



Achieving Accountable and Affordable Care

Key Health Policy Choices to Move the Health Care System Forward

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Introduction and summary

Reforming our nation's health care system so that it no longer delivers too much low-benefit care at too high a cost will require our new health reform law to spark a system-wide revolution. Disorganized care based solely on fee-for-service payments to a variety of unconnected physicians, hospitals, and clinics will have to give way to coordinated, integrated courses of treatment that deliver high-quality care at lower costs. Prevention and primary care will need to be stressed as much as treatment of the sick. And duplication and medical errors will have to be systematically found and eliminated.

We know medical care can be better organized and delivered. Virtually every industry in our economy over the past 15 years drove down costs, increased quality, and experienced a surge in productivity. The result: An increase in our national income at a rate not experienced since the 1960s. And the outlier in our economy? Our health care industry, which missed out on the productivity boom even as it incorporated all kinds of new and expensive life-saving equipment and services. The impact of this failure to innovate based on costs and quality in health care is enormous. Absent any savings from the recently enacted health reform law, federal spending on medical care is expected to hit 25 percent of gross domestic product (the total output of our economy) by 2035, up from 15 percent of GDP today.¹

In contrast, increasing health care productivity growth to the average of other industries could cut medical spending by over \$2 trillion and reduce federal government spending by almost \$600 billion over 10 years.² Family, employer, and state and local government budgets would benefit in the same way. The possibility of a more efficient, less costly health care system is universally shared. Every analyst who studies health care believes it is possible to simultaneously lower costs and improve quality. The major question is how to realize it.

Reflecting the bulk of studies, the idea underlying the new health reform law, the Affordable Care Act, is to promote efficiency through three interlocking steps. First, we need to gather the right data on what patients need and how best to pro-

vide that, and then feed that information to patients, purchasers, and providers. The American Recovery and Reinvestment Act of 2009 launched the health IT revolution, allocating \$30 billion to wire the medical system. The terms for accessing the money are set, and all observers look for a substantial increase in health IT investment as a result.

Second, we need to move health care payment systems away from rewarding the provision of more care to a system of rewarding better care. It is natural (indeed beneficial) that health care providers such as doctors, hospitals, and clinics respond to the economic incentives they face, which sends them looking for ever more sophisticated kinds of care to deliver to their patients. The problem is, performing coronary artery bypass surgery brings in thousands of dollars to hospitals and surgeons, while keeping diabetic patients healthy so they do not need surgery, in contrast, lowers profits. That's why payment incentives have to change.

Third, we need to encourage providers to reform their operations so that they can take advantage of the information resources and payment incentives. This third step is the subject of this paper, though the concept of the accountable care organization, or ACO, is clearly and directly related to the first two steps. Why? An accountable care organization is a group of medical care providers who accept responsibility for providing or arranging all care for a group of patients under a payment arrangement that allows them to profit from reducing costs and improving quality. Because patients need so many different types of medical care—primary care providers, specialists, hospitals, labs, pharmacies, and more—an ACO must necessarily coordinate care across different providers.

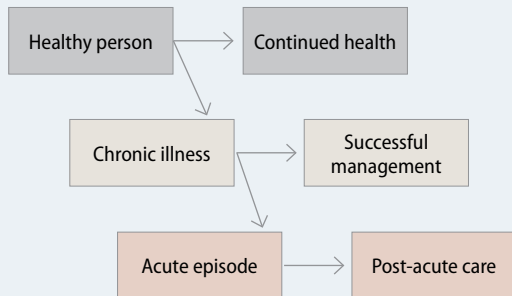
That's how an ACO works, good primary care to regularly assess and manage patients' care needs, information technology that facilitates efficient and effective care management, specialist care when needed, and bundled payment systems that reward quality care. An ACO can coordinate health care needs to boost quality and lower costs. (See box on page 3)

Where are the savings?

Thinking about people who start off healthy, develop one or more chronic illnesses, and ultimately need acute or post-acute care helps clarify three sources of savings:

- More efficient care in acute and post-acute settings
- Preventing acute illness
- Reducing administrative costs

Bearing in mind our health care flow chart below, let's see how coordination through accountable care organizations can best deliver these three types of savings:



More efficient care in the acute and post-acute setting

Patients who need acute or post-acute care often receive care that is not beneficial, or experience setbacks because of lack of coordination. The widely cited studies of the Dartmouth Atlas researchers show that care in acute settings varies greatly across the country, with little impact on patient survival or satisfaction.³

Preventing acute illness

The best way to minimize the cost of acute episodes of care is to prevent them from occurring. The problem is that prevention is very haphazard in the United States today. Only 43 percent of patients with diabetes in our country receive all recommended screenings. The share is over 60 percent in the United Kingdom and near that in the Netherlands.⁴ If our payment system were to promote better primary care to manage diabetes, as much as \$2.5 billion could be saved from avoiding hospital care.⁵

Reducing administrative costs

Coordinating among the many different providers in the United States involves significant administrative expense. Because records are not electronic, an enormous amount of time is spent on documentation, obtaining appropriate permissions, and ensuring appropriate reimbursement. A recent study estimated that administrative costs account for 39 percent of the difference in hospital and physician care between the United States and Canada.⁶

Accounting for accountable care

The total amount that could be saved through more efficient operations is enormous. The studies noted above suggest that about 30 percent of medical care spending is not associated with the improved health of patients, or improved “outcomes” in health policy parlance, and another 10 percent is wasted in administrative costs. The amount to be saved may be as high as 40 percent of total medical spending, or over \$2 trillion annually in the next decade.⁷

The Affordable Care Act requires the Centers for Medicare and Medicaid Services, or CMS, to start an accountable care organization program by January, 2012, inviting all organizations who qualify to participate for their Medicare patients. Learning from experience and building on success, the goal is to expand more effective payment and service delivery not only throughout Medicare but to all the institutions that pay for health care and the patients they cover over time.

The law is intentionally evolutionary, not revolutionary, because past experience—most notably the backlash against health maintenance organizations in the 1990s—demonstrates that forcing consumers and providers to become more efficient is neither welcome, effective, nor sustainable. Instead, the law aims to entice both consumers and providers into sharing in and delivering demonstrably better care at lower cost.

CMS is now in the process of writing the rules for the accountable care organizations. Equally important, the agency is creating a Center for Medicare and Medicaid Innovation, which will be broadly responsible for piloting complementary initiatives that promote better care along the spectrum of innovation. ACOs, the Innovation Center, and other pilot programs specified in the law represent companion pieces of an overall strategy to maximize the potential for sustainable and significant payment reform.

The success of health care reform will depend heavily on the way the tools that the law provides are actually put into effect. Certain features of an ACO program are generally agreed upon. Having good information and performance measures is key. To enable quality improvement at lower costs, CMS must collect outcome-and-cost information in real time and assure its availability to providers and consumers. Providers should readily understand how to form and sustain an ACO, and be held accountable for results, not each operational detail. And the opportunity to do well by doing good—that is, to benefit financially from efficiency—must be strong enough to entice participation and achieve intended results.

Less clear is how best to design policy to achieve both the goal of broad participation and the commitment to better, lower-cost care. New payment arrangements must not only be attractive but also have real potential to change behavior among health care providers and patients alike in order to improve quality and reduce costs. The choices that CMS makes in defining ACOs and related innovations will be critical to a successful launch of payment and delivery reform in the coming decade. Three aspects of design are particularly important:

- Whether payment reforms are designed around hospital systems or encourage new forms of integration among physicians and other health care providers
- How much payment incentives should limit payment for costs above expectations in addition to rewarding costs that are below expectations
- What rights and responsibilities consumers have in a system where providers are paid on a bundled-care basis and rewarded for more efficient care

Based on analysis of each of these three issues, this paper proposes answers to each question. Specifically:

- On payment reform, we encourage the development of physician-led accountable care groups alongside hospital-led organizations. CMS can encourage these organizations by tying financial rewards to reduction of preventable inpatient and emergency care, as well as providing organizational and technical support to physician-led organizations.
- On payment incentives, we suggest a payment system that first optionally and then as a requirement leads providers to share in the financial risks of overspending as well as in the savings from underspending, relative to spending targets.
- On rights and responsibilities, we believe that consumers should be active partners in improving the quality of their care. That means consumers should decide whether to join an ACO, and if they do, they should be able to count on rules for consumer protection and creative ways to benefit financially from seeking quality care at lower costs.

See our table on page 6 for a quick snapshot of our recommendations.

In the pages that follow, we will detail how accountable care organizations are designed to attract the participation of health care providers and their patients. Then we turn to how to ensure that these new arrangements actually deliver better quality at lower costs—avoiding the concentration of pricing power by promoting alternatives to hospital-led accountable care organizations, and assuring that payment incentives promote real change in the delivery of care. We close our paper with a discussion about how patients can partner with their health care providers in delivery reform and, together, build the confidence and commitment we'll need if innovations in health care provider practices and payment reform are to take hold.

Accountable care organizations

Quality care at lower costs

Summary of payment reform recommendations

Base requirements for setting up an accountable care organization

- Clear standards for becoming an ACO, such as having a minimum number of primary care physicians and the capacity to report basic performance measures
- Emphasis on primary and patient-centered care as the focus for care management
- Investment in data systems to measure and disseminate cost and quality information in real time to guide patient care
- Strong performance measures to assure that financial benefits reflect “better” not “cheaper” care

Participating providers

- Encourage physician-led organizations by stressing reduced hospital use in measures of quality, such as avoidance of ambulatory-care-sensitive admissions or emergency room visits
- Enable physician-led ACOs through CMS arrangements with organizations that have the technology and management capacity to support care coordination

Financial rewards and restraints

- Offer providers an initial choice between a payment arrangement that enables them only to share savings or a payment arrangement that offers health care providers a greater share of savings if they also agree to share some risk
- After three years, require providers to share in risk as well as savings

Consumer involvement

- Inform consumers about an ACO’s payment system and enable them to choose to participate
 - Provide consumer protection against poor quality ACO-provider choices and consumer benefits to using high-quality, low-cost care
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