Invited Commentary

Accountable Care Organizations 2.0
Linking Beneficiaries

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There is broad consensus among physicians, hospital and health insurance leaders, and policy makers to reform payment to health care providers so as to reduce the role of fee for service, which encourages high volume, and instead to use systems that reward better patient outcomes, such as bundled payments for a population or for an episode of care. Inspired by successful shared savings contracts between private insurers and health systems, such as Total Cost of Care contracts in the Minneapolis-St Paul, Minnesota, area and the Alternative Quality Contract in Massachusetts, the Affordable Care Act accelerated this movement by defining Accountable Care Organizations (ACOs), specifying how ACOs are to be paid and how they are to relate to beneficiaries. But the legislation essentially left beneficiaries out of the equation, not offering incentives to choose an ACO or to commit—even softly—to its health care providers. This absence may severely undermine the potential of this approach to improve care and control costs.

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These issues began to emerge during the process of issuing regulations to implement ACOs in Medicare. Even before the launch of the first Medicare ACOs, many questioned the wisdom of essentially keeping beneficiaries in the dark about their enrollment in an ACO. Under current regulations, beneficiaries do not choose an ACO. Instead they are "attributed" to an ACO retrospectively based on their use of primary care physician services during the contract year. So ACOs responsible for the cost and quality of care for a population of beneficiaries do not know in advance who those beneficiaries are, and the beneficiaries do not know they are in an ACO. Only policy makers wary of touching the so-called third rail of American politics—changing Medicare in a way that limits the ability of beneficiaries to obtain care in whatever manner they choose, fragmented or otherwise—would devise such a scheme.

The results of the study by McWilliams and colleagues[1] confirm the seriousness of failing to link Medicare beneficiaries with ACOs. Using 2010 and 2011 claims data, the study simulated the spending and care patterns for almost 525 000 beneficiaries attributed to 145 Medicare ACOs. The study found that only 66% of beneficiaries were consistently assigned to the same ACO in both years. For those attributed to an ACO, 9% of office visits to primary care physicians and 67% of office visits to specialists were provided outside of the assigned ACO. Leakage of specialty visits by high-cost beneficiaries occurred at an even higher rate. Finally, substantial proportions of services delivered to Medicare beneficiaries by ACOs went to beneficiaries not attributed to those ACOs. Beneficiaries have no incentives to stay within the ACO, and the study illustrates how little ACOs can do to guide beneficiaries to physicians or hospitals within the ACO.

These issues have arisen somewhat less in ACO-like contracting by private insurers. For the most part, these contracts have been limited to those enrolled in health maintenance organizations, which typically require enrollees to choose a primary care physician. So attribution of enrollees to an ACO can be based on these physician choices and are very straightforward. But this does not address the challenge for far more numerous enrollees in *preferred provider organization* products. A major insurer in California has addressed the issue by offering lower patient cost sharing when health care providers under an ACO contract are used.[2]

The extent to which an absence of a relationship between ACOs and beneficiaries is likely to impair the effectiveness of the ACO model in Medicare has led some policy thinkers to craft "second-generation" models of Medicare ACOs. Both the Bipartisan Policy Center (BPC)[3] and the Brookings Institution's Engelberg Center for Health Care Reform[4] proposed new models of Medicare ACOs in separate 2013 reports on comprehensive strategies to contain health costs over the long run.

The model in each report involved enrollment by beneficiaries in an ACO-like organization, with further engagement of beneficiaries through incentives. In the BPC report,[3] which used the term *Medicare Network,* reductions in Medicare Part B premiums are offered as an incentive for enrollment, as well as a share of any savings achieved by the Medicare Network. For those beneficiaries who enroll, network incentives would be offered so that cost sharing is reduced when they use health care providers who are part of the Medicare network they have enrolled in and increased when they use other health care providers. Physicians, hospitals, and other health care providers, such as those providing postacute care, could have 1 of 2 relationships with a Medicare Network. They could be part of the governance of the organization (resembling the current ACO program) and share in savings or losses. Alternatively, they could simply have a network relationship, reflecting what is common in private insurance today. This would address the issues that physicians in some specialties have with the current model where few ACOs seek to involve their specialty.

For these models to be effective, some complementary Medicare reforms, which have been discussed extensively independently of these models, would be needed. They include revamping the Medicare benefit structure to unify Part A and Part B benefits and provide protection against catastrophic expenses, as well as rules to prevent supplemental insurance from offsetting all patient cost sharing.

By creating a formal and mutually acknowledged relationship between ACOs and beneficiaries, health care provider organizations that make the investments needed to coordinate care, manage chronic diseases, and manage population health would be more likely to succeed.

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