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Perspective

Launching Accountable Care Organizations — The Proposed Rule for the Medicare Shared Savings Program

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A common criticism of U.S. health care is the fragmented nature of its payment and delivery systems. Because in many settings no single group of participants — physicians, hospitals, public or private payers, or employers — takes full responsibility for guiding the health of a patient or community, care is distributed across many sites, and integration among them may be deficient. Fragmentation leads to waste and duplication — and unnecessarily high costs.

Section 3022 of the Affordable Care Act (ACA) establishes the Medicare Shared Savings Program for accountable care organizations (ACOs) as a potential solution.[1] The creation of ACOs is one of the first delivery-reform initiatives that will be implemented under the ACA. Its purpose is to foster change in patient care so as to accelerate progress toward a three-part aim: better care for individuals, better health for populations, and slower growth in costs through improvements in care. Under the law, an ACO will assume responsibility for the care of a clearly defined population of Medicare beneficiaries attributed to it on the basis of their patterns of use of primary care. If an ACO succeeds in both delivering high-quality care and reducing the cost of that care to a level below what would otherwise have been expected, it will share in the Medicare savings it achieves.

On March 31, 2011, the Department of Health and Human Services took a major step toward establishing ACOs by issuing a notice of proposed rulemaking that will define how physicians, hospitals, and other key constituents can adopt this new organizational form. The issuing of the proposed rule follows months of obtaining informal and formal input from throughout the health care delivery system, but at this point the rule is only a proposal. The Centers for Medicare and Medicaid Services (CMS) will carefully review the comments we receive in response to the proposed rule before issuing a final rule later this year.

A critical foundation of the proposed rule is its unwavering focus on patients. We envision that successful ACOs will honor individual preferences and will

engage patients in shared decision making about diagnostic and therapeutic options. Information management — making sure patients and all health care providers have the right information at the point of care — will be a core competency of ACOs. Held to rigorous quality standards (see table), ACOs will be expected to be proactive in their orientation and to regularly reach out to patients to help them meet their needs for preventive and chronic health care. Patients who seek care at their ACO will know that their physicians are part of that ACO, but as beneficiaries of fee-for-service Medicare, they will continue to be free to seek care from any Medicare provider they wish. They will not be locked into seeing only particular health care providers.

U.S. health care is diverse in its leadership, organization, and structure; we expect that ACOs will be similarly diverse. Under the proposed rule, institutions and health care providers interested in forming an ACO will have considerable flexibility in the structure they assume. ACOs may be led by physicians in group practices, networks of individual practices, hospitals employing physicians, or partnerships among these entities and other health care providers. Whatever the leadership of an ACO, physicians and Medicare beneficiaries will have important seats at the table. The proposed rule stipulates that an ACO will be governed by a body that primarily comprises the health care providers in that ACO but also incorporates the voices of the community and the Medicare patients it serves. We expect that the transition to ACOs will unlock many opportunities and challenges; broad representation in ACO governance will ensure that these opportunities and challenges are met by an engaged set of critical stakeholders.

The financial opportunity for an ACO to achieve shared savings will vary according to its initial tolerance for risk. Two different models are proposed. In the first model, ACOs earlier in their evolution can elect to assume a smaller share of upside gains but no risk of loss for 2 years and then transition in year 3 to accepting risk. In the second model, organizations that are willing to take on both upside gains and downside risk can qualify for a higher proportion of shared savings from the start. The newly chartered Center for Medicare and Medicaid Innovation will concurrently launch aggressive testing of innovative models for a nationwide technical support platform for ACOs, to complement the numerous ongoing efforts in which the private sector is already engaged. The Center for Medicare and Medicaid Innovation is also now exploring ways to test alternative models of ACOs that differ from the models specified in the proposed rule.[2]

What can we reasonably expect of the coming wave of ACOs? We know that not all previous efforts at developing a model of shared savings have met expectations.[3] But many, like the Medicare Physician Group Practice (PGP) Demonstration, have offered important lessons on the best ways to achieve both quality improvement and cost savings.[4] Through their quality-improvement efforts, all 10 participants in the PGP demonstration met at least 29 of the 32 quality goals, most of which were process measures related to coronary artery disease, diabetes, heart failure, hypertension, and preventive care.[5] And 6 of the 10 demonstration sites produced savings — $78 million in total. Although this amount represents only a small fraction of total Medicare expenditures, it also represents a step in the right direction.

The proposed rule for ACOs draws on these lessons in an effort to develop a more robust model for shared savings. Although the savings achieved in the PGP experience were only modest, the demonstration helped to identify several factors that are critical to improving quality and increasing the opportunities for shared savings: an integrated organization that supports expending resources on programs to improve quality and reduce the provision of unnecessary services; dedicated physician leadership with a proven ability to motivate the implementation of quality-improvement programs; and a central role for health information technology in enabling the organization to manage population health and receive feedback at the point of care. The opportunities to refine new ACO models will be many; these lessons from the PGP demonstration and elsewhere will be important launching points for the transition to fully accountable care.

Accountable care is not a panacea but rather one of a number of complementary initiatives chartered by the ACA to help achieve the three-part goal of lower costs, improved care, and better health. Other delivery-reform efforts such as expanded use of medical homes, bundled payments, value-based purchasing, adoption of information technology, and payment reforms are under way or under consideration. A critical

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Proposed Measures for ACO Quality-Performance Standards.*	
Aim: improved care	
Patient and caregiver experience	• Getting timely care, appointments, and information • How well your doctors communicate • Helpful, courteous, respectful office staff • Patients' ratings of doctor • Health promotion and education • Shared decision making • Health status or functional status
Care coordination — transitions	• Risk-standardized, all-condition readmission • 30-Day post-discharge physician visit • Medication reconciliation • Care transitions measure • Management of ambulatory-sensitive conditions: diabetes; chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); dehydration; bacterial pneumonia; urinary tract infections (UTIs) • % of all physicians meeting HITECH meaningful use requirements
Care coordination — information systems	• % of PCPs meeting HITECH meaningful use requirements • % of PCPs using clinical decision support • % of PCPs meeting eRx incentive program requirements • Patient registry use
Patient safety	• Health care–acquired conditions composite (includes foreign object retained after surgery, central-line–associated bloodstream infections [CLABSI], falls and trauma, catheter associated UTI, and others) • CLABSI bundle use
Aim: improved health	
Preventive health	• Influenza immunization • Pneumococcal vaccination • Mammography screening • Colorectal cancer screening • Cholesterol management for patients with cardiovascular conditions • Adult weight screening and follow-up • Blood-pressure measurement • Tobacco-use assessment and intervention • Depression screening
At-risk population — diabetes	• Composite and individual measures (glycated hemoglobin, LDL cholesterol <100 mg/dl, blood pressure <140/90 mm Hg, tobacco nonuse, aspirin use) • Poor glycemic control (glycated hemoglobin >9%) • Blood pressure control in diabetes • Screening rates for microalbuminuria • Dilated eye exam; foot exam
At-risk population — heart failure	• Left ventricular function assessment • Left ventricular function testing • Weight measurement • Patient education • Heart failure prescription rates for left ventricular systolic dysfunction (LVSD) • Angiotensin-converting–enzyme inhibitor or angiotensin-receptor blocker (ACE/ARB) rates for LVSD • Warfarin therapy for patients with atrial fibrillation
At-risk population — coronary artery disease	• Coronary artery disease (CAD) composite and individual measures (oral antiplatelet therapy for patients with CAD; drug therapy for lowering LDL cholesterol; beta-blocker for patients with CAD with prior myocardial infarction; LDL cholesterol <100 mg/dl; ACE/ARB therapy for patients with CAD and diabetes, LVSD, or all of the above)
At-risk population — hypertension	• Blood-pressure control rates (<140/90 mm Hg) • Hypertension plan of care
At-risk population — COPD	• Spirometry evaluation • Smoking-cessation counseling • Bronchodilator therapy based on FEV_1
At-risk population — frail elderly	• Screening for fall risk • Osteoporosis management in women who had a prior fracture • Monthly INR for beneficiaries on warfarin

* Most measures and standards would be based on rates within the total eligible population. HITECH denotes the Health Information Technology for Economic and Clinical Health Act, LDL low-density lipoprotein, FEV_1 forced expiratory volume in 1 second, INR international normalized ratio, and PCPs primary care physicians.

success factor for ACOs will be their effective integration with these other efforts.

Whatever form ACOs eventually take, one thing is certain: the era of fragmented care delivery should draw to a close. Too many Medicare beneficiaries — like many other patients — have suffered at the hands of wasteful, ineffective, and poorly coordinated systems of care, with consequent costs that are proving unsustainable. CMS believes that with enhanced cooperation among beneficiaries, hospitals, physicians, and other health care providers, ACOs will be an important new tool for giving Medicare beneficiaries the affordable, high-quality care they want, need, and deserve.

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