



4 Accountable Care Challenges for CMS

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The Accountable Care Organization model presents extraordinary opportunities. It promises to move Medicare and potentially other payers from traditional, volume-driven, inherently inefficient, and counter-productive fee-for-service financing to a value-driven, patient-centric approach to payment and care delivery. And unlike a multitude of other reform initiatives affecting care delivery and payment, the Medicare ACO program will be a nationwide option, not a mere demo or pilot.

Working together under the umbrella of an ACO, health systems, physicians groups, and other health care providers will be able to redesign care and realign economic incentives. As evidenced by private sector projects led by Carol Corp and other innovators across the country, the benefits of accountable care are impressive: higher quality of care, increased patient safety, improved patient satisfaction, strong care management and coordination, and lower costs. In other words, a genuinely win-win scenario for patients, providers, and taxpayers. The entry of Medicare and the prospect of significant shared savings will serve to make accountable care a viable reform across the marketplace—provided the Centers for Medicare and Medicaid Services (CMS) adopts sound policies.

CMS plans to release proposed rules on the Medicare ACO program soon, with additional guidance also expected from the Federal Trade Commission and Office of the Inspector General. Final rules are needed by Spring of 2011 to meet the planned January 2012 launch of the new Medicare ACO option.

Given the range of factors and considerations, drafting these policies presents CMS with a major challenge. Fortunately, CMS is in a unique position to draw upon practical experience from successful private sector innovators, including the Carol team and pilots in the Brookings-Dartmouth ACO Collaborative.

Drawing upon our experience in helping health systems on the path to accountable care, we offer CMS these key lessons learned:

1. **New Approach to Clinical Performance:** Providers must look at clinical performance differently, and Medicare's ACO policies must explicitly support fundamental care redesign. From the perspectives of both clinical care improvement and population health management, this requires incorporation of new data sources, comprehensive decision support, and solid clinical analytics—all in a framework of continuous, data-driven, evidenced-based quality improvement.
2. **New Infrastructure for the New Value Paradigm:** The current infrastructure of health systems and other providers is based on encounters—the world of fee-for-service rates, relative value units, and quantities. ACOs require a new kind of infrastructure that is geared toward evaluating, managing, and promoting improved clinical performance as defined and rewarded by value-based payment.
3. **Strong, Multi-Payor Patient Base:** Successful ACOs will require a sufficient number of covered lives to serve. The law requires at least 5,000 Medicare beneficiaries per ACO. However, CMS should encourage and directly facilitate the creation of multi-payor ACOs. While Medicare is the largest buyer of hospital and physician services, it is essential for Medicaid, private health plans, and self-insured employers to join with Medicare wherever possible. The larger proportion of a provider's patient base covered under the ACO model, the stronger and faster will be the clinical and financial benefits for patients, providers, and payers.
4. **Sufficient Financial Incentives:** Implementation and operation of accountable care requires an investment. The financial incentives for high quality and elimination of unnecessary costs must be strong and reliable. The lessons from early pay-for-performance initiatives show how rewards must be high to provide a strong business case for transformation and overcome the inertia of fee-for-volume. Therefore, in setting the threshold trigger and proportion for shared savings, CMS should ensure a substantial portion of Medicare's savings is given directly to ACOs. The benefits of the ACO program and our nation's desperate need to move to value-based mode are too great to be penny wise and dollar foolish.

For the Medicare ACO program to succeed to the benefit of all concerned, it is imperative the CMS rules carefully and fully accommodate these and other early lessons from those already on the road to value-driven, accountable care.

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