
DECISION POINTS:

Public Policy Issues & Options
for Advancing Accountable Care Organizations

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As health care reform discussions move from congressional debate to regulatory implementation, many policymakers are looking toward Accountable Care Organizations (ACOs) to begin shifting provider incentives in ways that simultaneously improve health care quality and decrease health care cost growth. The federal health care reform legislation calls for the Centers for Medicare and Medicaid Services (CMS) to develop ACO demonstration projects by 2012,¹ and the Minnesota Legislature is considering enabling legislation to allow for or even mandate ACO contracting by state public programs.² Although interest and hopes are high, the ACO concept remains largely theoretical and amorphous:³ “the ACO is an impressively elastic concept that can mean a lot of different things to different people.”⁴

As ACO initiatives take form, significant policy decisions need to be made – decisions that will impact whether hospitals have a formal role within an ACO structure, whether ACOs will be mandatory or voluntary, and what kind of financial rewards or consequences ACOs will face for cost and quality performance.⁵ Thus, hospitals and health systems need to carefully consider how ACO projects are designed to best meet the needs of their communities, patients and payer mix.

This document summarizes the underlying theory of ACOs, discusses some of the many policy issues inherent in designing an ACO project, and explores the potential benefits and risks for hospitals and health systems in view of the various policy decisions’ implications.

¹ Patient Protection and Affordable Care Act, H.R. 3590, sec. 1899(a).

² See, e.g., S.F. 2337 (amendment A-9), lines 16.17 through 19.26.

³ See, e.g., Harold D. Miller, “Creating Accountable Care Organizations in Massachusetts,” at p. 15 (Nov. 2009) (“the core of the concept of an Accountable Care Organization is not a structure, or even a process, but an outcome”); see also Kelly Devers and Robert Berenson, “Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?” at p. 1 (Oct. 2009) (“The ACO concept is confusing partly because it is a concept with a history, one that is rapidly evolving and for which the terminology seems to keep changing.”)

⁴ Stephen Jenkins, “Accountable Care Organizations: An Old Idea for New Times,” SG2, at p. 1 (Jan. 27, 2010).

⁵ Devers & Berenson, *supra* n.3, at p. 1 (itemizing key variations in ACO models: (1) qualifying criteria and provider membership; (2) voluntary or mandatory ACO regulatory environment; (3) patient election or assignment to ACO; (4) various ACO payment methodologies; and (5) quality metrics and monitoring systems).

What is an ACO?

Generally, an ACO is conceptualized as a group of providers aligned either formally or informally in a manner that results in three essential characteristics: (1) the organization can provide or manage the continuum of care as a real or virtually integrated system, (2) is of sufficient size and capacity to support comprehensive performance measurement, and (3) is capable of prospectively planning budgets and resource needs.⁶ “The defining characteristic of ACOs is that a set of physicians and hospitals accept joint responsibility for the quality of care and the cost of care received by the ACO’s panel of patients. The goal is to create an incentive for providers in the ACO to constrain volume growth while improving the quality of care.”⁷

An ACO needs to have an infrastructure in place so that individual providers, as well as the collective whole, can measure and attribute patient care costs, quality and capacity. These metrics are then used to drive quality improvement and cost reductions to generate total-cost-of-care savings, which are shared between payers and the ACO providers. In this way, shared savings act as a practical incentive to impact providers’ behavior and the underlying performance measurement components that result in comparable data sets within the ACO, as well as for community or multiple ACO comparisons.⁸

As Medicare has envisioned ACOs, the minimum number of beneficiaries receiving primary care from an ACO is 5,000⁹ in order for the organization to have a sufficient number of patients to effectively impact costs and for the ACO to reliably predict total expenditures.¹⁰ One estimate is that this minimum patient panel threshold could be met by a group practice of ten primary care physicians.¹¹ To demonstrate that setting this minimum threshold would not significantly alter or reduce patient choice, a recent study analyzed current patient utilization practices and estimated that 78 percent of Medicare beneficiaries nationwide receive primary care within networks that provide such care to more than 5,000 beneficiaries.¹²

6 John Bertko Presentation, “Delivery System Reform: Accountable Care Organization Overview,” slide 4 (Oct. 19, 2009); Devers & Berenson, *supra* n.3, at p. 2.

7 Medicare Payment Advisory Commission (MedPAC), “Report to the Congress: Improving Incentives in the Medicare Program,” p. 39 (June 2009).

8 Bertko, *supra* n.6, at slide 7.

9 MedPAC, *supra* n.7, at p. 40; Elliott S. Fisher, et al., “Fostering Accountable Health Care: Moving Forward in Medicare,” Health Affairs, w224 (2009).

10 Bertko, *supra* n.6, at slide 10 (demonstrating Medicare spending predictability in networks of greater than 5,000 primary care patients to be within 0.04%); MedPAC, *supra* n.7, at p. 40.

11 Miller, *supra* n.3, at p. 16; but cf. MedPAC, *supra* n.7, at p. 49 (stating that primary care networks with more than 5,000 Medicare beneficiaries typically include more than 50 physicians).

12 Elliot S. Fisher, et al., “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” Health Affairs 26(1) w44-57 (2007) (using data from 2004).

Another aspect of an ACO is its actual capacity, or at least the alignment of incentives, to encourage joint decision making. Because the ACO will have significant pressure to reduce costs and improve quality across its multiple providers, there are several key operational issues that will require joint, unified decision making such as workforce complement (e.g., balance of duties between nurse practitioners and primary care physicians), internal process improvement, infrastructure needs and priorities, etc.¹³

How an ACO is ultimately structured and defined is subject to significant variation depending upon the regulatory requirements, payment methodologies and incentives, and quality or outcome expectations in place. Some ACOs may be formal, corporate, integrated care delivery systems with a form of capitated payments, while others could be informal or even unintended groupings of providers continuing to operate under fee-for-service payments with some form of shared financial incentives. As a result, in order to better understand the nature and structure of an ACO, one must examine the various policy decision points discussed below.

How are ACOs different from other types of health care reform proposals?

Baskets, bundles and episodes of care

Baskets of care in Minnesota, or bundles of care in CMS pilot projects, are a lump payment amount intended to cover all the projected costs of services for a defined episode of care or set of services.¹⁴ This single payment is often designed to incorporate the costs of services delivered by multiple providers, thereby creating greater pressure for those providers to work together to better control cost and quality.¹⁵ Bundled payments are typically limited to a specific service or condition and a group of providers is paid the bundled price for each episode of care delivered. Accordingly, a bundled payment “does not create any constraint on the number of episodes of care”¹⁶ performed by a provider, and the provider’s revenue remains intrinsically tied to the volume of bundles or episodes delivered.

While a group of providers delivering a bundle or basket of care assumes responsibility for the cost and quality of care associated with that particular service or condition, the group is not held accountable for the rest of the patient’s health. In other words, after the defined bundle of services is complete, the provider group is no longer financially or clinically responsible for the patient’s care or condition.

¹³ Bertko, *supra* n.6, slide 14; MedPAC, *supra* n.7, at p. 41.

¹⁴ Mark Heit and Kip Piper, “Global Payments to Improve Quality and Efficiency in Medicaid: Concepts and Considerations,” at p. 9 (November 2009).

¹⁵ *Id.* at pp. 9-11.

¹⁶ Harold D. Miller, “From Volume to Value: Better Ways to Pay for Health Care,” *Health Affairs*, vol. 28, no. 5, p. 1420 (Sept./Oct. 2009); see also Ann Robinow, “The Potential of Global Payment: Insights from the Field,” *The Commonwealth Fund*, p. 21 (February 2010) quoting physician interviewee (“This type of payment has some value, but it’s still just fee-for-service with a different unit.”).

An ACO, on the other hand, would be paid for and responsible for the overall health of the patient. Although bundles of care and episode-of-care payment methodologies might be included within an ACO structure or initiative, the ACO concept is much broader than bundles of care in terms of services provided, length of time, and general accountability and risk on the providers involved.

Health care homes

As Minnesota embarks upon its health care home initiative, which includes risk-adjusted, per-member, per-month coordination fees, policymakers and health care stakeholders will need to consider how an ACO project relates to the health care home initiative.¹⁷ Both initiatives emphasize primary care and create increased expectations of care coordination for the providers involved. However, substantial differences exist between the two efforts.

A key difference between Minnesota's health care home initiative (as well as most medical home projects) and ACOs is the scope of the patient population. In health care homes, certified providers identify patients with or at risk of developing medically complex or chronic conditions.¹⁸ ACOs, on the other hand, are not designed for certain classes of patients and, instead, are intended to address the needs of their entire patient population.¹⁹

Similarly, whereas individual providers or clinics are certified and measured as health care homes,²⁰ ACOs would encompass multiple providers and practices serving an entire community.²¹ Instead of focusing almost exclusively on primary care, an ACO would align primary care providers with specialists and perhaps hospitals and other facilities to deliver a wide range of care to an entire patient population.

Is an ACO a literal or virtual organization?

The question whether to base an ACO program on voluntary or mandatory participation by providers relates directly to whether an ACO must be a "literal" or "virtual" organization. In a voluntary model, provider groups will need to have a literal or formal organization and structure to allow its providers to make joint decisions regarding care practices, capital investments, etc. and to share and distribute financial incentives.²² Most significantly, a voluntary ACO environment inherently requires a literal organization in the sense that providers would need to proactively agree to participate, thereby necessitating a collective decision.

17 See e.g., MedPAC Presentation of David Glass and Jeff Stensland, "Accountable Care Organizations," slide 15 (April 2008) (identifying point of discussion whether ACOs complement medical homes).

18 Minn. Stat. sec. 256B.0751, subd. 3 (2008).

19 Glass & Stensland, *supra* n.17, at slide 5.

20 Minn. Stat. sec. 256B.0751, subd. 3(a) (restricting health care home certification to personal clinicians or primary care clinics in which all of the clinic's primary care clinicians meet certification criteria).

21 AcademyHealth, "Research Insights: Medical Homes and Accountable Care Organizations: If We Build It, Will They Come," at p. 2.

22 MedPAC, *supra* n.7, at p. 41.

On the other hand, if a mandatory ACO model is used, providers could be assigned to an ACO regardless of whether they have a contractual or other formal relationship with one another. This “virtual” ACO environment assumes that any financial bonuses and penalties would be assessed to individual providers directly rather than through a central ACO structure.

Although theoretically possible to create virtual networks or other provider assignment to an ACO,²³ most experts agree that organizations with existing integrated delivery systems will have an advantage at least in early ACO development.²⁴ This is particularly true if the payment methodology relies on global or capitated payments because “any provider accepting global payments will require an above average level of integration in both clinical and financial terms.”²⁵

For example, once an ACO meets necessary thresholds and receives bonus payments or a bulk global payment, the ACO must then internally reallocate that payment among the multiple providers participating in the ACO.²⁶ Accordingly, providers within an ACO, even those that are already part of the most sophisticated and integrated delivery systems, will need to contract with other providers and specialists.²⁷ While a daunting task on its own, it becomes even more complex and difficult for an ACO to balance when one takes into account the varying levels of negotiating power among different provider groups in a community.²⁸

It remains unclear whether or how smaller, independent hospitals or provider groups can align themselves and transform in ways to take advantage of an ACO initiative or whether a more formal or organized structure will be a precondition for ACOs.²⁹

Voluntary or mandatory ACOs?

Essentially, there are two stark policy models of regulatory environments for ACOs: voluntary or mandatory.³⁰

Under a voluntary model, policies and incentives would be established and providers or groups of providers wishing to become ACOs could elect to adopt and subject themselves to the necessary ACO payment and regulatory

²³ Heit & Piper, *supra* n.4, at p. 20 (“the absence of a single corporate structure does not necessarily denote the absence of integration within a provider system.”).

²⁴ MedPAC, *supra* n.7, at p. 44; Bertko, *supra* n.6, at slide 15; Heit & Piper, *supra* n.4, at pp. 20-21 (November 2009); Miller, *supra* n.3, at p. 16.

²⁵ Heit & Piper, *supra* n.4, at pp. 20-21.

²⁶ Miller, *supra* n.3, at p. 8.

²⁷ Devers & Berenson, *supra* n.3, at p. 3.

²⁸ Miller, *supra* n.3, at p. 8.

²⁹ AcademyHealth, *supra* n.21, at p. 1; Fisher, “Fostering Accountable Health Care,” *supra* n.9, at w222 (stating that formal legal structure would be required).

³⁰ Glass & Stensland, *supra* n.17, at slides 6, 15.

requirements.³¹ Those providers that do not choose to become ACOs would remain unaffected, other than indirect impacts resulting from market forces associated with competing against nearby ACOs. The federal health care reform legislation, for example, appears to adopt a voluntary ACO initiative.³² Because a voluntary ACO environment is dependent upon the incentives and regulatory burdens in place and the business judgment decisions of individual provider practices, it is impossible to predict how many providers would form ACOs in any current market.

On the other hand, policies and regulations could establish mandatory ACOs. In a mandatory ACO environment, primary care physicians would be assigned to ACOs based on their patients' health care utilization patterns,³³ whereas specialists might have their utilization and performance measures split between multiple ACOs depending upon their patient mix. Although individual physicians, hospitals and other providers may have no contractual or other relationship in place,³⁴ they would become an ACO by regulatory fiat based on the assignment of their patients. And, as a result, they would share in consequences of one another's performance and utilization. This forced community of interests would be intended to instill incentives for those providers to work together more deliberately to control their costs and improve quality,³⁵ thereby increasing the likelihood that they would receive whatever financial incentives are in place. In this mandatory ACO environment, virtually all physicians would be part of ACOs.³⁶

Each of these ACO models has public policy implications and trade-offs worthy of further evaluation.

Voluntary ACO Environment: Pros and Cons

A voluntary ACO environment will be easier for the health care stakeholders to support and will be met with less resistance from providers. Because participating providers will self-select, voluntary ACOs are predicted to have a better chance of instituting care coordination practices, global budgeting and a more thorough collaborative effort among the providers. Consequently, these early adopters could serve as models for others in the future.³⁷ Another potential advantage of a voluntary ACO program, at least initially, is that it would be smaller in scope, and easier to administer and modify.³⁸

31 Fisher, "Fostering Accountable Health Care: Moving Forward in Medicare," supra n.9, at w222.

32 Patient Protection and Affordable Care Act, H.R. 3590, sec. 1899(a)(1), (b)(1).

33 Glass & Stensland, supra n.17, at slide 9.

34 Ibid.

35 Ibid.

36 Id., at slide 6.

37 Devers & Berenson, supra n.3, at p. 5.

38 Ibid.

On the other hand, a voluntary ACO environment is likely to attract only those providers that believe they are very likely to receive the financial bonuses available.³⁹ Accordingly, the potential cost savings from voluntary ACOs could be smaller because fewer providers will opt in and those that do are likely to receive much of the financial incentives.⁴⁰

Compounding this dilemma, a voluntary ACO environment will require more of a bonus-structure payment model rather than one that relies on withholds or significant financial risk.⁴¹ “To induce physicians and hospitals to volunteer to form an ACO, [payers] would have to provide physicians with a significant upside reward and very little (if any) downside penalty.”⁴² Thus, the cost savings opportunities are further diminished⁴³ unless fee-for-service rates for non-ACO providers are correspondingly slashed. Doing so would create a greater incentive for providers to participate in an ACO.⁴⁴ In other words, it is unreasonable to expect a voluntary ACO program to generate sufficient savings to self-fund the bonuses to participating providers while simultaneously generating net gain for payers.

Therefore, a voluntary ACO program designed to result in overall cost savings appears to have three potential sources for those savings: (1) decreased payments to poor performing ACOs, which would not attract many providers willing to voluntarily participate in the program, (2) reduced payments to non-ACO providers that would generate savings, a portion of which would be used to pay for ACO providers’ bonuses, or (3) improved cost containment and quality improvement efforts by ACO providers that result in greater internal-ACO savings combined with financial bonuses rather than lost revenues from decreased services.

In addition, although early-adopter ACOs might offer case studies for future providers, some question their ability to serve as meaningful examples. Because the voluntary ACO provider groups will be self-selected, the results from such ACOs might be difficult to extrapolate to other providers.⁴⁵ So, even if the ACO experience produces positive results, those results might be discounted as unique to the type of providers that would volunteer for the project in the first place. For example, if the early entries into ACO models are large, integrated delivery systems, whatever outcomes they achieve or lessons

39 Ibid.; Glass & Stensland, *supra* n.17, at slide 8.

40 Devers & Berenson, *supra* n.3, at p. 5.

41 MedPAC, *supra* n.7, at p. 40

42 Ibid. (parenthetical original); see also Fisher, “Fostering Accountable Health Care: Moving Forward in Medicare,” *supra* n.9, at w222.

43 Glass & Stensland, *supra* n.17, at slide 8.

44 MedPAC, *supra* n.7, at p. 40 (favoring voluntary bonus-only ACO model with accompanying fee-for-service rate constraints), 53 (noting that fee for service rate cuts would allow for immediate cost savings and the potential for larger ACO bonuses); Robinow, *supra* n.16, at pp. 6, 19.

45 Devers & Berenson, *supra* n.3, at p. 5.

learned might be discounted by smaller, independent providers who could regard the research and data as unique to integrated systems.

Mandatory ACO Environment: Pros and Cons

Unlike a voluntary ACO model, both bonus and penalty incentives could be used effectively in a mandatory model in which providers are assigned to a virtual ACO. Doing so would allow the best performing providers to receive rewards financed by the penalties imposed on poorer performing providers.⁴⁶

In a mandatory ACO environment, the individual providers themselves might not have any contractual relationships with one another, or even be aware of which other providers are included in their ACO.⁴⁷ But, if the financial incentives are large, they would become acutely aware of their collective performance on cost and quality scores.

Compared to the limited number of providers electing to create ACOs in a voluntary regulatory scheme, a mandatory ACO environment would be inherently more comprehensive within the provider markets.⁴⁸ Because of this comprehensive scope, a mandatory ACO scheme could create more immediate incentives for providers to work together quickly to learn how their referral and utilization patterns effect total spending and health outcomes within the community. Because variation in provider practice exists within individual markets,⁴⁹ this mandatory environment could create peer pressure and beneficial motivation for providers to hold one another more accountable for the care they provide.⁵⁰ Any reduction in unjustified practice variation that results in lower spending or improved quality would be an improvement.

On the other hand, proposals to institute a mandatory ACO system are likely to attract significant opposition. Physicians may resist involuntary attribution to an ACO.⁵¹ Likewise, consumers might resist being ascribed to an ACO, especially if that is accompanied by any restriction – either real or perceived – on their choices of providers or available services.⁵²

Perhaps the most significant concerns about a mandatory ACO system is whether it will amount to significant behavioral change among providers. Peer pressure

⁴⁶ MedPAC, *supra* n.7, at p. 40, 44.

⁴⁷ *Id.* at p. 45.

⁴⁸ Devers & Berenson, *supra* n.3, at p. 5.

⁴⁹ *Ibid.*; Glass & Stensland, *supra* n.17, at slide 10.

⁵⁰ Jenkins, *supra* n.4, at p. 2.

⁵¹ Glass & Stensland, *supra* n.17, at slide 11; Devers & Berenson, *supra* n.3, at p. 5.

⁵² Jeff Goldsmith, “The Accountable Care Organization: Not Ready for Prime Time,” <http://healthaffairs.org/blog>, p. 2 (Aug. 17, 2009) (noting that employers and patients prefer open panels) and *id.* at p. 3 (arguing that patients should not be assigned without their knowledge because realigning care delivery and demand “will not work without patient cooperation”). See also, Devers & Berenson, *supra* n.3, at pp. 5, 9; Robinow, *supra* n.16, at p. 10.

might be insufficient to change provider behavior.⁵³ And, because providers in a mandatory ACO will not have existing contracts or revenue distribution mechanisms, any existing distrust could be exacerbated as providers blame one another for poor performance or dispute how bonuses are allocated.

Mono- or multi-payer ACO designs?

Generally, proponents favor ACO designs that include multiple payers aligned behind the same or similar payment methodologies, cost and quality calculations, data tracking and care design system. Most ACO commentators agree that any one payer alone, especially a public payer that often reimburses below cost, is unlikely to generate sufficient financial and quality incentives to generate the kind of decision-making changes necessary for providers to realign their services.⁵⁴

The goal is for providers to deliver care in a “payer neutral” manner.⁵⁵ In other words, a provider should treat patients in the same manner with the same incentives for efficiency and effectiveness. The more disparity in payment methodologies, quality measures, incentives, etc. due to multiple, uncoordinated payers the more difficult it is for a provider to truly reorganize its care protocols.⁵⁶ This all-payer alignment also helps protect against cost-shifting from one payer to another.⁵⁷

Another argument in favor of ACO initiatives with multiple payers is that providers will have to implement a variety of administrative and information technology systems to manage the ACO.⁵⁸ If the technical details or requirements for ACO participation differ from payer to payer, providers’ administrative costs, burdens and complexities will increase substantially and make it less likely that they will want to participate in a voluntary ACO initiative. Both of these outcomes would decrease the ACO project’s cost-saving potential.⁵⁹

On the other hand, the patient populations served by different payers have unique needs. Some commentators have questioned, for example, whether an ACO initiative effectively designed for a traditional Medicare population would function as effectively for a working-age, privately insured population.⁶⁰ These differences in patient populations might necessitate different care practices, different financial incentives and different quality metrics.⁶¹

53 Glass & Stensland, *supra* n.17, at slide 11; see also Jenkins, *supra* n.4, at p. 2.

54 Heit & Piper, *supra* n.4, at p. 24 (stating that Medicaid can participate in and help foster ACOs, but ACOs require other payers’ participation); see also Miller, *supra* n.3, at p. 10; MedPAC, *supra* n.7, at p. 52.

55 Miller, *supra* n.3, at p. 10.

56 *Id.* at pp. 13 (advocating for common payment methods), 15 (calling for use of common quality metrics).

57 *Id.* at p. 13 (“efforts should be made to avoid inappropriate differences in the amounts of payments across different payers that are unrelated to volume, in order to avoid cost-shifting between payers.”).

58 *Id.* at p. 10.

59 *Ibid.*

60 Devers & Berenson, *supra* n.3, at p. 8.

61 *Ibid.*

Furthermore, to the extent that an ACO model relies upon a global payment methodology (see discussion below), “no two arrangements are the same for providers contracting with multiple plans and for payers contracting with multiple providers.”⁶² Instead, “[e]ach payer-provider global payment arrangement considers multiple methodological variations” based on the particular payer and provider involved.⁶³

Scope of services and/or providers required: Hospital participation mandatory, optional or precluded?

In addition to questions concerning whether ACO projects should be designed around a single payer or multiple payers, there remain questions about which services and providers should be allowed or required to participate in an ACO. ACO proponents often refer to “total cost of care,” yet there remains a need for any ACO policy to clearly define which services fall within the scope of an ACO’s responsibility and which fall outside that scope.

For example, few people assume that an ACO will be held accountable to provide purely cosmetic services within its total cost of care target. Other questions regarding the scope of services provided by an ACO are subject to more debate. Depending upon the decisions reached and how the lines are drawn, the breadth of services within the scope of the ACO project could significantly impact the necessary size of a provider network within an ACO, the amount of financial risk an ACO takes on, and the extent of the financial incentives or consequences at stake. Decisions about which services are included in the ACO structure, as well as what incentives are placed on policyholders to select and comply with the terms of an ACO, will need to be determined between ACOs and payers.⁶⁴ The most apparent question involves whether hospitals fall within the required criteria for ACO certification.

Some ACO proponents believe that ACOs should be limited to physician-led organizations⁶⁵ and exclude hospitals (although hospital quality and cost measures would be included in the calculation of an ACO’s total expenditures for determining whether it met the targets and thresholds for financial penalties or incentives).⁶⁶ Others assert that hospitals should be allowed or even required to be part of an ACO.⁶⁷

62 Robinow, *supra* n.16, at p. 5.

63 Robinow, *supra* n.16, at p. 5.

64 Miller, *supra* n.3, at p. 18.

65 See, e.g., Jenny Minott, et al., “The Group Employed Model as a Foundation for Health Care Delivery Reform,” The Commonwealth Fund, p. 3 (April 2010) (“Physician leadership is critical” because it “encourages rank-and-file trust, promotes greater cohesion among physicians, and creates support for organizational policy and strategy.”); Robinow, *supra* n.16, at p. 9 (noting concerns about “hospital-centric structures” managing total-cost-of-care budgets); MedPAC, *supra* n.7, at p. 43, n.1.

66 Devers & Berenson, *supra* n.3, at p. 4.

67 Glass & Stensland, *supra* n.17, at slide 15; MedPAC, *supra* n.7, at p. 43; see also Miller, *supra* n.3, at p. 15 (“there is little agreement on which types of providers could play this role or the organizational structure under which they should operate.”); Devers & Berenson, *supra* n.3, at p. 4.

Relationships between ACO and non-ACO providers

Ideally, an ACO initiative would create financial protections or mechanisms to ensure that an ACO does not feel compelled to duplicate services that are otherwise plentiful in the community just because those services are provided by competitors and the ACO fears that it will be strapped with excessive mark-ups if its patients use those available resources.¹ In other words, an ACO will face the dilemma of creating duplicative infrastructure or specialty services or be held hostage to the prices demanded by local providers outside of the ACO's financial incentives.²

1 Harold D. Miller, "Creating Accountable Care Organizations in Massachusetts," at p. 9 (Nov. 2009).

2 Stephen Jenkins, "Accountable Care Organizations: An Old Idea for New Times," SG2, p. 2 (Jan. 27, 2010).

Those supporting criteria requiring ACOs to be physician-led and exclude hospitals, at least initially, hypothesize that physicians need to be more directly and financially aligned with the consequences of their decisions, and that hospital-physician relationships are too strained to successfully implement the kind of clinical and financial collaboration necessary for successful ACO implementation.⁶⁸ One commentator described this barrier to physician-hospital ACO development as resulting from "the level of suspicion that physicians have of their now much more powerful local hospitals" and the lack of confidence that shared savings would not be retained by the hospital.⁶⁹ He went on to question whether this same sense of distrust would also preclude physician-only ACOs: "There is also, sadly, a thundering absence of collegiality – in my view, the central precondition of assuming risk and managing care" that a successful ACO model depends upon.⁷⁰

Appearing to reject this view, the recently enacted federal reform bill is an example of a hospital-permissive model. The legislation does not require hospital participation in an ACO for Medicare demonstration projects, but it explicitly allows hospitals to be part of an ACO if they are in a joint venture or partnership with physicians⁷¹ or if they employ physicians.⁷² The argument supporting this flexible approach is that hospitals should be encouraged to participate in an ACO to help the initiative be as successful and inclusive as possible, but the early days of ACOs should remain open to test a range of different models and provider configurations.⁷³

At the other end of the spectrum, the Medicare Payment Advisory Commission (MedPAC) recommended that ACO policies require hospital participation. More specifically, it recommended that ACOs be comprised of physicians, specialty groups and at least one hospital.⁷⁴ MedPAC recommended requiring hospital participation because effective care coordination requires physicians and hospitals to work together, because hospitals have a greater ability to

68 Devers & Berenson, *supra* n.3, at p. 4.

69 Goldsmith, *supra* n.52, at p. 2.

70 *Ibid.*

71 Patient Protection and Affordable Care Act, H.R. 3590, sec. 1899(b)(1)(C).

72 *Id.*, at sec. 1899(b)(1)(D).

73 Mark McClellan, et al., "A National Strategy to put Accountable Care into Practice," *Health Affairs*, vol. 29, no.5, p. 983 (May 2010).

74 MedPAC, *supra* n.7, at 39 (June 2009); see also Bertko, *supra* n.6, at slide 5 (including primary care, hospital and some specialists as ACO components); but cf. Glass & Stensland, *supra* n.17, at slide 4 (stating that ACO would include a group of physicians and "possibly a hospital").

convene multiple physicians to develop and address care practices, and because much of the anticipated cost savings from an ACO will result from decreased hospital admissions so hospitals will want the opportunity to share in those cost savings to partially offset their loss of revenues.⁷⁵

Whether hospitals are allowed or required to participate in an ACO is perhaps the most significant example of a broader question that requires ACO policies to define the scope of services an ACO will be held accountable for managing. For example, depending upon the types of services included or excluded in the total-cost-of-care rubric, home health, mental and chemical health, and even long-term care providers might be other components of an ACO.⁷⁶ The addition of one or more of these providers would bring an ACO model closer to the goal of total-cost-of-care over the continuum and they are areas where greater care coordination between those providers and primary care providers and hospitals holds some of the greatest opportunities for improved health and lowering costs.⁷⁷ Including these services, however, would further compound the administrative complexities in managing the ACO.

As the scope and amount of services an ACO is responsible to provide expands, the ACO's payment will increase as will its administrative challenge of coordinating with those providers and distributing payments among them.⁷⁸ At the same time, an ACO's ability to coordinate a broader scope of providers and take on responsibility for allocating payments among them increases the ACO's market power.⁷⁹

Patient attribution: locked-in or free-range?

In order for a group of providers to align their clinical- and operational-decision making with the total-cost-of-care incentives in an ACO project, a large or even overwhelming proportion of patients in their practice would need to be within the ACO.⁸⁰ The manner in which patients will be assigned to an ACO "is perhaps the most complicated component of payment reform."⁸¹

Typically, ACO proponents recommend assigning patients to an ACO based on the providers from whom they receive their health care services.⁸² In other words, a patient would be assigned to an ACO based on the primary care

⁷⁵ MedPAC, supra n.7, at p. 43, n.1; see also Minott, supra n.65, at p. 4 (emphasizing importance of physician group and hospital integration to instill accountability and promote coordinated care).

⁷⁶ Bertko, supra n.6, at slide 5; see also Devers & Berenson, supra n.3, at p. 4; Heit & Piper, supra n.4, at p. 24.

⁷⁷ Heit & Piper, supra n.4, at p. 25 ("the absence of coordination between the acute and long-term care providers results in lower quality care, and frequent and unnecessary movement between both settings. . . . This same logic applies to behavioral health services.").

⁷⁸ *Id.*, at p. 24.

⁷⁹ *Ibid.*

⁸⁰ MedPAC, supra n.7, at p. 41.

⁸¹ Heit & Piper, supra n.4, at p. 32.

⁸² MedPAC, supra n.7, at p. 43; see, e.g., Bertko, supra n.6, at slide 6.

provider from whom he/she receives the majority of outpatient services.⁸³ The patients themselves might be completely unaware of this assignment.⁸⁴

Each ACO's patient mix must be carefully analyzed to prevent some ACOs from bearing too much financial risk, or from creating unwanted incentives for providers to avoid accepting certain patients into their panel. For example, Medicaid patients often present "unique characteristics" with "special needs not typically found in a commercial insurance population" that "demand special consideration when contemplating" global, bundled or capitated payment systems.⁸⁵ An ACO with a larger-than-average volume of Medicaid patients, therefore, is likely to have a greater reliance on services from children's hospitals, disability services and specialty providers,⁸⁶ and to have patients that fluctuate between being on-and-off Medicaid over the course of a year.⁸⁷

Furthermore, the patient assignment process has decision points and tradeoffs for various stakeholders. ACO providers will want to clearly understand the circumstances under which patients assigned to an ACO can voluntarily or involuntarily switch to another ACO.⁸⁸ Knowing which patients are in an ACO at any given moment is critically important for designing and delivering services.⁸⁹ ACO providers will also want to know how restricted those patients are to receiving services within the ACO's network of providers – not only to understand, predict and manage costs within the ACO's target, but also to ensure quality control.⁹⁰

Many patients and consumer advocates, however, will object to any restrictions on patient choice as a return to the failed capitation efforts of the 1990s.⁹¹ This concern might exist even if patients voluntarily select an ACO with limitations on providers to obtain other benefits. There could be circumstances, as in those involving mathematical assignment of patients based on usage patterns with no lock-in features, in which patients have no knowledge of their ACO assignment but later learn or believe that they have been assigned.⁹² In other words, the

83 Bertko, *supra* n.6, at slide 6; Fisher, "Fostering Accountable Health Care: Moving Forward in Medicare," *supra* n.9, at w223; Devers & Berenson, *supra* n.3, at p. 5.

84 Devers & Berenson, *supra* n.3, at pp. 5-6.

85 Heit & Piper, *supra* n.4, at p. 2.

86 *Ibid.*

87 *Id.*, at p. 33.

88 *Id.*, at p. 32.

89 *Ibid.*

90 *Ibid.*; Fisher, "Fostering Accountable Health Care: Moving Forward in Medicare," *supra* n.9, at w223 (urging empirical assignment of patients based on hindsight utilization without any restriction of choice or lock-in); Devers & Berenson, *supra* n.3, at pp. 5-6.

91 Goldsmith, *supra* n.52, at p. 2 (noting that employers and patients preferred open panels) and at p. 3 (arguing that patients should not be assigned without their knowledge because realigning care delivery and demand "will not work without patient cooperation"). See also, Devers & Berenson, *supra* n.3, at pp. 5, 9; Robinow, *supra* n.16, at p. 10.

92 Devers & Berenson, *supra* n.3, at p. 6.

fact that a provider had a financial motive to control cost and quality through referral patterns or care practices may jeopardize patients' support of ACOs as well as their confidence in their provider.⁹³

Target practice: Setting prospective spending and quality targets

Almost all ACO payment models contain the notion of prospective spending and quality targets or thresholds that an ACO is expected to meet with corresponding financial incentives tied to meeting or exceeding those targets. In short, “[i]f the ACO achieves both quality and cost targets, its members receive a bonus. If it fails to meet both quality and cost targets, its members could face lower ... payments.”⁹⁴

Each ACO would have a prospective spending target,⁹⁵ presumably for a year although some have urged a rolling three-year target to alleviate fluctuations. One suggestion is to set an ACO's spending target based on its patients' total Part A and Part B spending during the most recent three years adjusted by a projected growth rate.⁹⁶ Using a timeframe longer than a single year would minimize some of the annual variation that is unrelated to provider performance,⁹⁷ such as fluctuations in the severity of seasonal influenza, or a succession of unusually high-cost or complicated patients in a relatively short period of time. According to MedPAC, this annual variation could range 10 percent or more,⁹⁸ whereas when aggregated over a three-year timeframe, the variation in quality and cost measures falls to less than a four percent range.⁹⁹

While most agree that prospective benchmarks or targets are an essential element of an ACO project, how those targets are determined remains a complex and sensitive issue.¹⁰⁰ High-utilization or high-cost providers will advocate for spending targets based on individual ACOs' historical performance.¹⁰¹ Individualized targets would create a greater margin for these providers to decrease their costs and secure financial bonuses or avoid penalties. From a public policy perspective, this methodology would emphasize and reward improvement.¹⁰² Concerns with this approach center on its

93 Ibid. But cf., Robinow, *supra* n.16, at p. 10 (“patients who voluntarily opt into products that create an economic advantage for choosing a more-limited, managed network of providers are more receptive to some of the . . . limitations that these products may entail.”).

94 MedPAC, *supra* n.7, at pp. 39-40.

95 *Id.*, at p. 41.

96 Fisher, “Fostering Accountable Health Care: Moving Forward in Medicare,” *supra* n.9, at w223; see also H.R. 3590, sec. 1899(a)(1) (implying that Medicare ACO demonstrations will use Part A and Part B spending for establishing targets, although not defining time period used for creating benchmark).

97 MedPAC, *supra* n.7, at pp. 46, 50.

98 *Id.* at p. 49.

99 *Id.* at p. 50.

100 Glass & Stensland, *supra* n.17, at slide 12; Devers & Berenson, *supra* n.3, at p. 7

101 Glass & Stensland, *supra* n.17, at slide 8.

102 Devers & Berenson, *supra* n.3, at p. 7.

Infrastructure and start-up costs

While many policymakers and commentators pin great hopes on ACOs' potential to reduce costs and improve quality, creating and transitioning to an ACO initiative and its accompanying payment reforms will be neither easy nor cheap. Unfortunately, these additional start-up costs will be incurred before any cost savings materialize.¹

In the short run, even integrated provider groups will require substantial resources to reconfigure administrative, operational, clinical, information and financial systems.² They will need to develop care coordination agreements and mutual understandings about how global payments or bonuses will be shared and distributed with other providers.³ Accordingly, ACO payment amounts will need to be higher in the beginning and then phase down over time⁴ or amortized over time if multi-year contracts can ensure that ACOs making initial investments can recover these costs.⁵

1 Harold D. Miller, "Creating Accountable Care Organizations in Massachusetts," at pp. 7, 13 (Nov. 2009) (speculating that it will take a minimum of "several years" before ACOs achieve savings).

2 *Id.* at pp. 7, 9, 17; but cf., Jeff Goldsmith, "The Accountable Care Organization: Not Ready for Prime Time," <http://healthaffairs.org/blog>, p. 3 (Aug. 17, 2009) ("The sad reality is that most [provider groups], even the well-managed ones, simply lack the tools, leadership, and leverage to enable them to bear and manage global risk.").

3 Miller, *supra* n.1, at pp. 7, 17.

4 *Id.* at p. 7.

5 *Id.* at p. 9.

furtherance of the current system's inequities: the providers with the most to gain from this methodology are those that waste the most resources today.¹⁰³

Low-cost providers, those that are already performing better than average, will advocate for targets based on national averages instead.¹⁰⁴ They argue that their historical performance makes further efficiencies more costly to achieve and increases the risks that they will not achieve financial rewards as predictably as poor performing providers. They also assert that any rewards should be directed to those providers that deliver below-average spending to the system, regardless of their performance in the past. Or, stated the other way, that higher-cost providers should not be rewarded so long as they continue to cause above-average spending.¹⁰⁵

One proposed compromise is to begin with targets based on individual ACOs' historical data with subsequent updates of those targets based on average cost increases.¹⁰⁶ This would prevent efficient ACOs from earning bonuses without demonstrating any new cost savings, thereby alleviating concerns that bonus structures will increase total spending if national averages are used for spending targets. At the same time, the use of average spending growth rates to calculate subsequent update factors will provide more room for efficient ACOs to obtain bonuses while creating increasingly imperative incentives for high-cost providers.¹⁰⁷

Another possible scenario is to set targets based on individual ACOs' historical experience and then apply sliding scale update factors that would essentially

103 *Ibid.*

104 Glass & Stensland, *supra* n.17, at slide 8.

105 Devers & Berenson, *supra* n.3, at p. 7.

106 MedPAC, *supra* n.7, at pp. 41, 44; Glass & Stensland, *supra* n.17, at slide 12.

107 MedPAC, *supra* n.7, at p. 41.

provide greater or more obtainable bonuses for high-performing providers and smaller updates and more difficult targets for low-performing providers.¹⁰⁸

Other areas of concern regarding the calculations of spending targets raise questions about if and how those targets will accommodate expenses borne by providers that fulfill public needs but that would otherwise be jeopardized if those providers became subject to total-cost-of-care budgets. Medical education and workforce training, especially residency programs and clinical rotations, and research activities would be extremely difficult for an ACO to support while simultaneously striving to meet spending targets that are set based on other providers' averages.¹⁰⁹ Likewise, while the ultimate goal is to use spending targets against which to measure an ACO's performance by the total cost of care for its patients, some of those costs are not attributable to the ACO's actions, such as emergency services received from other providers while a patient is traveling.¹¹⁰

Payment methodology spectrum: From shared savings to global payments

As there are different opinions regarding the preferred structure of ACOs, there are a variety of views among experts regarding the payment methodology best suited for ACO projects.¹¹¹ At the broadest level, ACO proponents agree on the overall objective of placing providers' reimbursement and financial incentives at a macro or global level so that their choices in clinical delivery and capital expenses are based on a total-cost-of-care for an entire patient population. That general goal, however, has several different payment methodology options that range from building upon the current fee-for-service system to blended methods of "shadow capitation" or "global payments," to more traditional capitation models.

The majority of ACO models call for continuing fee-for-service payments, at least initially or during a transition phase, and tying those payments to financial bonuses or penalties based on whether the ACO meets its quality and spending targets.¹¹² These financial incentives can be accomplished through withholds and bonuses either individually or in combination with one another.¹¹³

A shared savings structure with bonus-only payments (no withholds or financial penalties), for example, would utilize and build upon the existing

108 Id. at pp. 41, 44.

109 Robinow, supra n.16, at p. 9 ("research and teaching revenue incentives are likely to be inconsistent with" ACO incentives).

110 Miller, supra n.3, at p. 9 (describing such costs as "insurance risks" rather than a provider's "performance risk").

111 Heit & Piper, supra n.4, at pp. 9-14 (discussing various payment reform concepts including bundled payments, episode-based payments, evidence-informed case rates, condition-specific case rates, global payments and pay-for-performance systems); see also Taylor Burke and Sara Rosenbaum, "Accountable Care Organizations: Implications of Antitrust Policy," p. 2 (March 2010).

112 MedPAC, supra n.7, at p. 46.

113 Glass & Stensland, supra n.17, at at slide 4.

fee-for-service system. Under this system, the payer would aggregate all of the reimbursements to ACO providers over the course of time, compare that total reimbursement against a preset annual spending target, and then pay out a bonus if those total costs of care received by the ACO's patient population fell below the target.¹¹⁴ Typically, the ACO providers' bonus would be tied to a percentage of total savings.¹¹⁵ The exact terms of this shared savings structure would be subject to policymakers' discretion or provider-payer negotiations. In the joint Dartmouth Institute for Health Policy and Clinical Practice and Brookings Institute ACO demonstration project, for example, providers and payers agree to an 80/20 split, respectively.¹¹⁶ Others have suggested a 50/50 split.¹¹⁷

The advantages of this shared savings structure with bonus payments are that it builds off of existing payment and claims systems, is relatively easy to administer, and makes it more attractive for providers to volunteer to become an ACO because it entails little or no risk.¹¹⁸ The disadvantages are that, at the individual provider level, most of the reimbursement remains tied to the volume of services provided. Therefore it retains the misaligned incentives of the fee-for-service system.¹¹⁹ In addition, because the incentives are reward-based, the opportunity for cost savings is diminished, especially over time as it becomes increasingly difficult for efficient providers to obtain bonuses and the fee-for-service, volume-driven incentives become more enticing than what are perceived as increasingly unachievable spending targets.

The same shared savings structure with financial bonuses, however, could be combined with financial withholds or penalties to increase the financial incentives' power to change provider behavior. Although this modified shared savings structure increases incentives for provider improvement, it continues to rely upon the underlying fee-for-service system and its misaligned incentives. Even with bonuses, withholds or penalties, or other financial incentives in place, if the vast majority of an individual's annual income is driven by volume, he/she will behave accordingly regardless of the outside hope of a relatively small bonus or withholding.¹²⁰

Rejecting these fee-for-service-based models, some commentators suggest moving health care payments to a modified form of capitation called global payments, or sometimes referred to as "shadow capitation," "comprehensive

114 MedPAC, *supra* n.7, at p. 44; Fisher, "Fostering Accountable Health Care: Moving Forward in Medicare," *supra* n.9, at w222; Devers & Berenson, *supra* n.3, at p. 6.

115 Devers & Berenson, *supra* n.3, at p. 7.

116 Bertko, *supra* n.6, at slides 12-13; MedPAC, *supra* n.7, at p. 52; Fisher, "Fostering Accountable Health Care: Moving Forward in Medicare," *supra* n.9, at w223.

117 MedPAC, *supra* n.7, at n.8.

118 Devers & Berenson, *supra* n.3, at p. 7.

119 *Ibid.*

120 MedPAC, *supra* n.7, at p. 51; Devers & Berenson, *supra* n.3, at p. 7.

care payment,” or “condition-adjusted capitation.”¹²¹ A global payment is a risk-adjusted prospective payment intended to cover the costs of care for a given patient taking into account the patient’s medical conditions and risks.¹²² In a global payment system, providers would be paid a set amount to deliver all care for a patient for an entire year.¹²³ Because providers’ reimbursements are set at a flat amount, the incentives to provide more care or more costly services is eliminated.¹²⁴

However, unlike traditional capitation, in which a provider is paid a flat, unfluctuating, set amount for each patient, global payment amounts vary for each particular patient.¹²⁵ Thus, a global payment for an older patient with chronic or complex medical conditions will be larger than one for a younger, healthier patient.¹²⁶ The fairness and adequacy of a global payment, therefore, intrinsically depends upon the risk adjustment system’s ability to accurately reflect the risk of each individual patient.¹²⁷

Ideally, a global payment system would remove incentives or disincentives that impede providers in the current fee-for-service payment system from delivering the most efficient and coordinated care possible. Instead, global payments would be intended to make it more financially viable for providers to improve a patient’s health in ways that decrease utilization of more expensive or on-going services, and reward providers that achieve the best outcomes for their patients at the lowest cost.¹²⁸ Of course, this ideal scenario is not easy to pinpoint.

If a global payment amount is set too low, an ACO will be forced to provide less care than is ideal, reduce access to services or face bankruptcy if the costs of services continue to exceed the global payment amount.¹²⁹ On the opposite extreme, if a global payment amount is set too high, the incentives to improve efficiency, innovate and decrease utilization of unnecessary services would be diminished.¹³⁰

Other concerns with global payments have been raised as well. A common concern with global payments is that they create an implicit incentive for providers to “skimp on care ... or refuse to care for patients who appear likely to have poor outcomes.”¹³¹

121 Miller, “From Volume to Value: Better Ways to Pay for Health Care,” supra n.16, at p. 1420.

122 Heit & Piper, supra n.4, at. 12; see also Miller, “supra n.3, at p. 7.

123 Heit & Piper, supra n.4, at p. 1.

124 Id., at pp. 1, 26.

125 Miller, supra n.3, at p. 8.

126 Ibid.; see also Robinow, supra n.16, at p. 3 (noting that global payment methodologies also vary based on the amount of risk a provider organization is capable of assuming).

127 Heit & Piper, supra n.4, at p. 26.

128 Miller, supra n.3, at p. 4.

129 Id. at p. 6.

130 Ibid.

131 Id. at p. 14; see also Miller, “From Volume to Value: Better Ways to Pay for Health Care,” supra n.16, at p. 1424.

Another concern is that global payments are administratively complex and expensive for providers and self-insured employers. Global payments, even when well tailored and appropriately risk adjusted, contain “many variations in ... methodological details” which “sustain the need for complicated, expensive billing and claims systems.”¹³² To the extent that high deductibles and co-pays remain a significant part of patients’ benefit structure, they further increase administrative costs and challenges for providers operating under a global payment methodology.¹³³ Finally, global payment systems are difficult for self-insured employers to administer.¹³⁴ As a result, policymakers need to take these administrative costs into account when projecting potential savings from moving to a global-payment-based ACO environment.

In almost any ACO payment methodology, including global payments, there are other decision points that must be determined if bonuses or penalties are involved. Just as a shared savings proportion needs to be determined, likewise the amount of any financial withholds or penalties an ACO will suffer for failing to meet spending or quality targets is a critical element that must be balanced.¹³⁵ Another issue that needs to be determined is when shared savings are triggered. An ACO could share in any savings based upon the agreed proportions. Or, more likely, a minimum savings threshold, such as two percent, could be set to ensure that the ACO achieves a certain level of cost reductions before any bonus payments or shared savings allocations are made.¹³⁶

Ensuring and measuring quality

A challenging issue for policymakers and/or payers and providers interested in pursuing an ACO project will be determining how multiple quality scores and resource utilization measures will be weighted and balanced to determine the threshold that will trigger financial penalties or rewards and the amounts of such incentives.¹³⁷ This issue is more complex when viewed in light of the ACO objective – improving population health – because “[t]here is no consensus on how to measure population health and its improvement.”¹³⁸

Some of the questions around establishing quality performance levels that an ACO would be required to meet involve defining the basis against which the ACO will be measured: by absolute performance (e.g., percentage of ACO patients immunized), by performance compared to other providers (and, if so, other providers nationally, regionally, locally?), or by improved performance

¹³² Robinow, *supra* n.16, at p. 7.

¹³³ *Id.*, at p. 10.

¹³⁴ *Ibid.*

¹³⁵ Bertko, *supra* n.6, at slide 13.

¹³⁶ *Ibid.*

¹³⁷ Glass & Stensland, *supra* n.17, at slide 12; Devers & Berenson, *supra* n.3, at p. 8.

¹³⁸ David A. Kindig, “A Pay-for-Population Health Performance System,” *JAMA* vol. 296, No. 21, p. 2612 (Dec. 6, 2006).

by the ACO over time.¹³⁹ Because assessing quality at an ACO level would be a new endeavor, some commentators have urged policymakers to assess the cost of producing new quality measures before imposing data collection and reporting requirements on providers.¹⁴⁰

These new ACO measures, however, hold promise for better identifying and tracking best practices in care coordination.¹⁴¹ Also, because these quality measures would involve large patient populations, they would be more statistically reliable.¹⁴²

Also, quality measurement systems, especially when they are tied to financial reimbursement rates, can create incentives for providers to avoid patients who may be more difficult to care for, less likely to comply with treatment regimens or have a higher risk of poor outcomes.¹⁴³ If, however, quality measures are not sufficiently robust, providers could reduce services to maximize their income without detection that would allow countervailing market forces to intervene.¹⁴⁴

Another issue with quality measurement systems: those in use today rely heavily upon fee-for-service billing systems to track if and when services are provided. Either these quality measurement processes need to be revised or some of the fee-for-service administrative costs will continue to exist within the ACO initiative.¹⁴⁵

Antitrust laws and ACOs

One of the vexing issues with ACO implementation is the existing array of federal and state anti-trust laws and the impediments they place on the kind of cross-provider or multi-payer alignment necessary to make ACOs successful.¹⁴⁶

If, for example, an ACO initiative is designed to include a multi-payer environment in which as many payers as possible have alignment in their payment methodologies, quality measures, and ACO requirements, achieving that alignment from a practical perspective runs the risk of violating federal antitrust laws.¹⁴⁷ Similar concerns exist for independent providers interested in exploring gain-sharing or other aspects of financial agreements that might be at

139 Miller, *supra* n.3, at p. 15.

140 See, e.g., *ibid.*

141 Devers & Berenson, *supra* n.3, at p. 8.

142 *Ibid.*

143 Miller, *supra* n.3, at p. 14.

144 Devers & Berenson, *supra* n.3, at p. 8.

145 Miller, *supra* n.3, at p. 14.

146 *Ibid.* at p. 19. For a thorough examination of statutory and regulatory restrictions on multi-provider collaborations associated with forming an ACO, see American Hospital Association, “Trendwatch: Clinical Integration – The Key to Real Reform” (February 2010); American Hospital Association, “Getting More from Health Reform: Five Barriers to Clinical Integration in Hospitals (and what to do about them)” (February 2010); and Burke & Rosenbaum, *supra* n.111, at .

147 Miller, *supra* n.3, p. 10.

the core of initial ACO negotiations.¹⁴⁸ While some commentators are confident that an ACO will meet the necessary financial and clinical integration tests used by federal antitrust authorities,¹⁴⁹ discussions among independent providers prior to such integration can be subject to significant enforcement actions.¹⁵⁰

HIT and data availability

Health information technology (HIT), especially electronic medical records (EMRs), is a key component of an ACO's success.¹⁵¹ EMRs alone, however, are insufficient. An ACO must also have technological capacity to foster communication among providers, both within and outside of the ACO network; to capture and report multiple quality indicators; to track and respond to utilization patterns; and to receive, allocate and distribute new reimbursements such as withholds, bonuses, global payments or shadow capitation.¹⁵²

And, in order to appropriately provide for and respond to the needs of its patients, an ACO must have real-time data resources¹⁵³ identifying the patients in its panel and the multiple levels of care they receive. "Most providers do not have access to comprehensive data on the nature of current services received by patients, current payment levels for those services, etc. This will make it difficult for them to assess the potential financial opportunities and risks associated with" an ACO initiative, especially one that relies upon global payments.¹⁵⁴ Currently, only the payer community has this level of data.¹⁵⁵

When fully implemented, an ACO's primary target is population health. Accordingly, an ACO's data and technology infrastructure need to support "population care management."¹⁵⁶ Few, if any, provider systems have such infrastructure in place.¹⁵⁷

148 Miller, *supra* n.3," at p. 16; see American Hospital Association, "Trendwatch," *supra* n.146, at p. 10-11; Burke & Rosenbaum, *supra* n.111, at p. 7.

149 Burke & Rosenbaum, *supra* n.111, at p. 14 ("A comparison of ACO characteristics and those used by the FTC to determine whether the goal of clinical integration has been met to a degree sufficient to justify collective financial negotiation shows a high degree of concordance. This degree of concordance would be even more so in ACO models that employ both clinical integration and financing arrangements that rely on population-based capitation and use of salary-plus-performance-bonus payment system.").

150 John G. Liethen, "A Path to Accountable Care Runs through the FTC," *Law360*, p. 2 (April 2010).

151 Bertko, *supra* n.6, at slide 15; Heit & Piper, *supra* n.4, at pp. 20, 22 (stating that global payment methodology "relies on the use of HIT").

152 Heit & Piper, *supra* n.4, at p. 20; Robinow, *supra* n.16, at p. 6 ("For providers to effectively manage patient care costs they must have accurate and current financial data.").

153 Miller, *supra* n.3, at p. 22 (emphasizing that "timeliness of data is critical").

154 *Id.* at p. 16. But see Robinow, *supra* n.16, at p. 6 ("Today, providers with fully implemented electronic medical records ... have real-time, clinically complete information available.").

155 Miller, *supra* n.3, at p. 17.

156 *Id.* at p. 22.

157 McClellan, *supra* n.73, at p. 986.

Risk adjustment and the need for reinsurance

One of the most significant assumptions made by ACO proponents is that risk adjustment mechanisms can sufficiently distinguish between patients and their health conditions.¹⁵⁸ Proponents assert that risk adjustment methods can be used to flex providers' reimbursement to account for the health condition of their assigned patients, thereby alleviating any financial motivation for providers to manage or manipulate their patient population based on health status.¹⁵⁹ "Because providers can get paid more for taking care of sicker patients and are correspondingly paid less for their healthy patients, they are actually motivated to attract the chronically ill and aggressively manage their care."¹⁶⁰

Without an accurate risk adjustment, however, ACO providers will take on greater and greater risk for health costs that are beyond their control or for which they should not reasonably be held financially responsible.¹⁶¹ ACO providers' natural response to such risks are to begin escalating prices to offset the additional risk or, in a competitive environment, begin marketing and other tactics designed to attract healthier, low-cost patients and repel unhealthy, high-cost or high-risk patients.¹⁶² Either of these responses would undermine the underlying objectives of the ACO initiative.

Despite significant advances in risk adjustment methodologies, they "were not developed for the purposes of setting rates for physician or hospital panels," as would be required in an ACO or global payment system.¹⁶³ Also, risk adjustment systems often fail to account for socio-economic factors that are known to have significant impacts on patients' overall health status, outcomes of services and costs of appropriate care.¹⁶⁴ Moreover, even if these methodologies are further refined or equipped for the needs of an ACO initiative, "risk adjustment methodologies will never be perfect,"¹⁶⁵ and consequently, payment amounts and adjustments need to mitigate this inherent risk for ACO providers.

As providers take on more risk in an ACO environment and in recognition of the imperfections of even the best risk adjustment systems, other

158 Heit & Piper, supra n.4, at p. 26; Robinow, supra n.16, at p. 4 (asserting that risk adjustment systems can address the "risk to providers of enrolling large numbers of very ill patients").

159 Heit & Piper, supra n.4, at p. 26; Robinow, supra n.16, at p. 8 ("the expected resource needs of a patient population can be anticipated and payments [sic] rates adjusted based on their health status.").

160 Robinow, supra n.16, at p. 8.

161 Ibid. ("The importance of risk adjustment ... cannot be overstated.").

162 Glass & Stensland, supra n.17, at slide 12; Heit & Piper, supra n.4, at p. 26; see also Miller, supra n.3, at p. 6.

163 Heit & Piper, supra n.4, at p. 26; see also Miller, supra n.3, at p. 8 ("Although a variety of severity/risk adjustment systems exist today to determine which patients have more severe conditions or at greater risk of developing conditions, most have been developed for research or quality reporting purposes...." citing example Society of Actuaries, A Comparative Analysis of Claims-Based Tools for Health Risk Assessment (2009)).

164 Miller, supra n.3, at p. 8.

165 Ibid.; Heit & Piper, supra n.4, at p. 26.

reinsurance policies can be implemented to offset that risk.¹⁶⁶ Without such reinsurance mechanisms, one complicated or unusually expensive patient could significantly impact an ACO's overall spending and even jeopardize its financial security.¹⁶⁷

Risk corridors could be used to limit an ACO's financial risk within a certain amount of cost. In other words, an ACO may be at risk within a prospective global payment for its patients' actual incurred costs up to 120 percent of the amount of the ACO's reimbursement.¹⁶⁸ Any costs incurred above that amount may be the responsibility of the patient's payer (public, HMO, ERISA plan or other) or could be split between the ACO, payer and/or patient.

Similar to risk corridors, risk pools can be used to mitigate costs of unexpected risks or certain conditions. Some conditions can be quite unexpected yet extremely expensive. Actuarial schedules can accommodate for these risks to an extent, but doing so can cause unnecessary price inflation or, especially for smaller ACOs, undue risk even though the risk might be quite small. For these rare but costly conditions, risk pools can be used to separate the costs for those unusual circumstances from the global payment rates of an ACO.¹⁶⁹

Ultimately, even with reinsurance mechanisms and risk adjustment systems, unless an ACO is designed as a voluntary, shared savings bonus-only model, the participating providers will be accepting some level of financial risk. Quickly following this assumption of risk will come issues of solvency, adequacy of reserves and other complexities that will raise questions of whether ACOs fall within insurance regulations.¹⁷⁰

The \$64,000 question: Will ACOs reduce spending growth?

There is current enthusiasm for ACOs, but even the strongest ACO proponents concede that they “are uncertain about how much participating providers would actually change their behavior and reduce spending growth.”¹⁷¹ Consequently, one of the challenges for policymakers and stakeholders will be managing expectations of any ACO initiative. While some have concluded that “ACOs are no game changer,” many believe that ACOs in combination with other quality improvement and cost containment strategies are worth pursuing.¹⁷²

¹⁶⁶ Miller, *supra* n.3, at p. 8 (citing Network for Regional Healthcare Improvement, “From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs,” p. 25-26 (Nov. 2008)); Robinow, *supra* n.16, at pp. 4, 8

¹⁶⁷ Robinow, *supra* n.16, at p. 8.

¹⁶⁸ Heit & Piper, *supra* n.4, at p. 28; Robinow, *supra* n.16, at p. 4.

¹⁶⁹ Heit & Piper, *supra* n.4, at p. 28.

¹⁷⁰ Devers & Berenson, *supra* n.3, at pp. 1, 7.

¹⁷¹ Fisher, “Fostering Accountable Health Care: Moving Forward in Medicare,” *supra* n.9, at w227.

¹⁷² Devers & Berenson, *supra* n.3, at p. 3. See also *id.* at p. 10 (“ACOs will not be a real game changer in the short run but are definitely worth a concerted try.”).