be assigned to a given network to form an ACO. Fee-for-service payments would still be made to individual doctors for their services, but part of the money would be withheld. It would only be returned if the entire ACO organization met certain government-determined targets for quality and cost savings.10

It is worth noting that the formation of ACOs fulfills a longtime regulatory pursuit of the Medicare program: to get more leverage over providers. The geographic dispersion of doctors into small practices has made them hard for a central agency like Medicare to regulate. Failing to get enough leverage to regulate individual medical procedures and doctors’ decisions to adopt certain approaches to care, the Medicare program has turned to regulating the technology that patients and doctors employ. Once doctors are consolidated into ACOs, it will be easier for Medicare to gain more direct leverage over their clinical decisions. Instead of being required to reach down to the individual doctors, Medicare will now be able to regulate ACOs, which will in turn exert the necessary leverage over doctors.

**The Obama Team’s Vision for ACOs Takes Shape**

Even after the passage of the PPACA, many details of how ACOs will operate are being worked out by the Department of Health and Human Services. The regulations were scheduled for release in fall 2010 but have been delayed until the end of February or early March. While MedPAC’s sweeping vision is unlikely to take
shape, it is expected that Medicare patients will be assigned to ACOs. Moreover, it is not clear that doctor participation will be voluntary. Some doctors could be compelled to participate in ACOs if they want to bill Medicare or accept health plans offered in the new state-based insurance exchanges that will begin in 2014.

Health care policymakers inside the White House and Centers for Medicare and Medicaid Services (CMS) may also be crafting new rules that would provide ACOs favorable treatment in the health insurance exchanges. These efforts are premised on the belief that ACOs could eventually function in place of traditional for-profit health plans in the new exchanges.

Under this construct, ACOs would market themselves in the exchanges as something akin to staff-model HMOs and offer comprehensive health care benefits directly to consumers. The administration has said its goal is to put an additional 30 million Americans under the care of these kinds of “integrated delivery systems” in the next three years.

This model has appeal among health policymakers who discount the value added by insurance companies, viewing them simply as costly middlemen. California has advanced state rules that would regulate ACOs operating on its state exchange as insurance companies. This is a measure of how political authorities intend to position ACOs as a stand-in for traditional insurance companies.

Here again, the problem is not the concept but the government rules that tilt the market in favor of a desired set of winners and losers. The PPACA already gives CMS the authority to grant ACOs waivers that would permit arrangements that might otherwise trigger concerns around “gainsharing” or violation of antitrust provisions. Among the specific policy breaks for ACOs that the administration is considering are exemptions from some of the Stark Rules (which outlaw health care entities that accept government reimbursement from referring patients to facilities they own, a concept referred to as self-dealing) and immunity from some antitrust requirements that would normally prevent local health care institutions (such as hospitals) from consolidating and controlling a majority of the health care providers in any given region. CMS recently held a joint meeting with the Federal Trade Commission to discuss which antitrust provisions might be loosened to facilitate the expansion of ACOs.

The prospect of consolidated power is already raising costs to consumers. If ACOs contract directly with patients on a health exchange by setting themselves up as entities that resemble staff-model HMOs (similar to the way Kaiser Permanente operates), some may partner with traditional health insurers to re-insure a portion of the risk they will be taking on. But on the whole, the problem with cutting out the health insurers from these arrangements is that consumers will ultimately be left with fewer provider options if they become tied to a local ACO. The ACOs are likely to maintain closed networks and would have incentives to make it expensive for consumers to go outside their network of local physicians.

Additionally, by displacing traditional insurance companies on the exchanges, ACOs will inevitably lead to less price competition and pressure to improve quality. This is because ACOs will not have the same incentive to form networks with the best providers and inpatient facilities. The primary focus of a hospital-led ACO will be on achieving geographic concentration rather than a high-quality network. In many respects, the idea of ACOs offering comprehensive health plans is a throwback to the 1990s provider-sponsored organizations, which failed largely because of their inability to manage risk or costs.

Organized medical groups, such as the American Medical Association, have generally favored the development of ACOs. This is premised, in part, on their belief that the market leverage that ACOs afford providers will give doctors the clout to secure better pricing for their services. But if ACOs contract directly with consumers and cut out insurers entirely, they will also diminish the market-based pricing for medical services. Instead of negotiating rates with multiple insurance companies, doctors bound to ACOs may find that rates are set by the federal agency overseeing ACOs. The result could be the same kind of administered pricing that doctors are subject to under Medicare.

**Private Ventures: The Real Origins of Health Care Innovation**

The Obama administration believes that the ACOs, and the hospitals that operate them, will invest in new innovations in the delivery of medical care that lead to better coordination of health care services. The trouble with this vision is that hospitals have never been sources of innovation in the way medical care is organized and
delivered. Over the last several decades, most of the notable innovations in health care services have been developed in for-profit companies, often run by entrepreneurs and backed by venture capital.

The venture-backed company Surgical Care Affiliates largely developed the concept of outpatient surgery centers. Another venture-backed company, US Healthcare, led the development of the first for-profit HMO in 1982. Pioneers in the physician-practice management space that continue to operate today—including Pediatrix (which specializes in neonatology) and US Oncology (which specializes in cancer care)—were similarly backed by entrepreneurs and supported by venture-capital investments. Rehabilitation hospitals and subacute care companies such as Integrated Healthcare, outpatient dialysis clinics such as US Renal Care, long-term care hospitals such as Select Medical, and pharmacy-benefit managers such as Caremark also resulted from new concepts in medical care delivery pioneered by entrepreneurs and supported by private capital.

Many of these companies proved that they could simultaneously improve the delivery of medical care while lowering health care costs. Many of these innovations were first aimed at hospitals and sought to move patients treated in costly, inpatient facilities to less expensive outpatient settings. In many cases, the innovations they introduced were eventually adopted by hospitals, which started operating their own rehab facilities, long-term care hospitals, and home dialysis services. The problem is that under today’s market rules, hospitals do not have the incentive to innovate and invest in improved delivery models. They lack the managerial experience and financial incentive to drive change in the delivery of health care services.

But post–health reform, the entrepreneurs and investors who built new companies and drove improvements in health care delivery are leaving the sector because the new political landscape is tilted so heavily against their success. The PPACA targets these for-profit health endeavors, in some cases with new taxes on their profits. This is not being done to improve the delivery of care but to generate additional revenue to help pay for the expansion of other government-run health programs. As a result, the capital that has flowed into startup health care services ventures has diminished since the passage of the PPACA.

This also means that there is little private capital available to fund the formation of ACOs. A number of large medical practices and private entrepreneurs have circulated business plans to secure the capital needed to form an ACO. However, there are no meaningful examples to date in which these non-hospital-based ACO ventures have acquired private funding. Integrated medical practices are also struggling to raise the capital needed to expand and form ACOs. Surveys show that credit being extended to physicians has declined. The hospitals are stepping in to form ACOs as much by political design as by default, since they are the only entities that still have capital cushions to invest in them.

Once doctors are consolidated into ACOs, it will be easier for Medicare to gain more direct leverage over their clinical decisions.

In 2009, the year health care reform was debated and voted on, health care services attracted just $40 million in new, early-stage venture-capital investment, according to a July 2010 survey published by PricewaterhouseCoopers and the National Venture Capital Association. In 2010, it garnered a little more than $100 million in traditional venture investment. By comparison, medical devices still attracted $338 million in investments in 2009, and biotech $500 million—levels similar to 2000. These two sectors—medical devices and biotech—attracted even more venture money in 2010. This demonstrates that the scale of the falloff in health care services investments is not explained by the economic effects of the recession on overall venture-capital flows into the health care sector. To gauge the magnitude of these investment disparities, consider that in 2000 health care services attracted about $450 million in venture-capital investments annually. Even though the economic downturn has brought overall venture-capital flows in biotech and medical devices back to 2000 levels, investors are still disproportionately shunning the health care services sector.

Today, many of the venture-capital firms still investing in new health services endeavors are placing their bets in countries such as China, Brazil, and India, but there was one notable exception in the health care services space. Venture investors did increase their investment in a sector at the intersection of health care and technology: medical software and information services. Political and regulatory uncertainty created by health reform has a direct impact on both capital investment and entrepreneurship in health care services. One recent
survey of early-stage health care investors found a close association between regulatory and policy risk and the willingness of venture-capital firms to enter a health care sector such as drugs, medical devices, or health care services. Two-thirds of respondents said that increases in political and regulatory risk would lead them to shift investments within or across health care sectors or to reduce health care investments altogether. Shifting investment capital out of health care and toward other endeavors is often as easy as rebalancing a portfolio. Of the billions invested in health care by venture firms since 2000, about 80 percent came from firms that invested in other areas such as media and clean energy. Because firms that invest across other sectors are making most of the health care investments, it is easy for them to take money out of one declining sector and steer it into other areas of their portfolios.18

The largest flows of new capital into health services are coming not from venture capitalists focused on developing new concepts in how health care services are delivered, but from private equity investors who are raising funds to acquire—and consolidate—existing health care companies. More than $7 billion was invested in health care private equity last year alone. Most of that came from leverage buyout shops,19 and much of this money is aimed at buying hospitals and other service providers. Private equity is focused on consolidating and streamlining health care businesses. In some cases, it has been used as a way to wring money out of existing entities, consolidate them, and gain market leverage that lets providers drive up prices. But such financial engineering rarely creates new innovation.

In Britain, for example, private equity firms control more than 70 percent of the private hospitals, and private equity investors run five of the seven largest hospitals. These hospitals play an increasingly important role in providing services to a crumbling National Health Service, but they have not led to advances in the way care is delivered. They have developed merely to bring some new efficiency to the same outdated hospital-based model on which Britain relies.20

Can Entrepreneurship and Health Care Coexist?

When venture capitalists spot a profit opportunity, it usually involves a shift of patients from one setting of care to another—for example, moving patients from inpatient to outpatient care, moving from general hospitals to specialty hospitals, and developing new sites for care. This latter opportunity explains the rise of rehabilitation, hospice, or long-term care hospitals, among others. This is how new ventures can grow market share under the existing regulatory rules. Many of these endeavors have been shown to reduce costs while improving outcomes, but these site-based innovations challenge the established order—especially nonprofit hospitals that have considerable political clout in Washington—so the private ventures become a political mark.

The capital that has flowed into startup health care services ventures has diminished since the passage of the PPACA.

The private companies that succeed earn above-market returns relative to their former rivals. The profits are a measure of their success, but they also act as a bull's eye that invites additional targeting. Progressive health policymakers are suspicious of the elements that define success in private health care markets—expanding profit margins, increasing revenues, and growing market share. They regard capital returned to investors in the form of profits as wasted money that should have been spent on providing direct patient care. As a result, when genuine innovation in the delivery of health care inevitably leads to successful enterprises and highly visible profits, political recriminations follow.

The current issues swirling around hospice care illustrate the problem. The idea behind hospice is that patients who are terminally ill can stay out of the hospital and instead die more peacefully in a facility that is focused on end-of-life issues such as pain management and comfort care. The concept has its origins in charity work, but it gained wider adoption through the entry of some for-profit hospice providers. Medicare, recognizing the opportunity to avoid costly charges for unnecessary hospital stays while improving the quality of medical care, encouraged the concept by broadening its reimbursement.

Not surprisingly, utilization of hospice services grew, along with the number of private firms providing these services. Like a lot of other good concepts, it has excess utilization on the margins. Patients started to turn up in hospice centers who did not meet the criteria. They ended up living for long periods of time there and,
therefore, were not truly “terminal” when they first entered the hospice facility. At the same time, the profits of the hospice providers continued to rise. Medicare has recently announced that the profit margins of the hospice providers are simply too high, so it is in the process of creating a new reimbursement scheme that will cut the current payment levels.

Progressive health policymakers are suspicious of the elements that define success in private health care markets—expanding profit margins, increasing revenues, and growing market share.

Conclusion

ACOs repeat many of our past mistakes. For one thing, regulators will likely bar them from competing for more patients in an open marketplace. Yet this is the only incentive that would spur an ACO to innovate and improve its delivery of medical care. In addition, they rely too heavily on existing hospitals rather than attracting private capital to form new, entrepreneurial ventures. The entire health care plan is explicitly designed to penalize above-average rates of profitability. The end result is to discourage private investment in ACOs, as well as other delivery innovations.

Writing in the *Annals of Internal Medicine*, DeParle notes that “the health care system will evolve into 1 of 2 forms: organized around hospitals or organized around physician groups. These coordinating functions, to the extent that they currently exist, traditionally have been managed by hospitals or health plans. Only hospitals or health plans can afford to make the necessary investments in information technology and management skills.”

DeParle is quick to point out that this evolution toward a hospital-centered model for the practice of outpatient medicine is not inevitable. Indeed, the prospect that hospitals will soon own a majority of medical practices in the United States is already worrying some doctors and policymakers.

But many of the provisions of the Obama plan, especially the way ACOs are being envisioned and constructed, push the entire market precisely in this direction. In the meantime, private investors are exiting health services and entrepreneurs are putting their energies into other endeavors. These marketplace developments, more than anything else, make the Obama plan’s reliance on public financing and central planning self-fulfilling and—in the end—make the entire scheme self-defeating.

Notes

2. Ibid.


15. The venture-capital firm Warburg Pincus was one of the early backers of US Healthcare. The HMO was later sold to Aetna in 1996.

16. The venture-capital arm of Welsh Carson was the principal investor behind each of these endeavors.

17. Spurred by the Obama administration’s stimulus law, which set aside $19.2 billion in spending for health care information technology, firms invested $498 million in 2010 in that sector.


19. Many private equity shops are still in the midst of raising new pools of capital or have recently closed new funds. In addition, Texas Pacific Group and Welsh Carson, two enormous pools of capital with long track records in the creation of new health care endeavors, each recently announced that they would now be allocating new capital to private equity investments in health care services.


The Affordable Care Act is a once-in-a-generation change to the U.S. health system. It guarantees access to health care for all Americans, creates new incentives to change clinical practice to foster better coordination and quality, gives physicians more information to make them better clinicians and patients more information to make them more value-conscious consumers, and changes the payment system to reward value. The Act and the health information technology provisions in the American Recovery and Reinvestment Act remove many barriers to delivering high-quality care, such as unnecessary administrative complexity, inaccessible clinical data, and insufficient access to primary care and allied health providers.

We hope that physicians will embrace the opportunities created by the Affordable Care Act that will enable them to provide better care for their patients and lead the U.S. health system in a more positive direction. To fully realize the benefits of the Affordable Care Act for their practices and their patients, physicians will design their offices for seamless care, employing new practice models and using technology to integrate patient information with professional society guidelines to keep patients with chronic conditions healthy and out of the hospital. Under the Affordable Care Act, physicians who effectively collaborate with other providers to improve patient outcomes, the value of medical services, and patient experiences will thrive and be the leaders of the health care system.

Key Summary Points: How the Affordable Care Act and the American Recovery and Reinvestment Act Are Likely to Affect the Practice of Medicine

- Focusing care around exceptional patient experience and shared clinical outcome goals.
- Expanding the use of electronic health records with capacity for drug reconciliation, guidelines, alerts, and other decision support.
- Redesigning care to include a team of nonphysician providers, such as nurse practitioners, physician's assistants, care coordinators, and dietitians.
Establishing, with physician colleagues, patient care teams to take part in bundled payments and incentive programs, such as accountable care organizations and patient–centered medical homes.

Proactively managing preventive care—reaching out to patients to assure they get recommended tests and follow–up interventions.

Collaborating with hospitals to dramatically reduce readmissions and hospital–acquired infections.

Engaging in shared decision–making discussions regarding treatment goals and approaches.

Redesigning medical office processes to capture savings from administrative simplification.

Developing approaches to engage and monitor patients outside of the office (e.g., electronically, home visits, other team members).

Incorporating patient–centered outcomes research to tailor care appropriate for specific patient populations.

Physicians have a moral calling to promote the health of their patients and the overall health of all citizens. Many barriers have prevented U.S. physicians from fully realizing these ideals. The Affordable Care Act not only removes many of these barriers but also puts in motion new policies and economic incentives that will change the practice of medicine for clinicians and the experience of care.

The Act does this by guaranteeing access to health care for all Americans, providing physicians with incentives and information to change the way that they deliver care, offering patients new and better information about practitioners and treatment options, creating strong incentives to improve quality and reliability both in hospitals and throughout the continuum of care, and implementing policies that will slow the rate of cost growth to make health care more affordable. Although full implementation will take a decade, many of the most important patient protection and delivery system provisions either have already been implemented or will be enacted in the next year. For this reason, it is important that physicians make themselves aware of the objectives, major provisions, and physician implications of the Affordable Care Act (Table (1)).

Table. Summary of Affordable Care Act Objectives, Major Provisions, and Physician Implications
Guaranteeing Access to Health Care for All Americans

More than 45 million Americans are uninsured, and as a result, they experience increased morbidity and mortality (2). Even Americans who have insurance often face financial and other barriers to getting care. The Affordable Care Act removes most of these financial barriers. It closes the "doughnut hole" for Medicare beneficiaries over the next decade, reducing a financial barrier that decreases medication adherence, which should lead to better health (3). Similarly, the Act removes annual and lifetime limits and outlaws other insurance practices, such as rescissions, that frequently deny people care when they most need it. Finally, it will lower other health care costs. For example, it makes preventive screening visits free by eliminating cost sharing and copayments, so serious conditions can be diagnosed when treatments are most effective. In these and many other ways, the Affordable Care Act will make it easier for physicians to get their patients the right tests and treatments.

Improving Information and Creating Incentives to Change Clinical Practice

While the United States certainly has some of the world's best physicians and health facilities, U.S. medicine fails to deliver reliably high-quality care: We have far too many unplanned readmissions, medication errors, and hospital-acquired infections (4). We also fall far short of delivering effective primary and secondary prevention for patients with chronic conditions who account for a majority of health care costs (5). Numerous barriers inhibit achieving higher-quality care. One barrier relates to patients' utilization of primary prevention. Because a patient is not feeling sick, engaging in prevention seems optional. Other barriers include patient financial responsibility as a substantial barrier to utilization of prevention, poor reimbursement, and underdeveloped clinical reminders at the point of care that assure patients are getting appropriate preventive services (6).

The Affordable Care Act addresses 2 major barriers to consistently delivering high-quality care: information and incentives. Too often have physicians lacked information on whether their patients are taking their medications and following through on prevention recommendations and referrals. In some cases, they also lack information about what treatments work best for which patients. Physicians rarely get patient-specific reminders about treatment goals, gaps in care, or risk-reduction approaches at the point of care, when physicians and patients are most likely to be responsive to information.

The combination of the American Recovery and Reinvestment Act and the Affordable Care Act should help address these information gaps. The American Recovery and Reinvestment Act provides about $25 billion in incentives for physicians and hospitals to use electronic health records. Achieving the full extent of benefits necessitates streamlining office practices to enhance patient tracking, teamwork, and patient outcome orientation. The Affordable Care Act provides long-term funding for patient-centered outcomes research, which should give
physicians and patients the clinical and research information they need to make better informed and personalized decisions.

The Affordable Care Act provides physicians with financial support for making these changes. Today, the fee-for-service system encourages ordering tests and performing interventions. It does not support—and may discourage—coordinated care that averts complications and secondary prevention. The Affordable Care Act changes this by encouraging and establishing patient-centered medical homes and accountable care organizations that should allow physicians to focus on coordinating care and preventing avoidable hospitalizations. Similarly, the pilot projects on bundled payments reward physicians for providing care that keeps chronically ill patients healthier and out of the hospital (7).

**Removing Other Barriers**

Administrative overhead and lack of primary care providers are also perceived to be barriers to the delivery of high-quality care. The Affordable Care Act is a major step forward in each of these areas. One of the nightmares of the health care system is paperwork. This results in the need for millions of workers just to fill out forms for insurance companies. Under the administrative simplification provisions of the Affordable Care Act, physicians will be able to reliably find out electronically whether a particular test is covered, how much the insurance company is paying, and how much patients have to pay. These simple changes are expected to save the government $20 billion over the next decade and save hospitals, physicians, and insurers far more in both cost and frustration (8).

We also need more primary care providers to improve quality and coordination of care (9). The Affordable Care Act includes a 10% payment bonus for qualified primary care physicians and provides and increases funding for the National Health Service Corps by $1.5 billion over 5 years. It also includes a set of provisions, and millions of dollars in additional funding, to support medical education and increase the number of primary care providers, physician's assistants, and nurse practitioners. The bundling and patient-centered medical home programs add value to primary care and can make the field more attractive to current and future clinicians, so that we have enough skilled clinicians to play the coordination and management roles conceived of in patient-centered medical home and accountable care models (10).

Finally, we acknowledge that many physicians are disappointed that Congress has not yet enacted a long-term fix to the sustainable growth rate formula. No one is more disappointed than President Obama, who made clear: “For years, I have said that a system where doctors are left to wonder if they'll get fairly reimbursed makes absolutely no sense. And I am committed to permanently reforming this Medicare formula in a way that balances fiscal responsibility with the responsibility we have to doctors and seniors." The uncertainty surrounding the sustainable growth rate policy is a distraction and potentially a barrier for some physicians to embrace the Affordable Care Act. But physicians should not let their frustration
over the sustainable growth rate distract them from the improvements that health care reform delivers to their patients and the profession.

10 Changes That Will Reshape the Practice of Medicine

By removing barriers, the Affordable Care Act provides physicians with the opportunity to evolve the way in which they deliver care. They will have appropriate incentives to focus on coordinating care so that patients get the prevention they need and those with chronic conditions avoid complications. Delivering on the promise of reform will require the full engagement of physicians. The Affordable Care Act and the American Recovery and Reinvestment Act are likely to affect the practice of medicine in 10 major ways (see Key Summary Points).

These reforms will unleash forces that favor integration across the continuum of care. Some organizing function will need to be developed to track quality measures, account for and manage shared financial incentives, and oversee care coordination. Consequently, the health care system will evolve into 1 of 2 forms: organized around hospitals or organized around physician groups. These coordinating functions, to the extent that they currently exist, traditionally have been managed by hospitals or health plans. Only hospitals or health plans can afford to make the necessary investments in information technology and management skills. This is not inevitable. As physicians organize themselves into increasingly larger groups—patient-centered medical home practices and accountable care organizations—they are, out of necessity, investing in information technology tools that are becoming both cheaper and more capable and investing in the acquisition or development of management skills that could provide these organizing functions efficiently for physician groups.

Physicians who embrace these changes and opportunities are likely to deliver the greatest benefits to their patients, the health system, and themselves. Physician practices that accept the challenge will be rewarded in the future payment system. Once we accomplish this transformation, the U.S. system will be more reliable, will be more accessible, and will offer higher-quality and higher-value care. For physicians, this means a profession that is more rewarding, more productive, and better able to realize its moral ideal.

Article and Author Information

Note: Dr. Emanuel is the Special Advisor on Health Policy, Office of Management and Budget; and Ms. DeParle is the Counselor to the President and Director, White House Office of Health Reform. Dr. Kocher’s service at the White House ended on 9 July 2010. He wrote the paper while he was working for the National Economic Council.
Potential Conflicts of Interest: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M10-1569.


Dr. Emanuel: Office of Management and Budget, The White House, 1600 Pennsylvania Avenue, Washington, DC 20502.


Author Contributions: Conception and design: R. Kocher, E.J. Emanuel, N.M. DeParle.

Analysis and interpretation of the data: R. Kocher, E.J. Emanuel.

Drafting of the article: R. Kocher, E.J. Emanuel.

Critical revision of the article for important intellectual content: R. Kocher, E.J. Emanuel, N.M. DeParle.

Final approval of the article: R. Kocher, E.J. Emanuel, N.M. DeParle.

Administrative, technical, or logistic support: R. Kocher.

Collection and assembly of data: R. Kocher.

References


---

**Related articles**

**Letter:**  
**Comments on the Affordable Care Act and the Future of Clinical Medicine**
Douglas A. Perednia  

**Excerpt**  
Full Text  Full Text (PDF)

**Letter:**  
**Comments on the Affordable Care Act and the Future of Clinical Medicine**
Quentin D. Young  

**Excerpt**  
Full Text  Full Text (PDF)

**Letter:**