

# Spending to Save — ACOs and the Medicare Shared Savings Program

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Before the ink was dry on the proposed rule spelling out requirements for accountable care organizations (ACOs) under the Medicare Shared Savings Program, the criticism began coming fast and furious, much of it claiming that the Centers for Medicare and Medicaid Services (CMS) had set the bar way too high. Common themes of the complaints from health care providers were the disadvantages of not knowing ahead of time which Medicare beneficiaries would be attributed to a particular ACO, the fear that the potential savings would be too low in relation to the needed investments, and the concern that the quality standards being set would be too tough.

For the many hospitals and physician groups throughout the country that have indicated that they plan to become ACOs, the proposed rule is a wake-up call: it suggests that CMS is serious about ensuring that the Shared Savings Program achieves a “three-part aim of better care for individuals, better health for populations, and lower growth in expenditures.”<sup>1</sup> Despite the ACO drumbeat that is building among health care providers, CMS’s expectations for the Shared Savings Program — which may also reflect its goals for the first year — are modest, with an expected 75 to 150 ACOs forming in the first 3 years to provide care for 1.5 million to 4 million beneficiaries.<sup>2</sup>

Experienced regulation watchers perceive an unusual degree of willingness on the part of CMS to consider changes based on what

will no doubt be voluminous stakeholder comments arriving by the June 6 deadline. Although many comments may help point the way for the agency to achieve its triple aim in a more workable manner, CMS shouldn’t be too quick to lower the ACO bar too far: the initial ACO opportunity should not be for everybody.

The ACO model is a reaction to the failure of both fee-for-service payment, which offers incentives to provide excessive services but not to devote resources to managing chronic disease or coordinating care, and capitated payment, which offers providers incentives to stint on care and take on more financial risk than many can handle. The ACO concept represents an attempt to control costs and improve the quality of care in ways that are more acceptable to patients and physicians than those associated with capitation. Built on a fee-for-service chassis, but with unrestricted patient choice, safeguards to prevent stinting on needed care, and quality standards, the Medicare Shared Savings Program attempts to avoid the pitfalls of capitation but still offer ACOs a financial upside if they reduce costs relative to a benchmark and report strong results on quality metrics.

One of the more controversial aspects of CMS’s proposed rule is its method of attributing beneficiaries to ACOs. In an effort to promote more organized care delivery without interfering with beneficiaries’ choices of providers, CMS opted for retrospective attribution: it will attribute beneficia-

ries on the basis of which primary care physician provided a plurality of their primary care services. Although such retrospective attribution will be more accurate than attribution based on beneficiaries’ prior use, ACOs won’t know which beneficiaries they’re accountable for until at least 6 months after each year in a 3-year contract. CMS will, however, provide extensive data on beneficiaries who *would have been* attributed to an ACO on the basis of previous claims. The agency hopes that ACOs will work to improve care for all Medicare beneficiaries, not only those attributed to the ACO, in which case the delay in attribution should not have major consequences.

Also controversial is the proposed system for sharing savings. Basing benchmarks on historical per-beneficiary costs means that ACOs that are already efficient will have to work harder to become more efficient. This problem is eased by the fact that the yearly increase in the benchmark will be a nationally uniform dollar amount per beneficiary. Setting a benchmark on the basis of an ACO’s historical costs is the only fiscally responsible way to conduct a voluntary program, and CMS should place a higher priority on getting inefficient organizations into this program than on attracting ones that are already efficient. But if ACOs succeed and become a large part of the delivery system, evolution toward national or regional benchmarks is inevitable, and already-efficient ACO providers will then get larger rewards.

The proposed rule reflects a strong commitment to tying the quality of care to financial rewards. ACOs must report their results on 65 quality measures, grouped into five domains — patient and caregiver experience, care coordination, patient safety, preventive health, and health of at-risk and frail elderly populations. Although claims data can provide information on some of these measures, ACOs will have to obtain information on others from medical records or surveys — a highly expensive proposition, at least for some. CMS needs to focus on “value” in quality measurement as well as in care. The agency has made it clear that quality measurement will evolve over the life of ACO contracts, but this proposition increases the degree of risk for ACOs; it would be better for CMS to commit to stability over the duration of a contract. After all, there will be additional contracts down the road that can incorporate advances in quality measurement.

The other side of the coin, however, is a real risk that the bar is set so high that too few ACOs will apply. Noting the sub-

stantial investments required for ACOs to improve care delivery, some have concluded that the prospects for earning an acceptable return on investment are small and that CMS may have been too ambitious in trying to generate large savings in what is, in essence, a voluntary demonstration.<sup>3</sup> But providers should consider ACOs as more than a short-term business opportunity. The shift from volume-driven to value-driven payment is inevitable, and getting limited shared savings while embarking on the needed investments to build the infrastructure and relationships for improving delivery is better than getting no rewards under the fee-for-service system. It may be better to spend now in order to save later and avoid the consequences of the inevitable ratcheting down of fee-for-service rates.

Clearly, much is at stake. As the country's single largest purchaser of care, Medicare has the potential to push care delivery in a new direction. Interest in ACOs is so high that many would-be ACOs probably aren't ready for prime time. CMS is right to set the bar relatively high to keep its management chal-

lenge within its abilities (could the agency really manage 1000 ACO contracts?) and reduce the risk of financial or quality-of-care disasters that undermine support for the ACO concept. But getting too few participants is also a risk, and CMS clearly already recognizes that substantial changes are needed. Sometimes in Washington you only get one chance.

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1. Centers for Medicare and Medicaid Services. Summary of proposed rule provisions for accountable care organizations under the Medicare shared savings program: fact sheet 2011. ([http://www.cms.gov/MLNProducts/downloads/ACO\\_NPRM\\_Summary\\_Factsheet\\_ICN906224.pdf](http://www.cms.gov/MLNProducts/downloads/ACO_NPRM_Summary_Factsheet_ICN906224.pdf))

2. Medicare shared savings program: accountable care organizations and Medicare program: waiver designs in connection with the Medicare shared savings program and the innovation center; proposed rule and notice. Fed Regist 2011;76:19528-654. (<http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf>)

3. Haywood TT, Kosel KC. The ACO model — a three-year financial loss? *N Engl J Med* 2011;364(14):e27. (Available at [NEJM.org](http://NEJM.org).)

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## Integrating Neglected Tropical Diseases into AIDS, Tuberculosis, and Malaria Control

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Today, approximately 1.4 billion people in the world live in extreme poverty, with incomes so low that they cannot fill their basic needs. In 2000, when eight Millennium Development Goals (MDGs) were set to guide efforts to combat various dimensions of extreme poverty, a specific call

was made in the sixth MDG “to combat HIV/AIDS, malaria, and other diseases.” In response, new financing and delivery mechanisms for disease control were introduced through the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as well as the U.S. President's Malaria Initiative (PMI)

and the President's Emergency Plan for AIDS Relief (PEPFAR). To date, approximately \$20 billion has been committed to the Global Fund, \$32 billion to PEPFAR, and \$1 billion to PMI. Many billions of additional dollars are promised through 2014. This level of support for antiretroviral drugs,