Delivery Method Changes

One of the major changes occurring, in large part due to the Affordable Care Act, is the formation of accountable care organizations (ACOs). Most would agree that “fixing” the health care system will be impossible without accelerating changes in how providers deliver and are compensated for care. But this won’t just happen by wishing it so. ACOs could bring significant transformation to how care is delivered and financed. If their potential is realized, the promise of high-quality affordable health care may be in reach.

This article explores:
• The root cause issues that have handicapped the value in our delivery system historically
• The critical requirements to overcome those issues
• How commercial and Medicare ACOs attempt to address those issues
• Potential land mines in the transition to a new paradigm.

It will finish with the principles that plan sponsors should consider in understanding and integrating these organizations into their health care benefits strategy.

The Promise
Employers have managed health benefits costs that have increased at almost twice the pace of wages by focusing on demand-side strategies. Employers want employees to be...
more aware of health care costs and to take better care of themselves. These strategies have helped decrease the demand for services and thus reduce the pace at which benefit costs have grown. However, there are limits to how these strategies can impact health care cost increases over the long haul, and demand-side strategies will do little to impact the 70% of health care costs that are beyond the financial means of most families.

In spite of best intentions, there are still strong economic incentives to provide more care, not higher value care, and certainly not to reverse the artificially high levels of expenditures built into the current infrastructure. Innovation in every other industry has led to greater efficiency and better value, serving as an engine for American competitive advantage. In health care, innovation generally adds more costs and only marginal value. Bottom line, there is no health reform without payment and delivery reform.

ACOs are the latest attempt to reform provider payment systems. However, the opportunity today may be greater due to improved analytic and measurement tools, improved health information technology support for care coordination, facilitated financing of health information technology transformation due to the Affordable Care Act, and the significant potential weight of Medicare reimbursement to refocus and accelerate the efforts.

A 2012 study showed that 25 million to 31 million Americans, or roughly one in ten, currently receive health care through ACOs. With the addition of 106 new Medicare Shared Savings ACOs starting January 1, 2013, there are roughly 260 Medicare-oriented ACOs operating across the country.

Even more encouraging is that the private sector is outpacing Medicare in terms of developing ACOs by a four-to-one margin. In these private ACO models, providers are working collaboratively with each other and often with payers to be responsible for the quality, care and cost of health care services to the ACO members. Integral to these private ACOs is a provider-payer contract that incorporates budget planning and shared savings distribution. Under the private commercial ACO models, private payers offer a number of alternative payment arrangements. These arrangements can include subcapitation, case rates, bundled payments and global payments. In most of these arrangements, private payers share savings and providers accept greater financial risk. The payment methods chosen are usually dependent upon an ACO's capability to manage the various levels of risk.

The Affordable Care Act regulations offer new shared savings arrangements where the provider can choose between several options, including both retroactive and prospective calculation of shared savings. There will be further innovations with alternative payment options being created in the private sector, and additional Centers for Medicare and Medicaid Services (CMS) payment alternatives are being developed through the CMS Innovation Center.

With 30% of health care spending considered as potential waste, the opportunities are great. The waste yields poor quality from unnecessary tests, lack of adherence to evidence-based guidelines, redundant services, a care-delivery-technology arms race and a dearth of care management technology to share information. Payment and delivery reform efforts do not compete with current efforts to improve patient engagement and enhance population health, but rather serve to reinforce and support those efforts. By realigning incentives and transforming the delivery of care, the promise is to align the health care value chain around improved health, efficiency and value (Figure 1).

The Perils

However, in some ways, we have been down this path before. There were significant efforts in the 1990s by payers to shift risk to providers, including initiatives to narrow networks during the peak of managed care. We have also seen past efforts by providers to buy physician practices to become more integrated delivery systems. These efforts had some success, but many turned out to be unsustainable efforts in transforming the system to realize its full potential. Some lessons learned include the following:

- **Provider consolidation must be aligned with payment reform.** Provider consolidation (hospitals buying doctor practices, hospitals consolidating into large systems, physicians merging into larger group practices) has the potential to lead to increased pro-
vider market power and potentially raise health care costs in a given market. While there is the potential to achieve efficiencies through improved delivery integration and economies of scale, the reimbursement incentives must be realigned concurrently so that the overall market impact is positive, not negative. Providers that become “too big to ignore” effectively become utilities within their communities and will require value-based incentives and oversight at the community level.

- **Market share and alignment matter if incentives are to incentivize.** Past efforts to realign incentives have often been done independently by individual health plans, each of which has very low market share. These efforts have tended to be marginalized by the provider systems since the preponderance of reimbursement incentives guide how they manage their systems. To the extent that metrics and incentives are not aligned across the entire payer community (including Medicare and Medicaid), they are less likely to get integrated into the way the delivery system manages itself.

- **Incentives at the top must align with incentives at the bottom.** While much effort may be focused on incentives at the top of the provider supply chain, there needs to be an equal focus on how those incentives are then translated below to the actual provider practice and other contributors to the system. Transforming the supply chain cannot stop at the health system level but must translate through to all providers to ensure system success.

- **Risk shift to providers should match the maturity of the delivery system.** Risk shift without delivery reform can lead to financial losses and relationship damage. Delivery transformation takes time, and moving to full risk transfer prematurely can (1) lead
to significant and potentially unsustainable provider losses if set too low or (2) lock in unnecessarily high cost structures if set too high.

- **Transition and transformation is complex and will require unprecedented provider leadership and payer partnership.** No matter how we approach payment and delivery reform, the transition will be tricky. Health systems have significant overhead to support. To be successful in new payment arrangements, new population management technology and data are required to understand system performance and manage toward value-based metrics. Furthermore, any change in incentive structures will face a steep backdrop of fee-for-service legacy reimbursement mechanisms that may provide counterincentives to delivery reform. (For example, it will take true transformation for hospitals to work aggressively to lower occupancy.)

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**The Pathway to Value**

The pathway forward is not simple but it is essential (Figure 2). Employers and other purchasers play an essential role in making this happen. Some key guideposts for this journey include:

- **Promote and support payment reform.** In health care, employer purchasers are the top of the supply chain, and what they care about and how they buy matters. Plan sponsors should insist on payer partners that are committed to (1) payment transformation toward value and efficiency, (2) industrywide collaboration on common provider quality and performance metrics and (3) public reporting of costs and quality metrics. At the same time, subject to their normal fiduciary responsibilities, plan sponsors should be open and commit to paying into new reimbursement methodologies (e.g., bonuses, global payments) that are...
“value-based” to do their part to accelerate care delivery system transformation.

- **Shine a light on provider comparative value.** In itself, the label ACO does not connote higher value. And most employers would agree that provider efforts at delivery transformation are good, but positive results are essential. It will take time, but payment and delivery reform should improve provider value and performance. Purchasers need to help promote greater awareness and transparency on that performance by publishing and supporting industrywide standardized metrics as well as simplified rating systems designed to make it easier for consumers to understand and act on that information. This will not only support more value-based choices by the consumer, but also reinforce to providers the need to continuously improve value and “bend the cost curve” of care delivery.

- **Tailor “value-based benefits” toward care delivery.** The movement toward broad uniform networks has created consumer-based incentives that are largely one-size-fits-all and do little to promote delivery-based value. This is particularly true for higher cost procedures where employees and their families are necessarily sheltered from the high costs of the care they receive. Plan sponsors need to be willing to create imbalance where provider performance varies or where providers resist the transformation of payment and delivery reform. At a minimum, plan sponsors should consider tightening the “escape valve” of out-of-network reimbursement, particularly as the bar gets raised on provider performance. Secondly, plan sponsors should consider providing direct and indirect incentives for employees and their families to utilize higher performing providers in their communities and outside of their communities if appropriate.

- **Selectively integrate delivery partners, disruptors and advocates.** Plan sponsors, no matter what size, cannot materially influence provider performance by themselves. However, in their larger locations, as part of their health strategy, they can elect to integrate part of the delivery system through on-site clinics or local primary care medical homes that can then serve as a natural gateway to overall health care delivery. For more mobile or dispersed populations, telehealth can serve as a convenient option for employees with minor issues and a value-based alternative to traditional provider delivery systems. Finally, the ability to implement strong care advocates can help to educate and support employee care choices and coordinate care delivery. These partners, disruptors and advocates can help employees better understand their choices, use the available tools and information, and support improved value in their

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**Sample ACO Payment Arrangements**

Attempts to address misaligned incentives in traditional fee-for-service arrangements by creating payment systems that better align payments with value and performance include:

- **“One-sided” or “two-sided” shared savings.** Providers receive a portion of savings if they meet quality-of-care standards while providing care at lower-than-projected costs. If “two-sided,” they may bear some downside risk if budgets or quality targets are not met as well.

- **Partial capitation/global payments.** An ACO is at financial risk for some, but not all, of the items and services provided to its patients.

- **Global payments.** An ACO is paid specified monthly or annual payments regardless of services rendered or costs incurred by providers.

- **Bundled/episode payments.** Provider organizations receive a single payment for all the services a patient requires for an entire episode of care.
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health care consumption and in the overall system over time.

Summary
The past decade has focused largely on demand-based strategies by encouraging consumers to be engaged in their personal health habits and the care they receive. However, demand-based strategies will always be limited in their abilities to manage health care costs if we continue to support a provider reimbursement system that rewards volume, not value. While ACOs are the newest attempt at supplyside health care strategy, we need to learn from past efforts to understand and overcome the perils of payment and delivery reform.

The Affordable Care Act has helped create some initial momentum in this direction, but employers and their commercial payer partners will be critical stakeholders in helping achieve and sustain a transformation that permanently bends the cost curve, reverses the waste and produces a health care system unparalleled in performance (not cost).

While plan sponsors cannot achieve these changes on their own, the goal of delivery system transformation and higher value care cannot be achieved without parallel strategies executed by the plan sponsor community.

If each of the stakeholders does its part, we will accelerate better health, improved outcomes and lower costs for our people and our communities.

Endnotes
2. CMS MSSP, Pioneer and Brookings Dartmouth publicly listed Medicare ACOs.