



A Closer Look at ACOs

A series of briefs designed to help advocates understand the basics of Accountable Care Organizations (ACOs) and their potential for improving patient care.

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Putting the Accountability in Accountable Care Organizations: Payment and Quality Measurements

Introduction

Every year, health care in the United States becomes more expensive. Yet despite the growth in health care costs, quality has not kept pace. As a result, people in the United States pay more for their health care but receive lower-quality care than people in other developed countries such as Germany and Japan.

One of the reasons for this is the way we pay for health care. Most insurers pay providers for each health care service they deliver, regardless of the quality. The more care that is delivered, the more the provider is paid. Providers are not usually paid to work together and coordinate a patient's care, nor are they paid to help patients be active participants in their health care (for example, by jointly developing a care plan). This poorly structured payment system has created a highly fragmented health care system that is very inefficient, with duplication of tests, preventable hospitalizations, and poor care for chronic conditions. This inefficiency causes costs to rise even further and leads to more poor-quality care.

To begin to address this problem, the Affordable Care Act included many new initiatives that are designed to change the way health care services are delivered and paid for in Medicare and Medicaid. One of the new models is the Accountable Care Organization (ACO). An ACO is an entity made up of health care providers that agrees to be held accountable not just for lowering the cost of health care, but also for improving health care quality across the continuum of care, including acute care, post-acute care, long-term care, and behavioral and mental health care.

Advocates have an important role to play in helping develop ACOs that are focused on the beneficiary and that are accountable to the community in which they are located. The goal is to improve the care that beneficiaries receive, not simply to create a new way to pay providers. Advocates can work with payers, such as Medicaid and private insurers, or with providers, such as a local hospital, to ensure that there is an appropriate balance between the financial incentives and the accountability measurements that providers must meet. This means ensuring that there is a meaningful link between financial incentives and quality improvement, as well as ensuring that there are adequate and appropriate quality measurements that evolve over time.

When working to strike this balance, advocates will face several key challenges. This brief examines some of the challenges that advocates will face when working with policy makers, insurers, and providers to develop accountability mechanisms for ACOs that ensure that beneficiaries receive high-quality care at a lower cost.

Background

ACOs aim to change the way providers deliver care by changing the financial incentives. There are different payment structures that can be used to encourage providers to lower costs, improve quality, or both. Since the goal of an ACO should be to both lower costs and improve quality, using an accountability payment structure—one in which cost and quality are linked—will be the most effective.¹ Under this kind of payment structure, ACOs will have to lower costs *and* improve quality to receive the financial incentive. This is the payment structure that Medicare will use in the Medicare Shared Savings Program ACO (MSSP ACO).²

In an accountability payment structure like the Medicare Shared Savings Program ACO, providers are rewarded for delivering high-quality care while lowering costs by linking payment to minimum quality performance requirements. If the ACO does not meet minimum quality performance measurements, the ACO does not receive the financial reward. By requiring providers to meet minimum quality measurements to receive payment, payers can ensure that providers do not reduce costs by skimping on needed care.

It is important to note that the Medicare Shared Savings Program ACO is not the only model for paying ACOs. Other payers, such as Medicaid and private insurers, may take a different approach to structuring their payment mechanism for ACOs. For example, either lower cost *or* higher quality could be the focus, and the incentive payment would be structured accordingly. For example, if the ACO lowered health care costs but there was no change in the quality of care, the ACO would still receive the financial incentive.

Payment structures like this are problematic because ACOs could lower costs simply by limiting access to medically necessary care or by providing lower-quality care. In the alternative, if the focus is on quality improvement only, quality may improve, but costs could increase. This could harm consumers in the short term by imposing higher out-of-pocket costs, and over the long term, the system could become financially unsustainable.

Whether the ACO model succeeds in changing the way health care providers deliver care will depend on two key elements: financial incentives and performance requirements. If the financial incentives are not strong enough, providers will not be encouraged to change the way they deliver care. If the performance requirements are not set high enough, then quality will not improve and could even decline.

Discussion

Challenge 1: How Will ACOs Be Paid?

ACOs can be financed through a variety of mechanisms, including shared savings, shared savings and losses, partial capitation, full capitation, or some combination of these. All of these mechanisms can be part of an accountability payment structure.

■ The Shared Savings Model

Initially, the shared savings model is likely to be the most common way to pay ACOs. This is because it is a less drastic change in the way health care providers are paid. Under this model, providers will continue to be paid on a fee-for-service basis. But if the ACO lowers expenditures (generates savings), it will be able to share in a portion of the savings, say 50 percent. (See [Accountable Care Organizations: Determining Shared Savings or Losses](#) for a more complete discussion of this issue.) Because the providers continue to be paid on a fee-for-service basis, there is no financial risk to them: if they do not lower expenditures, they may not receive an incentive payment, but they also will not lose any money.

The incentive payment, in the form of shared savings, is a way to encourage providers to change the way they deliver care, providing higher-quality care at a lower cost but still benefitting financially from doing so. This has been referred to as the “evolutionary,” rather than “revolutionary,” way to change the way health care providers practice, because it moves providers to a new payment and health care delivery system slowly.³

■ The Shared Savings and Shared Losses Model

While the shared savings model has the benefit of slowly moving health care providers to a new system, thereby increasing the likelihood that they will accept the new model, it has been criticized for not doing enough to encourage providers to change their behavior.⁴ Because there is no down side for providers—they are not likely to face any financial consequences if they do not change the way they deliver care—some critics believe that the shared savings model will not be effective in generating real change.⁵ These critics advocate for an alternative payment model, such as a shared savings and shared losses model. Under this approach, providers would continue to be paid on a fee-for-service basis and would be eligible to share in savings if they lowered costs and improved quality, but if they did not lower costs and instead increased costs (generated losses), the ACO would be responsible for paying back a portion of the losses. (See [Accountable Care Organizations: Determining Shared Savings and Losses](#).) This would put the ACO at risk, which would provide a financial incentive to ensure that expenditures did not increase.

■ The Capitation Model

Another payment mechanism that could be used to pay ACOs is capitation. In this model, providers are given a set payment per patient, rather than per service. The payment would be a set dollar amount per patient, regardless of how many health care services the patient received. It would usually be a lump sum payment that would be made each month (often referred to as a per-member per-month payment). Under a **partial capitation** approach, some, but not all, of the health care expenditures would be paid on a per-patient basis, and the remainder would be paid on a fee-for-service basis. Under **full capitation**, all of the health care expenditures would be paid on a per-patient basis.

Capitated payments put providers at the greatest risk: If health care expenditures are greater than the capitated payment, the provider is responsible for the loss and cannot ask the insurer for more money. On the other hand, if expenditures are lower than the capitated payment amount, the provider keeps the entire difference.

While payment models that put providers at financial risk are more likely to induce ACOs to control spending and improve efficiencies, thereby lowering health care expenditures, these benefits may be outweighed by the multiple possibilities for harm to beneficiaries if the capitation model is poorly implemented. For example, health care providers that fail to manage risk may go out of business, which means patients would lose access to their providers.

There are many providers that are currently in a position to take on risk, but there are also many who are not. For example, a large, integrated delivery system such as Kaiser Permanente in California is likely capable of taking on risk. However, an ACO that is made up of solo or small group practices may not be in a position to do so. If an ACO takes on risk through a capitated payment model and is unable to deliver care within the capitated rate, the ACO's providers may have an incentive to deny or restrict medically appropriate care. This is particularly true if the ACO lacks the resources to deliver care in a more efficient manner by, for example, using health information technology.

Rigorous accountability measures, such as those discussed below, can mitigate the potential danger to patients. But the pressure to achieve near-term savings is likely to be even more acute in situations where the ACO is ill-prepared to bear financial risk. As a result, it's important to be cautious about payment models that require the ACO to bear risk, such as capitation. It is vital that protections be built in to ensure that providers do not take on too much risk too fast. For example, some providers may need to become ACOs with a shared savings only payment model and then slowly transition to a risk-bearing payment model, either a shared savings and shared losses model or a capitated payment model. In all cases, the ACO should be evaluated early on to ensure that it can assume risk before it does so.

Issues for Advocates

As advocates work with payers and providers in developing ACOs, there are key questions that must be answered to ensure that the proper payment structure is put in place. A payment structure that incentivizes lowering costs while improving quality of care will be the most effective way to drive change that is in the best interest of patients.

- ▶ What payment model (shared savings, shared savings and shared losses, capitation) will be used to pay the ACO?
- ▶ What is the link between the incentive payment and quality (an accountability-payment structure)?
- ▶ Is the link between the incentive payment and quality strong enough so that quality will not suffer at the expense of lowering health care costs?
- ▶ If the ACO is put at risk, are there adequate protections built in to ensure that providers do not take on too much risk? For example, if the ACO transitions from a shared savings to a shared savings and shared losses model, will there be an evaluation to ensure that the ACO can make the transition?

Challenge 2: How Are ACOs Held Accountable?

Quality improvement must be the hallmark of ACOs. The intent of ACOs is to promote accountability for the care that beneficiaries receive, and quality measurement is a key element of accountability. Without such measurement, it will be very difficult to assess the quality of care that beneficiaries receive and determine whether that care improves over time.

The Institute of Medicine defines quality as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with professional knowledge.”⁶ In other words, did the patient receive the right care at the right time in the right place? The Agency for Healthcare Research and Quality (AHRQ) groups health quality measurements into two categories: 1) health care delivery measures and 2) population health measures.⁷ Health care delivery measures evaluate the performance of doctors, hospitals, and other providers. Population health measures evaluate the performance of the health care system in a community or for groups of people overall. For example, how many children in a community receive all recommended vaccinations?

Within these broad categories are sub-categories of measurement: **process**, **outcome**, and **efficiency** measurements. A **process** measurement determines whether a specific health care service was provided to a patient consistent with clinical guidelines. For example, when a patient with symptoms of a heart attack goes to the emergency room, was he or she given an aspirin?

An **outcome** measurement looks at the health status of a patient after he or she has received health care services. For example, did the patient with diabetes have his or her blood sugar under control six months after a hospitalization? **Efficiency** measurements evaluate the relationship between the cost of care that has been provided and the quality of that care. For example, did the provider use an expensive procedure, such as an MRI, when a less expensive procedure, such as an ultrasound, would have provided equally reliable results?

Quality measurements can be collected for different purposes, including quality improvement, accountability, and/or research. In the ACO context, measurements will be collected for both accountability (determining payment levels) and quality improvement (is the care that's provided getting better over time). It is important to determine the purpose of these measurements to ensure that the proper measures are selected.

■ **Selecting Quality Measurements**

When determining which aspects of quality ACOs should be required to measure and report, it is important to keep three things in mind: 1) the importance of the measurement, 2) the scientific soundness of the measurement, and 3) the feasibility of the measurement.⁸ The measurements should be relevant to all stakeholders—patients, providers, and payers.

Quality measurement should lead to quality improvement. Therefore, results from measurements should be actionable, meaning the provider can use the results from the measurement to make changes that result in improved care. Measurements should be selected because there is evidence that there is a need for the measurement; for example, because quality is consistently low or highly variable across providers. Measuring an area in which providers consistently perform well will not help improve care.

Quality measurements should be adequate and appropriate to the particular patient population. An ACO that predominantly treats children will likely have very different measurements from one that treats an older population. The quality measurements must also be developed in a way that recognizes the current capabilities and limitations of the health care system. For example, less than half of primary care providers use an electronic medical record system, which may limit the number and types of measurements that can be collected and reported.⁹ Nonetheless, the minimum quality requirements must be set high enough to encourage meaningful change but not so high that they are unachievable.

The measurements selected should be reliable and valid, which ensures that the measurement is reproducible and that it truly measures what it is intended to measure. This is particularly important since, in the ACO context, the measurements will determine provider payment and will help inform patient decision making on which provider and ACO to use. It is also important to select measurements that have been tested and for which there is evidence of their appropriateness.

Finally, there must be a way for providers to collect the data to implement the measurement. This data can come from a variety of sources, including claims data, patient files, and surveys. But it should be data that providers and payers can readily access. As more providers implement electronic medical records and other forms of health information technology, it will be easier to collect a wide range of data for a variety of measurements.

When selecting measurements, it may be easier to achieve agreement from providers by selecting consensus measurements—measurements that have been evaluated and endorsed by respected health care organizations, such as the National Quality Forum. It's also important to build in a means to update quality measurements as clinical guidelines change over time. This may require adding or retiring measurements or modifying existing measurements. To limit the burden that data collection would place on providers, Medicare, Medicaid, and private insurers should work together to try to ensure that the requirements are consistent across payers.

For all of the quality measurements that are used, it is important that these measurements include patient and caregiver experiences of care. Measurements of patient and caregiver experiences of care include more than what would be collected by a patient satisfaction survey. Like a satisfaction survey, an experience of care survey does include ratings of the patient's doctor. But it goes further by asking the patient about other aspects of his or her experience, such as whether he or she received instructions about how to take a new medication and understood those instructions. Such measurements provide a good picture of how well ACO providers are engaging patients and their caregivers. They are also more actionable than general satisfaction ratings. If patients consistently state they did not receive care instructions or did not understand them, the health care provider can take the necessary steps to remedy that problem. Experience of care measurements also evaluate whether patients are able to get the care that they need when they need it, and whether the providers are respectful of the patients' values and preferences. All of these are important indicators of whether the ACO providers are delivering patient-centered care, which should be a central focus of ACOs.

Whatever tool is used to measure experiences of care, it should be accessible to all patients, including those with limited English proficiency. And it may be necessary to consider exactly how the survey is given to patients. Surveys can be mailed, conducted by telephone, or available online. But for some populations, none of these methods is ideal, so it may be appropriate to consider doing the survey onsite.

Quality measurements should be used not only to hold ACOs and their providers accountable for the care they deliver, but also to drive quality improvement. ACOs should be required to have a plan to use the quality measurements to improve care. This plan should explain how the measurements will be used to improve patient care, including how the ACO will work with providers that do not appear to be improving.

■ Making Quality Data Useful

In addition to linking payment to quality, ACOs can be held accountable through public reporting of quality measurements and health care expenditures. This information should be publicly reported in a standardized format and be understandable to the typical consumer. The website should also be easy to search so that patients can easily navigate the information. An example of such reporting is the Centers for Medicare and Medicaid Services (CMS) “Hospital Compare” website (<http://www.hospitalcompare.hhs.gov/>). Hospital Compare allows patients to compare local hospitals based on a select set of data that hospitals voluntarily report. The measurements include process, outcome, and patient experience of care measurements, among others. Another example is CMS’s “Nursing Home Compare” website (www.medicare.gov/NHCompare). This website provides star ratings in a range of categories, including health inspections, staffing, and quality.

Using an approach similar to the Hospital Compare and Nursing Home Compare websites, which allow patients to search for local providers and compare them, will enable patients to make informed decisions about where to seek care. It will also ensure that ACOs are truly held accountable to beneficiaries. And, just as importantly, it will encourage quality improvement, since it will allow ACOs to compare themselves to other ACOs. In addition, if ACOs report data at the provider (e.g. physician or nurse practitioner) level, it will allow providers to see how they are doing compared to other providers.

While some providers have expressed concern about the burden of quality measurement and reporting, the benefit and importance of quality improvement outweigh any potential burden on providers. Only with robust quality measurement and reporting will beneficiaries, insurers, and the public be able to evaluate how ACOs are performing and be able to guard against skimping on care in pursuit of short-term savings.

A good quality measurement strategy will include a combination of process, outcome, patient experience of care, and efficiency measurements that are appropriate to the patient population and that target areas where improvement is needed. Such measurements may include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) experience of care survey, the number of patients receiving recommended preventive services (such as colorectal cancer screening and flu shots), the rate of hospital-acquired conditions (such as pressure ulcers), and the rate of hospital readmissions within 30 days of discharge.

Issues for Advocates

To ensure that ACOs are not used just as a way to lower costs, advocates will need to encourage adoption of an adequate number and type of quality measurements, including experience of care measurements. Linking the quality measurements to payment and publicly reporting the measurements will hold providers accountable to patients, payers, and the community. Key questions that advocates should ask about quality measurements include the following:

- ▶ What quality and performance measurements will the ACO measure and report on?
- ▶ Are the measurements adequate and appropriate to the ACO's patient population?
- ▶ Do the measurements include patient and caregiver experience of care measurements?
- ▶ Are the minimum quality requirements set high enough to ensure meaningful change among providers and ensure that beneficiaries receive high-quality care?
- ▶ If the ACO has contracts with other payers, is it possible to standardize the measurements across all payers?
- ▶ How will the quality measurements be used to drive improvement among ACO providers?
- ▶ How will the ACO publicly report these measurements?

Conclusion

Accountable Care Organizations must be more than a new way to pay health care providers. Instead, they must be a way to encourage providers to change the way they deliver care by improving quality, by coordinating care, and by offering patient-centered care.

If ACOs are to fulfill their potential to lower costs and improve quality, it is crucial to structure their payment models and quality measurement requirements appropriately. The focus must not be solely on lowering costs—payment models need to be structured in a way that will encourage meaningful change by health care providers. Linking any payment or financial incentive to quality measurements and performance requirements will ensure that providers are lowering health care costs through delivering improved care and not by limiting access to medically necessary care. And publicly reporting the quality measurements and cost information will provide a new level of accountability to patients, the public, and payers.

Resources

ACO Learning Network

<http://www.acolearningnetwork.org/>

Medicare Shared Savings Program Final Rule

<http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

Medicare Shared Savings Program Proposed Rule

<http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>

National Quality Measure Clearinghouse

<http://qualitymeasures.ahrq.gov/about/index.aspx>

National Quality Forum

<http://www.qualityforum.org/Home.aspx>

Endnotes

¹ Engelberg Center for Health Care Reform, The Brookings Institution, *ACO Learning Network Tool Kit* (Washington: Engelberg Center for Health Care Reform, January 2011), available online at <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>.

² The MSSP ACO is one model that advocates, providers, and payers can use when designing an ACO. It is the most clearly defined ACO model to date, with all of its requirements and parameters set out in regulation. However, there are other models in the health care market, including the Brookings Institution and Dartmouth pilots and Colorado Medicaid's Regional Care Collaborative Organizations.

³ Judy Feder and David Cutler, *Achieving Accountable and Affordable Care: Key Health Policy Choices to Move the Health Care System Forward* (Washington: Center for American Progress, December 2010), available online at <http://www.americanprogress.org/issues/2010/12/pdf/affordablecare.pdf>.

⁴ For example, see Medicare Payment Advisory Committee, *Comment on the Centers for Medicare and Medicaid Services (CMS) Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program* (Washington: MedPAC, November 2010), available online at http://www.medpac.gov/documents/11222010_ACO_COMMENT_MedPAC.pdf.

⁵ For example, see Robert A. Berenson, "Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere?," *The American Journal of Managed Care* 16, no. 10 (October 2010), available online at http://www.ajmc.com/media/pdf/AJMC_10oct_Berenson_721to726.pdf.

⁶ K. N. Lohr (Editor), Institute of Medicine, *Medicare: A Strategy for Quality Assurance, vol. 1* (Washington: National Academy Press, 1990).

⁷ Agency for Healthcare Research and Quality, *Tutorial on Quality Measures: Varieties of Measures in NQMC* (Washington: Agency for Healthcare Research and Quality, 2011), available online at <http://www.qualitymeasures.ahrq.gov/tutorial/varieties.aspx>.

⁸ Agency for Healthcare Research and Quality, *Tutorial on Quality Measures: Desirable Attributes of a Quality Measure* (Washington: Agency for Healthcare Research and Quality, 2011), available online at <http://www.qualitymeasures.ahrq.gov/tutorial/attributes.aspx>.

⁹ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011* (Washington: The Commonwealth Fund, October 2011), available online at www.commonwealthfund.org.

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