



Issue Brief

How Can Medicare Lead Delivery System Reform?

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ABSTRACT: The current fee-for-service system of paying for health care emphasizes volume and complexity, and often discourages attempts to improve effectiveness and efficiency. This brief discusses several policies that could begin to move away from the adverse incentives embedded in the current system to incentives that encourage better care and better value. The authors believe that U.S. health care would be better and more efficient if the system as a whole functioned the way top-performing providers do, with greater accountability for specific populations and for the totality of care delivered. They argue that the Medicare program is an ideal starting point for delivery system reform.

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OVERVIEW

Most of the debate over health reform has focused on the process by which insurance coverage will be expanded to the uninsured, the cost of doing so, and the role of the federal government. While these issues are crucial to how health reform unfolds, the long term success of any policies enacted this year—and, indeed, the long-term viability of the U.S. health system itself—will be determined in large part by the nation's ability to change the way health care is organized and delivered. Without a shift in emphasis from more services to more effective care, and from more complex procedures to more appropriate treatment, any reform that extends coverage will place greater burden on a system that is already on an unsustainable path.

Achieving needed change in health care delivery requires change, as well, in the way we pay for care. The current fee-for-service system emphasizes volume and complexity, and often discourages attempts to improve effectiveness and efficiency. This paper discusses several policies that could begin to move away from the adverse incentives embedded in the current payment system to

incentives that encourage better care and better value. The discussion is largely from the perspective of multispecialty group practices, which exhibit many of the traits that are thought to be desirable system-wide, but the principles upon which it is based could be applied to a variety of organizational models. And while the focus is on Medicare's role in developing and implementing payment system reforms, all of these policies would be most effective in the context of multipayer initiatives.

BACKGROUND

There is widespread agreement that expanded access to care cannot be sustained without containing costs. This is not a new insight; indeed, the challenge of cost containment has bedeviled attempts at health reform for the past 50 years. What's new this time around is policymakers' increasing recognition of the link between cost containment and the organization (or lack thereof) of health care delivery. Analyses of geographic variations in cost and quality provide policymakers with an idea of how care *could* be delivered effectively and efficiently, based on the top-performing areas.¹ And in many cases, the favorable results in those top-performing areas are driven by large, multispecialty medical groups and the larger health systems with which they are affiliated.

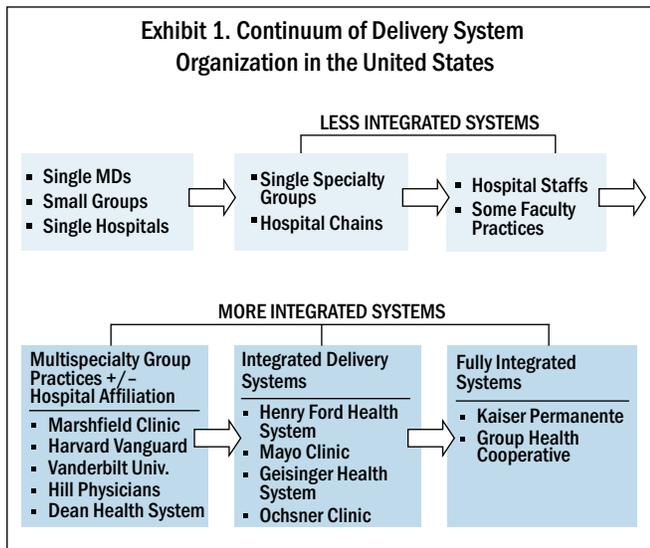
With health reform high on the policy agenda, the time is ripe for concrete proposals to achieve major changes in care delivery to foster improved quality and efficiency. A key element in accomplishing this goal will be reforming the way providers are paid. The current fee-for-service system encourages greater volume and intensity of services, rather than higher value—and there generally is no accountability for health care quality, outcomes, or cost. Until we move away from this type of payment, we will continue providing inappropriate incentives and will continue to hinder progress toward more effective and efficient health care delivery.

However, with most providers across the country configured in small, independent units, it may be difficult to change health care delivery through

payment reform alone. Changes in payment and organizational structure need to be pursued together, so that payment incentives encourage integration and accountability at the same time the delivery system becomes able to respond to those incentives. The Medicare program, as the country's largest payer for health care services, has the potential to lead such changes and is the logical choice to play that role.

We observe a continuum of delivery system organization, from small physician practices and unrelated hospitals to fully integrated delivery systems (Exhibit 1). In between these extremes are primary and specialty care physician groups, multispecialty group practices, and hospital systems. A reformed delivery system is one in which providers are able and willing to take collective responsibility for their patients, the care they provide, and the resources used in the process. This type of care is more typical of organizations that lie on the more integrated side of the continuum than on the less integrated side. However, we do not advocate a single organizational model. Rather, the delivery system we envision would be characterized by different types of provider organizations, all with the common feature that they are clinically and financially accountable for their patients and the care they provide.

For the purpose of this discussion, we designate such organizations “accountable care organizations” (ACOs). We use this term not in reference to any specific ACO model currently being proposed, but in the sense of Shortell and Casalino's “accountable care system,” which they define as “an entity that can implement organized processes for improving the quality and controlling the costs of care and be held accountable for the results.”² Shortell and Casalino also describe a number of organizational forms that might fit this definition, some of which have been termed “ACOs” in the current health reform debate. These include the extended hospital–medical staff, the physician–hospital organization, the interdependent practice organization (similar to an independent practice association, but with stronger governance and leadership and a culture of performance improvement) and the health plan–provider organization. We would add to this list the fully



integrated delivery system. Our use of the term “ACO” encompasses all of these forms, as well as others that are doubtless yet to be proposed.

To better understand how Medicare payment reform could make accountable care organizations more widespread, it is useful to draw on the expertise of the country’s existing multispecialty group practices. These groups are arguably already in the best position to respond to the payment incentives that we hope to see under a reformed health system. To that end, the Council of Accountable Physician Practices, The Commonwealth Fund, and the Kaiser Permanente Institute for Health Policy brought together several dozen leaders of multispecialty group practices and other health policy experts to engage in a discussion about specific actions Congress could take to implement delivery system reform in Medicare. This brief is informed by that discussion, although it should not be taken as specifically representing the opinion of any attendee at that meeting.

DESIGN ISSUES FOR MEDICARE DELIVERY SYSTEM REFORM

The ideal Medicare program would pay accountable care organizations for a set of services or a defined period (rather than paying service by service) for a defined population. To reach this point, several important design issues would need to be considered:

1. An array of approaches to Medicare delivery system reform may be necessary to correspond to the wide range of characteristics of local systems, which will be more or less able to adopt any single approach.
2. Medicare payments to provider organizations in a new program should be designed to share savings relative to a benchmark estimate of expected costs, as well as the attainment and maintenance of a high quality of care and improved outcomes (i.e., the use of a “carrot”).
3. The need to abandon the adverse incentives embedded in the current system must be emphasized by the expectation of deteriorating fee-for-service payments in Medicare over time (i.e., the use of a “stick”).
4. The strength of new incentives can be increased by encouraging “all-payer” approaches, in which Medicare and one or more commercial carriers use the same payment structure—recognizing that the inclusion of other payers may complicate the process.

A number of additional design issues warrant further discussion.

Voluntary vs. Mandatory Participation

Should Medicare’s organizational and payment changes be voluntary for both providers and patients? What should the ramifications be for providers and patients who choose not to participate in the new care organizations and accompanying payment systems?

For providers, a voluntary program would mean they could participate in Medicare as they do now. A mandatory program would mean there is no way to participate in Medicare other than as a member of an accountable care organization receiving the new payment method. For patients, a voluntary program would mean they could choose to affirmatively join an ACO (there could be incentives for making such a choice), but they would not be required to do so and could continue to receive care as they do now.³ Mandatory

models are felt to be politically infeasible, while voluntary models raise many technical issues and dilute the strength of incentives for improvement.

Attribution to Organizations

How should patients be “attributed” to accountable care organizations under a new payment system? That is, how would Medicare decide which patients should be assigned to each organization for purposes of paying those organizations accurately and gauging their performance? Attribution raises both policy and technical questions; how it is done depends largely on whether participation in the program is mandatory for patients.

If patients are not required to actively choose an ACO, it would be necessary to use “virtual” attribution to determine to which organization those patients belong. In a virtual-attribution model, patients would be attributed after the fact to the organization where they received most of their care during a specific period. There are many technical issues that would need to be solved under this scenario, but, as Fisher and colleagues suggest, it can be done.⁴ These researchers found that many fee-for-service Medicare beneficiaries opt to receive 75 percent or more of their care in a given year from a single primary care provider and the hospital, or hospitals, in which that provider most often practices. Using quality and cost data, Medicare could reward these “virtual networks” deemed accountable for such beneficiaries for superior performance, irrespective of where the care was actually delivered.

Skeptics of the virtual-attribution model contend that retrospective assignment of responsibility for specific patients makes it difficult to take responsibility for their care. Furthermore, even patients who are attributed to a virtual network of providers may obtain a significant portion of their care elsewhere—so that providers might be held accountable for services they neither deliver nor manage.

Attribution is much simpler under an “enrollment” model, in which beneficiaries are required to actively choose an accountable care organization from which they will receive their care for a given period.

As further incentive for choosing an ACO, beneficiaries could be offered benefit enhancements, such as a reduction in premiums or other out-of-pocket costs. This is hardly a novel idea: for several decades, beneficiaries have been making such choices to join group and staff-model HMOs in the Medicare Advantage program and its predecessors.

Regardless of whether patient participation is mandatory and attribution is enrollment-based or virtual, it is also important to determine whether patients should be attributed to individual physicians or to systems, and how broadly those systems could be defined.

Role of Fee-for-Service Payment

Should the new payment system build on fee-for-service (FFS) or scrap it entirely? Most Medicare payment reform proposals advocate one of the following three methodologies (or a combination thereof):

- FFS payment with bonuses, under which, in addition to the normal payment for services performed (either in full or with a portion of the amount withheld), rewards are given for high performance on quality, outcomes, or efficiency;
- episode-based payment, or “bundling,” which begins to move away from FFS payment by paying for a specified set of services provided during a given period, usually related to a category of care (e.g., primary care), the occurrence of an initial health-related event (e.g., a hospital admission), or the presence of a chronic condition (e.g., congestive heart failure); and
- global comprehensive care payment, or “capitation,” which would eliminate FFS payment and replace it with a fixed payment for all health care provided to each patient for a fixed period, such as a year.

Rewards for high performance could be combined with any of the approaches mentioned here. The addition of rewards to FFS payment has the advantage and disadvantage of bearing the closest resemblance to the currently predominant payment approach. The

objective of this payment methodology is to counter the adverse incentives of FFS with an explicit message—supported by financial impact—that quality, good outcomes, and efficiency are desired by patients and payers, and that value, rather than volume and intensity, should be the focus. Pay-for-performance (for quality and outcomes) and shared savings (for efficiency) are two versions of this approach. Rewards for efficiency through shared savings can be tied to performance on quality and outcomes, as in the Medicare Physician Group Practice (PGP) Demonstration. Critics of this approach argue that the ability to measure quality is still too crude to ensure that rewards are targeted appropriately. Some stakeholders believe that the amount of payment devoted to these rewards in the United States tends to be too small to effectively counter the powerful adverse incentives of FFS payment.

Bundling mitigates one of the most the most troubling aspects of FFS by eliminating additional payment for each individual service provided to the patient. For the specified bundle—whether defined by a category of care, an initial event, or a condition—the incentive to providers is to produce the bundle in the most efficient way possible, because, all things equal, the use of additional resources means a reduction in net income. Advocates of bundling argue that it is an interim step between FFS payment and capitation, because it requires providers to work together to manage a patient, event, or condition efficiently, and such cooperation sets the stage for the further integration necessary to accept capitation. Critics of bundling point out that developing clear and generally acceptable definitions of bundles can be complicated, that it is difficult to allocate the bundled payment across the providers responsible for the bundle, and that there are strong incentives both to stint on care and to “unbundle” services—that is, to change practice so that services normally thought to be part of a bundle are considered separately and therefore generate additional payment.

Some experts believe that bundling based on conditions leads away from the kind of multispecialty integration that is necessary for providers to accept capitation. Instead, this kind of bundling may

encourage the formation of disease-specific provider organizations (sometimes called “focused factories”), which might include many types and levels of care, all focused on a given condition. Such an organization would not be able to accept capitation for the full spectrum of patients’ care. At issue is a question about the goal of payment reform. If the goal is, as we believe, to encourage greater integration of the delivery system for improved quality and efficiency, it will be important ultimately to move away from FFS payment altogether and toward capitation. As an interim measure, bundling based on events could be an important tool to encourage collaboration among providers. However, bundling based on conditions may further entrench the silos that have been created under the current FFS system.

We do note that full, global capitation—or full transfer of risk from payer to provider for all health care services—will not be feasible, or even desirable, for all provider organizations. It is useful to consider a range of capitation approaches with different degrees of risk-sharing between payer and provider, depending on the provider’s capabilities. There is a continuum of services for which a provider organization could accept risk. At the most basic level, a provider organization could accept risk only for professional, primary care services. Moving up the continuum, an organization could accept risk for any or all of the following: specialty care services, diagnostic tests, inpatient care, pharmacy, occupational medicine, and long-term care. More sophisticated delivery systems can accept risk (or capitation) for more of these services, and as an organization becomes more integrated it could take on additional risk.

Furthermore, there are varying degrees of risk that could be shared for each of these services. Kaiser Permanente is an example of a sophisticated, integrated organization where financial risk is shared between the payer, Kaiser Foundation Health Plan, and the physicians, the Permanente Medical Groups. Risk assumption by the medical groups is broad in scope (including physician services, hospital services, and pharmaceuticals) but limited in scale to a modest portion of the annual physician income pool.

Relationship Between Physicians and Hospitals

How should the relationship between physicians and hospitals be accounted for in a new payment system? Some stakeholders believe that hospitals do not need to be included with physicians in the same organizational framework. Underlying this view is the notion that with any new payment system aimed at improving quality and efficiency, hospitals will, of necessity, suffer a reduction in admissions and a loss of revenue, and it is unreasonable to expect them to actively participate in such a program. In some areas where hospitals have monopoly (price-setting) power, it might be preferable to hold physicians accountable for the rate of hospital use only, rather than hospital costs, because costs are less likely to be under their control.⁵

Other stakeholders believe there can be no improvement in quality and efficiency without hospitals involved, particularly around the difficult issues of transitions in care from the hospital to the community. One reason for including both hospitals and physicians in accountable care organizations is to align incentives between the two parties. Another reason is that with both hospitals and physicians covered under the same payment, the amount of funding available to create incentives for desired behavior is greater than if only physician funding were included.

There may be a need for interim measures to ease physicians and hospitals into structures in which they could receive a joint payment. For example, during a transition period, physicians and hospitals could each receive separate payments designed to allow physicians to build their capability to reduce hospital utilization, and to allow hospitals to restructure themselves to adapt to lower utilization. A second approach to partially protect hospitals from financial loss as part of an ACO would be to increase payments for specific diagnosis-related groups (DRGs) and allow hospitals to share any savings that are achieved.

THE VIEW FROM MULTISPECIALTY GROUP PRACTICES

When we brought together the leaders of multispecialty group practices and other health care experts at the June 5 roundtable, we asked them to consider the above design issues. We found that there were some areas of general agreement (but not necessarily consensus), and other, more controversial areas where agreement was more elusive. Areas of general agreement were as follows:

- There is an urgent need for a Medicare demonstration or waiver program to encourage delivery system reform.
- Medicare's Physician Group Practice Demonstration can serve as a model for future initiatives, but several improvements could be made. The significant lag between delivery of care and access to performance information from Medicare is one problem. Another is the imposition of a threshold of 2 percent savings before participating groups could receive a performance reward, which made it difficult for several of the groups early on to recoup the initial investments they made in improvement.⁶
- Any new payment system should shrink unwarranted geographic variation in Medicare FFS rates.
- It may be necessary to allow different geographic areas (regions, states, or smaller areas) to implement new payment incentives in different ways. It would also be helpful if Medicare could participate in state-level and all-payer efforts to improve quality and efficiency through payment reform.
- Financial incentives will go a long way toward encouraging providers to improve quality and efficiency. However, in many cases, simply removing financial *disincentives* for innovative care delivery methods will be sufficient. Furthermore, sharing performance data can be an important motivational tool for providers,

who often are naturally driven by professional pride and responsibility to provide high-quality care.

- Finally, it is critically important to increase the number of primary care physicians to sustain any accountable care organization.⁷ Primary care needs to be more attractive to new physicians in terms of pay, training, and support to assume care management roles.

PROPOSALS FOR MEDICARE-LED DELIVERY SYSTEM REFORM

We believe that the Centers for Medicare and Medicaid Services (CMS) may currently be ill-equipped to lead the redesign of delivery system structures and payment models. This is due partly to the limited nature of its demonstration authority, partly to hurdles presented by the process of identifying, approving, and implementing demonstrations, and partly to limited CMS resources available for the task.⁸ To address this problem, Congress could establish an Office of Payment and Delivery System Improvement within the Department of Health and Human Services (or CMS). This idea is not to detract from CMS's authority, but rather to focus resources on an area requiring intense attention. The purpose of this office would be to recommend to Congress over the next few years a series of CMS fast-track waiver authorities regarding the formation and payment of integrated, accountable care organizations (again, not referring not to any specific model) and similar approaches. (Note: As this brief went to press, both houses of Congress, as part of comprehensive health care reform bills, were about to consider the creation of a very similar entity, to be called the "CMS Innovation Center.") Following are some ideas for waivers that could be implemented either alone or in combination with others.

Per Capita Prepayment or Retrospective Bonuses for Accountable Care Organizations

Congress could allow CMS to prepay accountable care organizations a global *per capita* amount (including Parts A, B, and D) for members who proactively enroll

to receive their care from an ACO. Alternately, or in conjunction with this payment option, Congress could give certain ACOs that do not use fee-for-service payments the opportunity to receive a bonus for the care of beneficiaries attributed to the ACO, based on retrospective usage patterns. It is not clear whether prospective payment is necessary to change delivery system behavior, or whether retrospective rewards create sufficient incentives for change.

The question of prospective versus retrospective payment is closely related to the attribution issues discussed previously in this brief. As noted, there are different views about the best way to attribute beneficiaries to an ACO. Such attribution is necessary if the ACO is to be accountable for the cost and quality of care it delivers: it must know for whom it is responsible for providing care. Prepayment methodologies will work better with active or enrollment-based attribution models, in which beneficiaries choose a specific delivery organization and agree to receive their care there for a specified period. Retrospective bonus payment methodologies are more compatible with a virtual-attribution model, in which beneficiaries are assigned to an ACO—for purposes of payment only—based on retrospective care patterns.

CMS may wish to test both prospective and retrospective payment methodologies, along with both enrollment-based and virtual-attribution models, to determine which works most effectively. There may turn out to be geographic differences in the fit of one model or the other. It is also possible for CMS to pay accountable care organizations simultaneously, using both payment models, if both turn out to be effective at improving quality and reducing costs.

Beneficiary Incentives to Choose Accountable Care Organizations

CMS could allow ACOs using an enrollment-based model to encourage such enrollment through improved benefit incentives for beneficiaries. Some beneficiaries may be reluctant to enroll in an ACO, even a known and trusted one, because of the perceived loss of choice of provider—a popular characteristic of the current

traditional fee-for-service Medicare program. On the other hand, as noted recently by the Medicare Payment Advisory Commission (MedPAC), an ACO model with enrolled beneficiaries is likely to have greater control of the care delivered, accept and succeed with stronger financial incentives, and potentially produce greater savings for Medicare than would the virtual-attribution ACO.⁹ Therefore, sufficient savings could likely be demonstrated from the enrollment model to allow for modestly improved benefits, or discounts on premiums, while returning a net savings to Medicare.

Improved Access to Information from the Common Working File

CMS could provide virtual-attribution ACOs with information from the Common Working File, enabling them to see the entire spectrum of Medicare utilization for their attributed beneficiaries. The Common Working File contains the records of all claims processed for all Medicare beneficiaries, as well as extensive demographic and eligibility data. As noted above, one disadvantage of the virtual-attribution model is the lack of information coming to the ACO about care delivered to attributed beneficiaries in other settings. If a patient attributed to Geisinger Health System opts to receive cancer care at New York's Memorial Sloan-Kettering Cancer Center, for example, Geisinger might or might not be aware of this, and as such, might have little chance of "repatriating" the patient or influencing the quality and cost of that care. This situation could be remedied, at least in part, if CMS were to provide timely and accurate information to ACOs about such external services (although it is possible that such sharing of personal health information across unrelated providers would require patient permission). Alternatively, ACOs could be granted direct access to the CMS data file itself and use such access to develop internal reports for both clinical and business uses.

Exemption from Payment Update Processes

Congress could grant a waiver to allow hospitals and physicians that are part of ACOs to be exempt from the hospital payment update process and Sustainable Growth Rate (SGR) physician payment update process, respectively. Neither practicing physicians nor the hospital industry is happy with the current formulas that Congress uses to produce annual payment updates. Hospitals believe that their costs are underappreciated, while physicians chafe under the annual payment cuts produced by the SGR formula.¹⁰ At the same time, the work necessary to form an ACO that is capable of receiving and succeeding with prospective forms of payment is not easy. In many parts of the country, the formation of new ACOs will require the breakdown of isolation and distrust among community physicians and between physicians and hospitals.

Congress could gradually increase the relative attractiveness of undertaking ACO formation by exempting ACOs from the current, unpopular payment update formulas and establishing separate update formulas for them that reflect performance in quality improvement and the mitigation of unnecessary costs. Over time, the level of payment received by such organizations would reflect their performance on quality, outcomes, and efficiency.

Reduction of Unnecessary Geographic Variation in Spending

The Centers for Medicare and Medicaid Services could set payment benchmarks for accountable care organizations in a way that recognizes and reduces utilization-based geographic variations in Medicare expenditures. Among the difficulties inherent in establishing payment rates for ACOs—both existing and new ones—are the disparities across the United States in both utilization-driven Medicare costs and input-cost-based Medicare payment rates. In the extreme, very efficient, high-quality ACOs in rural parts of the country could be disadvantaged, and inefficient ACOs in high-cost areas unfairly advantaged, unless Congress directs the design of ACO payment to take into account legitimate baseline performance differences. Problems emerge

whether payment benchmarks are based on national or local cost and quality trends; a solution may be to blend the two approaches.

“Rebuttable Presumptions” of Regulatory Compliance

To enable hospitals and physicians to work together as ACOs and share savings with each other and with Medicare, Congress could allow limited “rebuttable presumptions” of adherence to specific Federal Trade Commission regulations, civil monetary penalty regulations, and self-referral/anti-kickback rules. A variety of federal regulations, most well intended, have the aggregate effect of inhibiting the development and testing of innovations related to the financial and clinical integration of hospitals and physician groups. In general, regulators have been reluctant to provide “safe harbors” for organizations seeking to test such innovations, out of concern that these will abet abusive practices. Regulators have instead preferred to provide retrospective judgments on a case-by-case basis. This pattern has created a fear of prosecution (whether or not such fear is warranted) and has dampened enthusiasm for innovation.

To be fair, there are examples of anticompetitive behavior in health care delivery, including that exhibited by some newly created entities, such as single-specialty medical groups. These examples have reinforced the reluctance of legislators and regulators to relax regulation broadly. However, some forbearance may be possible through a moderate shifting of the burden of proof in regulatory enforcement by the rebuttable presumptions of regulatory compliance in certain situations, such as hospital/physician gainsharing for quality improvement and cost-reduction efforts. (MedPAC has recommended that Congress allow limited gainsharing arrangements for this purpose.)

Nevertheless, the development of accountable care organizations has raised a legitimate concern about the potential for abusive pricing behavior. There may already be some examples of this in parts of the country. This problem will have to be addressed either by a restructured regulatory environment or,

more likely, by the evolution of a coordinated payer environment.

Government Support for Accountable Care Organization Development

Congress could authorize and fund HHS to support the development and success of ACOs. In the early 1990s, the seemingly inevitable growth of managed care and concomitant prospective payment methodologies led to the rapid creation, in many parts of the country, of physician hospital organizations and other integrated delivery systems. Later, as managed care retreated in the face of public opprobrium, many of these organizations disintegrated because they were poorly conceived and more poorly executed. In many cases, neither the hospital executives nor the physician staff leaders had the requisite knowledge or experience to make these entities successful. Sadly, this period of change was too short to really test whether or not these models could have been made to work properly.

Many believe that to be successful, ACOs, like the physician hospital organizations preceding them, must find models of structural, financial, clinical, and cultural integration between hospitals and physicians. Much of the potential savings in U.S. health care spending may come from the prevention of unnecessary hospital admissions and the efficient delivery of services during necessary admissions. Such savings will require alignment of incentives among, and common actions by, hospital administrators and physicians. There are many examples of successful integrated delivery systems, but no commonly accepted model about how to create one de novo.

Congress could charge the new Office of Payment and Delivery System Improvement with the specific task of designing constructive support processes for the creation of new integrated delivery systems. The Health Maintenance Organization Act of 1973 is an example of just such a government-sponsored initiative. The office could ask for cooperation from existing successful organizations to create a “business incubator” as part of overall health care reform efforts. It is likely that a number of existing

successful organizations would respond to such requests out of a desire to see overall health care reform succeed. There were examples of such cooperation following the passage of the 1973 law.

Full Conversion to Accountable Care Organizations by 2020

Congress and/or the President could set a direction and timetable for conversion to ACOs, albeit a somewhat distant one. For example, Congress could choose to pass a joint resolution indicating a strong preference for the Medicare program to favor beneficiaries receiving care from ACOs by a date certain, such as 2020, with exceptions allowed for sparsely populated areas or other special circumstances. Such a preference could take the form of payment update incentives for ACOs or beneficiary incentives to enroll with ACOs, among other possibilities. The government's establishment of such a clear direction could spur physicians and hospitals to undertake the hard work necessary to prepare for a new future.

CONCLUSION

U.S. health care would be better and more efficient if the system as a whole functioned the way top-performing providers do, with greater accountability for specific populations and for the totality of care delivered. We do not believe there is a single organizational model for achieving such accountability. While this brief is informed by the perspective of the leaders of multispecialty medical groups, we do not presume that all providers should look like such groups (indeed,

they do not even look like one another in many cases). Rather, we believe all providers need to be prepared to be accountable, in one form or another, for all aspects of their patients' care, including quality, outcomes, and costs.

The U.S. needs delivery system reform, and the Medicare program is a good place to start. If there is health reform, Medicare should adopt policies that are consistent with the objectives of such reform and should play a lead role in achieving those objectives. However, Medicare needs to do something regardless of whether there is broader health reform or what form it takes.

Medicare should try a new approach to provider payment *soon*. There is a real sense of urgency, given the Obama administration's push for health reform this year, and it should be open to a variety of methods to encourage increased integration in local delivery systems. Moreover, if Medicare engages in such initiatives, other payers can be expected to follow suit. In fact, the program's involvement in multipayer initiatives—either initiated by Medicare, or with Medicare joining in with other payers to develop payment system reforms—could make any such initiatives more effective and more beneficial overall.

It is not inappropriate to think about some “radical” ideas to extract the U.S health care delivery system from the current quagmire in which it finds itself. The large multispecialty medical groups are ready now to participate in such a new approach and would be eager to operate under a system that rewards higher quality, greater efficiency, and more accountability.

AUTHORS' NOTE

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NOTES

¹ E. S. Fisher, D. E. Wennberg, T. A. Stukel et al., “The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality and Content of Care,” *Annals of Internal Medicine*, Feb. 18, 2003 138(4):273–87; and E. S. Fisher, D. E. Wennberg, T. A. Stukel et al., “The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care,” *Annals of Internal Medicine*, Feb. 18, 2003 138(4):288–98.

² S. M. Shortell and L. P. Casalino, “Health Care Reform Requires Accountable Care Systems,” *Journal of the American Medical Association*, July 2, 2008 300(1):95–97.

³ Under some voluntary scenarios, patients who did not choose to participate might still be “attributed” to an accountable care organization for purposes of payment, but this attribution would be largely invisible to the patient.

⁴ E. S. Fisher, D. O. Staiger, J. P. W. Bynum et al., “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” *Health Affairs* Web Exclusive, Dec. 5, 2006, w44–w57.

⁵ Obviously, this would not be a concern for Medicare, which sets its own prices for hospitals, but it would be a concern if private payers were involved.

⁶ It should be noted, however, that there is a sound actuarial reason for imposition of the 2 percent threshold: without any threshold, in a “reward only” payment incentive system, year-to-year random variation in performance results would generate higher-than-appropriate payments.

⁷ D. R. Rittenhouse, S. M. Shortell, and E. S. Fisher, “Primary Care and Accountable Care—Two Essential Elements of Delivery-System Reform,” *New England Journal of Medicine*, published online Oct. 28, 2009.

⁸ The Medicare Payment Advisory Commission (MedPAC) has repeatedly noted the need for expanding CMS resources, to be applied to solving a variety of problems.

⁹ Medicare Payment Advisory Commission, *Report to the Congress: Improving Incentives in the Medicare Program* (Washington, D.C.: MedPAC, June 2009).

¹⁰ The SGR formula may be repealed or “rebased” as part of health care reform, but it is unlikely that Congress will ignore the impact of volume-of-service increases in establishing a future physician payment update formula.

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