

## EXECUTIVE SUMMARY

- Rather than generating savings as expected, the Medicare Shared Savings Program (MSSP) has created losses for the Medicare program for four years in a row.
- Calculations by the Centers for Medicare and Medicaid Services (CMS) appear to show that ACOs with downside risk produce higher savings than the “upside-only” ACOs. However, Medicare actually spends more per beneficiary in the downside risk ACOs than in other ACOs, with no difference in quality. Moreover, ACOs that have moved to the downside risk tracks have saved less after doing so.
- The risk adjustment and benchmarking formulas used by CMS can penalize ACOs that serve higher-need patients and patients living in rural areas. The greater savings attributed to downside-risk ACOs may have more to do with differences in the types of patients they see than differences in the way they deliver care.
- Concerns about the problems with the risk adjustment and benchmarking methodologies in the MSSP have made many ACOs unwilling to enter the downside risk tracks. Requiring all ACOs to move to downside risk could force successful ACOs to leave the program, thereby reducing Medicare savings and harming the quality of care for millions of beneficiaries.
- There are other options for modifying the Medicare Shared Savings Program in order to increase Medicare savings, including dropping ACOs from the program if they fail to achieve savings after two consecutive years, reducing shared savings payments for ACOs that incur losses before achieving savings, reducing the shared savings rate below 50% for Track 1 ACOs, and/or enabling ACOs to take accountability for the specific types of services they can control rather than placing them at risk for total Medicare spending.
- Neither shared savings nor shared risk payment models solve the fundamental problems in the fee-for-service payment system. As a result, it is unlikely the MSSP will ever result in significant savings or improvements in quality, and it has the potential to harm patients by rewarding providers that withhold necessary services.
- Instead of continuing to modify the Medicare Shared Savings Program, CMS should focus on implementing Patient-Centered Alternative Payment Models that provide the resources physicians, hospitals, and other providers need to successfully address their patients’ healthcare needs while holding the providers accountable for those aspects of spending and quality they can control.

## Lackluster Performance from Medicare’s Biggest Alternative Payment Model

The current fee-for-service payment system is a major reason why healthcare spending continues to grow faster than inflation without producing corresponding improvements in the quality of patient care. To address this, Congress has created significant incentives for physicians to participate in Alternative Payment Models (APMs) designed to reduce spending or to improve quality without increasing spending.

For the vast majority of physicians, the only opportunity to participate in an Alternative Payment Model in 2018 is through the Medicare Shared Savings Program (MSSP). Under this program, if a physician practice, a group of practices, a health system, or other entity forms an Accountable Care Organization (ACO) and successfully

reduces Medicare spending for beneficiaries who are assigned to the ACO, the ACO providers can receive a share of Medicare’s savings.

Despite high hopes that ACOs would both create savings for Medicare and improve the quality of care for patients, Figure 1 shows that the Medicare Shared Savings Program resulted in net losses for four straight years from 2013 through 2016. Every year, slightly more than half of the ACOs generated savings, but the rest did not. The Centers for Medicare and Medicaid Services (CMS) paid more in shared savings payments to the successful ACOs than it received in net savings from all ACOs, resulting in higher-than-expected Medicare spending rather than savings.

Many people have been led to believe that ACOs that accept “downside” or “two-sided” risk (i.e., the ACOs agree to make a payment to CMS if spending increases) are more likely to achieve savings than those that are “upside only” (i.e., the ACOs receive a payment from CMS when

savings are achieved, but they have no obligation to pay for any portion of spending increases.) Although CMS has created several downside risk “tracks” in the MSSP (Track 2, Track 3, and Track 1+ which was introduced in 2017) and it has created two separate demonstration programs in which ACOs accept downside risk (the Pioneer ACO and Next Generation ACO programs), over 80% of ACOs in 2018 are still participating in the “upside only” Track 1 component of MSSP.

Some policy-makers and healthcare theorists have promoted the idea that the best or even the only way to eliminate the financial losses in the ACO program is to remove the opportunity for “upside only” shared savings and require all ACOs to take downside risk. However, a careful analysis shows that such a requirement would likely make things worse, not better.

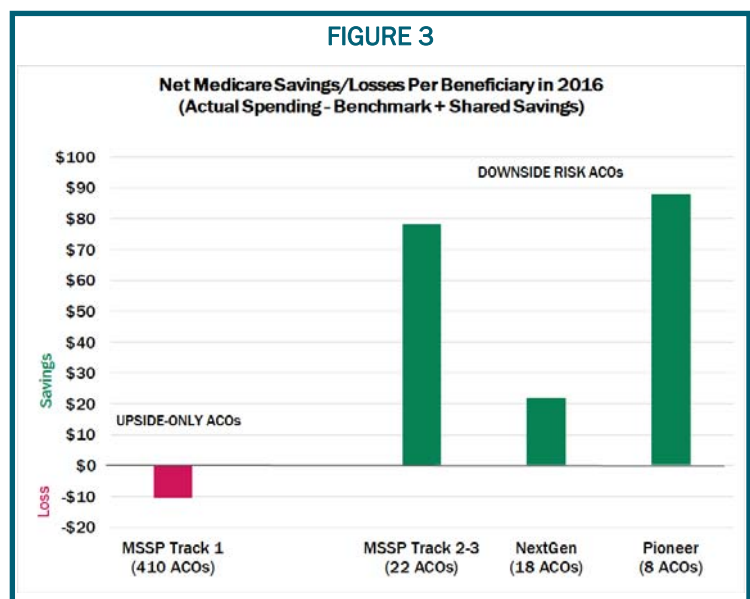
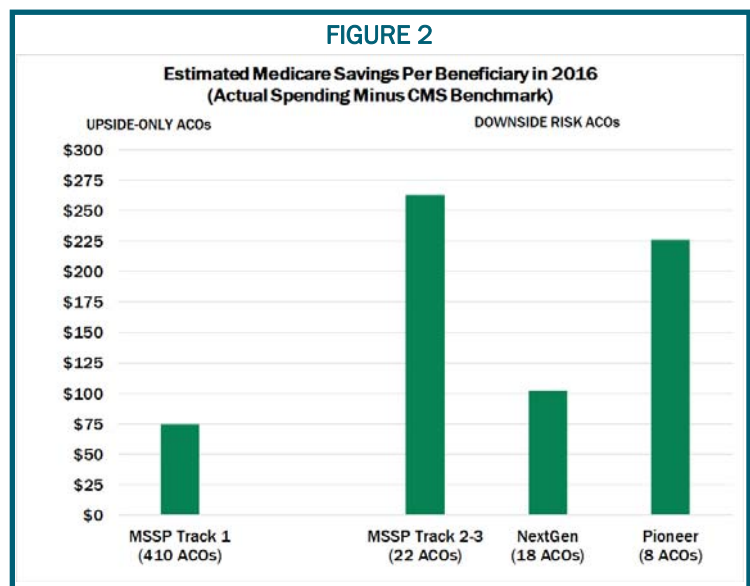
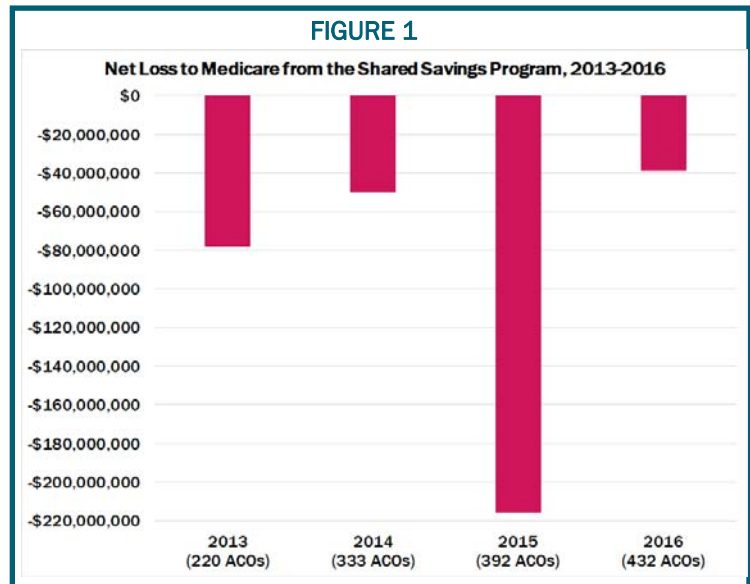
### Are ACOs With Downside Risk More Successful Than “Upside-Only” ACOs?

The best data available (as of May 2018) for comparing downside-risk ACOs to upside-only ACOs come from 2016. This is the most recent year for which performance data are available on any of the CMS ACO programs, and it is the only year in which there were more than a few MSSP ACOs that had accepted downside risk for Medicare spending.

Figure 2 shows the average Medicare savings per beneficiary in 2016 for the 410 Track 1 MSSP ACOs (the upside only ACOs), the 22 MSSP ACOs in Track 2 or Track 3 (those with downside risk), the 18 Next Generation ACOs, and the 8 Pioneer ACOs (a program which no longer exists). (MSSP Track 1+ was created after 2016.) “Savings” means the difference between actual spending in 2016 and a CMS-calculated benchmark spending level for the ACO; the “benchmark” is the maximum amount that CMS estimates the ACO “should have” spent on the Medicare beneficiaries attributed to it during the year.

On average, the ACOs in every one of these categories collectively generated savings, at least according to the methodology CMS used to calculate savings. In both the upside-only and downside-risk tracks, some ACOs produced savings while others did not, but the combined savings from those that did produce savings were greater than the total losses from the others.

Figure 3 shows the net impact on Medicare spending after CMS made shared savings payments to the ACOs that generated savings and collected repayments from the downside risk ACOs that did not produce savings. For the upside-only ACOs, Medicare ended up losing a very small amount (\$10 per beneficiary, or less than one-tenth of one percent), while for the downside-risk ACOs, Medicare saved a small amount (\$77 per beneficiary, or less than 1%). Because there were so many more beneficiaries in Track 1 MSSP ACOs than the others, the small per-beneficiary loss translated into a \$72 million loss in aggregate. That amount exceeded the \$33 million in net savings generated by the downside risk ACOs, resulting in the \$39 million overall net loss to Medicare that is shown in Figure 1.



However, just because CMS formulas estimate that per-beneficiary savings are higher in the downside risk ACOs, that does not mean that Medicare is actually *spending* less on beneficiaries in those ACOs. In fact, the exact opposite is true:

- Figure 4 shows that on a per beneficiary basis, Medicare spends more on patient care in the downside risk ACOs than the upside-only ACOs.
- Figure 5 shows that ACOs with downside risk had bigger “savings” because they delivered more expensive care to begin with. Even in the 186 Track 1 ACOs where spending was higher than the benchmark calculated by CMS, the average Medicare spending per beneficiary was lower than in the 22 MSSP ACOs and 18 Next Generation ACOs that were taking downside risk.

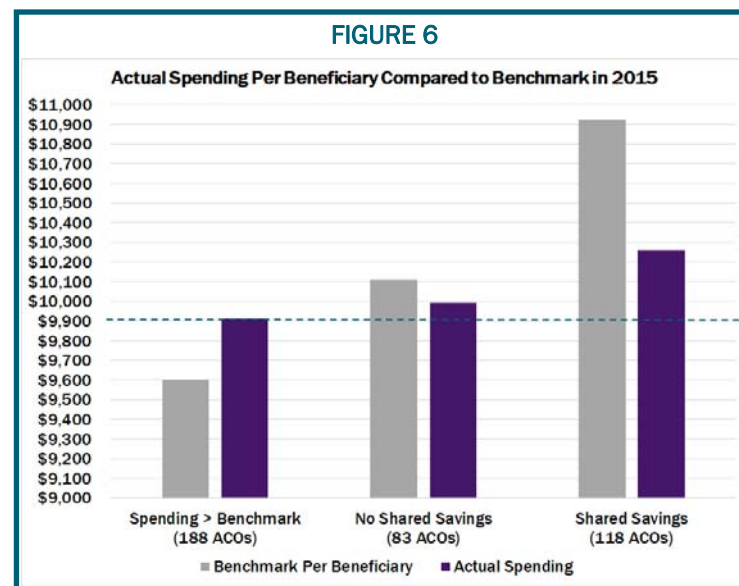
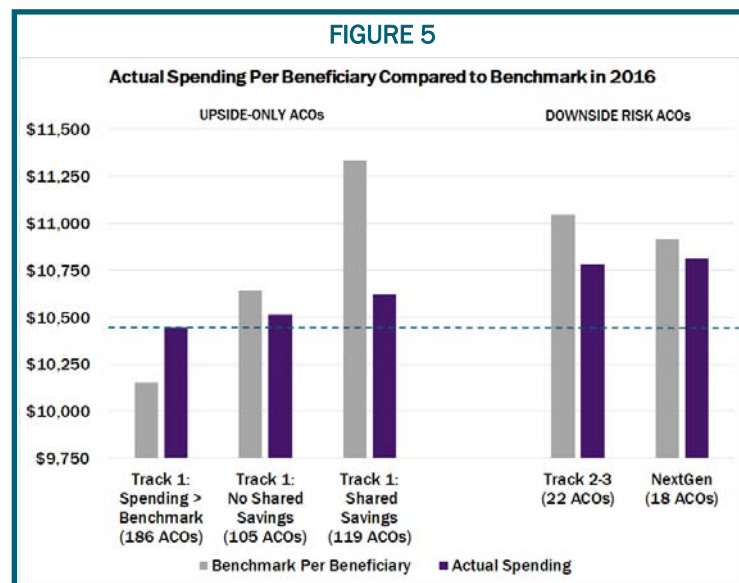
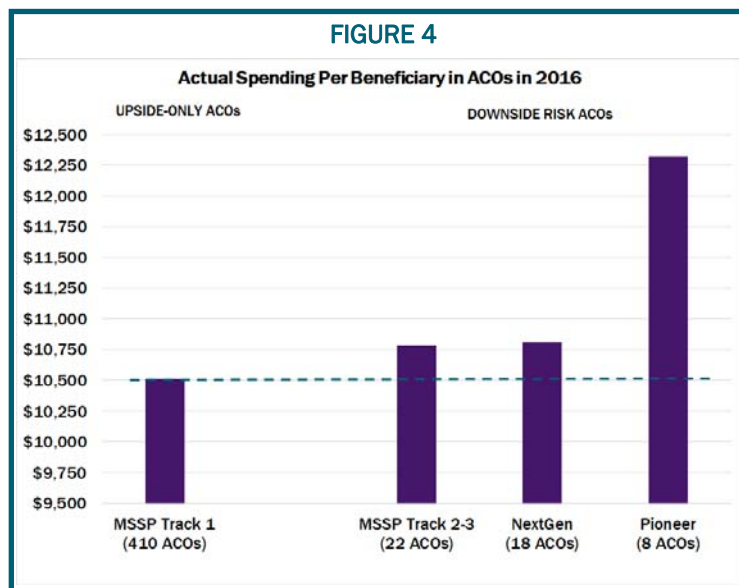
Average quality scores in all of the different ACO tracks were virtually identical, so the Track 1 ACOs where spending was higher than CMS benchmarks actually delivered the “highest value” among all of the MSSP Tracks, since they delivered equally-high quality care at the lowest cost per beneficiary.

There was a similar pattern in previous years. Figure 6 shows that in 2015, the ACOs that failed to achieve savings under the CMS benchmarking methodology spent less than those receiving shared savings bonuses. (The chart only shows the Track 1 ACOs because there were only 3 ACOs that year with downside risk.)

## Should ACOs Be Rewarded for Savings, Efficiency, or Quality?

It is clearly much easier to achieve “savings” if you’re spending more to begin with. ACOs that have higher rates of avoidable hospitalizations, unnecessary tests, etc. will also generally have higher levels of spending per patient. If an ACO successfully reduces those types of utilization, it may be able to reduce total Medicare spending. In contrast, ACOs that already have low rates of avoidable and unnecessary utilization will have a much harder time achieving savings. The physicians, hospitals, and other providers in the lower-spending ACO were already saving money for Medicare before they entered the Medicare Shared Savings Program, but the way the MSSP has been structured, there is no reward for *maintaining* low spending, only for reducing it further.

Although Medicare’s ACO programs are also ostensibly designed to encourage the delivery of higher-quality care, ACOs receive no financial reward for high-quality care unless they can also achieve savings for Medicare. Even worse, ACOs may be financially penalized for taking actions to improve quality. For example, an ACO that is seeking to improve care for its assigned beneficiaries may find that some patients are not receiving the services they need today to prevent more serious and expensive problems in the future. The quality measures in Medicare’s ACO programs encourage ACOs to achieve high rates of preventive screening, but since preventive screening is a billable service, higher rates of screening will increase Medicare spending in the short run. In fact, the data show that in the subset of Track 1 ACOs where



spending was higher than CMS benchmarks, patients were more likely to receive cancer screenings and blood pressure screenings than in the Track 2 and Track 3 ACOs where spending was below CMS benchmarks.

Moreover, it costs more to deliver primary care and preventive services in rural areas than other communities. In many rural areas, the only source of primary care is a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). Because of the low population densities in rural areas, Medicare payments to FQHCs and RHCs are based partially on their actual costs, and payments for an FQHC/RHC visit are typically 2-3 times as high as for an average physician visit. In the ACOs where spending exceeded the benchmarks, far more patients received primary care from an FQHC or RHC than in other ACOs. (The rate of FQHC/RHC visits was 2.5 times higher in the ACOs whose spending exceeded the CMS benchmark than in the downside-risk ACOs.) Moreover, Medicare spending per beneficiary is lower in smaller counties than in larger counties, which means there are fewer opportunities in rural areas to reduce spending on avoidable services. The net result is that delivering better primary care in rural ACOs can result in higher average Medicare spending per beneficiary, at least in the short run. CMS does not make any adjustments in its ACO benchmarks to reflect these differences, and that can penalize ACOs operating in rural areas.

## The Serious Problems with ACO Risk Adjustment

An obvious question is whether the ACOs with downside risk spend more because they are less efficient or because they treat sicker patients. The only data available to assess that are the Hierarchical Condition Category (HCC) scores that CMS assigns to all Medicare beneficiaries and that CMS uses to risk-adjust the benchmarks for the ACOs. An HCC score is derived by determining which of a series of eligible health problems a patient has and multiplying each of those problems by a weight intended to predict the incremental Medicare spending associated with the problem. For example, average Medicare spending on a patient with an HCC score of 1.10 is assumed to be 10% higher than for a patient with an HCC score of 1.00.

In 2016, the HCC scores for patients in the Track 2 and Track 3 MSSP ACOs were about 5-6% higher than for patients in the Track 1 ACOs. If you simply divide average spending by the average HCC score, you might conclude that the ACOs with downside risk spend slightly less on a risk-adjusted basis than the upside-only ACOs. However, actuarial evaluations of the HCC system consistently show it overpredicts spending for patients with above-average HCC scores (by 2-4% or more) and it underpredicts spending for patients with below-average HCC scores (by 4-5% or more). Since CMS uses the HCC scores to set the benchmark for each ACO, it's entirely possible that the ACOs with lower average HCC scores spent more than their CMS-assigned benchmarks because the benchmarks were unrealistically low, not because the ACOs were spending too much.

It's not surprising that HCC scores are so bad at predicting appropriate levels of spending when you understand how fundamentally flawed they are. HCC scores can't accurately tell you how sick an ACO's patients were in 2016, because the scores are based only on the health problems and chronic conditions patients had *prior* to 2016. HCCs are a *prospective* risk adjustment system that was developed to predict *future* expenditures for Medicare Advantage health insurance plans, so the scores are based on conditions that are most likely to affect spending in future years. But CMS is using the same HCC scores in its ACO programs to estimate what spending should be in the *current* year. Obviously, if a patient develops a new health problem in 2016, the problem should be treated in 2016, and that will increase spending in 2016. However, the CMS methodology would penalize the ACO providers for delivering that treatment by failing to adjust the benchmark for the new health problem.

- For example, cancer is a diagnosis that increases HCC scores, but it will only increase a patient's score in the year after cancer is first diagnosed. If some of the patients in an ACO are newly diagnosed with cancer and begin treatment during the year in which spending is being evaluated, those patients will have the same HCC scores as similar patients who don't have cancer, even though Medicare spending on the cancer patients will obviously be higher in the current year because of the need to treat their cancer. As an illustration, the rate of new lung cancer diagnoses is about 300 per 100,000 Medicare beneficiaries, which means that an ACO with 10,000 assigned beneficiaries might expect to see an average of 30 new lung cancer cases each year. However, the number could easily vary significantly from year to year. Since treatment for lung cancer can cost as much as \$100,000 per patient, an ACO that had 35 lung cancer cases in a year could spend as much as \$1,000,000 more than an ACO with only 25 such cases, solely due to the difference in the number of cancer cases. That alone would make the first ACO's overall average spending per beneficiary 1% higher than the other's. If both ACOs had achieved a 3% reduction in spending on all other services, only the second ACO would achieve the minimum savings rate in the MSSP. In the downside risk program, an ACO might be forced to pay a penalty to Medicare simply because of an increase in spending due to how many patients developed cancer.
- Some types of conditions, such as osteoarthritis, aren't counted in the HCC scores at all, even if they existed in the past. That means that a patient whose only problem is severe osteoarthritis of the knee that prevents them from walking will have the same HCC score as a similar patient without that problem. If patients with osteoarthritis receive knee replacements, it will increase an ACO's spending relative to benchmarks, even if the surgeries were justified and enabled the patients to stay more active and healthy, and even though that could reduce Medicare spending in the future.

- An HCC score is based solely on diagnoses that are recorded on claims forms, with a preference for diagnoses recorded during hospitalizations, so it is impossible to know whether a new patient with a low HCC score is actually healthier or whether they simply haven't had all of their health problems identified and treated. ACOs that do more outreach to patients often identify health problems that patients have been ignoring, but a newly identified health problem will only increase a patient's HCC score in the year after the problem is first treated.

Even if an ACO's patients develop new chronic conditions that would increase the ACO's overall HCC score in the following year, the CMS benchmark spending level won't change, even though it's obvious that the new health problems will require additional treatment and increase the amount Medicare will have to spend. CMS will only increase the benchmark if *new* patients coming to the ACO are sicker than in the past, not if *existing* patients develop new problems. This is intended to protect CMS against "upcoding" by ACOs (i.e., adding new diagnoses solely to increase HCC scores and spending benchmarks), but it creates a financial penalty for ACOs that manage the same group of patients over time compared to ACOs with high levels of patient turnover.

The failure to adequately adjust for patient characteristics, drug costs, and other drivers of spending that are beyond the control of ACO providers, as well as problems in the methodologies used for patient attribution, trend factors, etc., has led several ACOs to drop out of the downside risk ACO programs and has discouraged many providers from participating in any of the ACO programs. The adjustments CMS has made to the benchmarking formulas fail to address these fundamental flaws.

## Requiring Downside Risk Could Make Things Worse, Not Better

Advocates for downside risk claim it will give ACOs more "skin in the game" and thereby lead to greater savings. However, at least as of 2016, the experience in the Medicare Shared Savings Program did not provide any reason for believing that ACOs will achieve more savings when they have downside risk than when they don't.

In 2016, 17 ACOs switched from the upside-only Track 1 to one of the downside risk tracks (Track 2 or Track 3). All of them had been in the MSSP since 2012 or 2013. 127 other ACOs had been in Track 1 of the MSSP since 2012 or 2013 and remained there in 2016. Comparing these two groups shows that:

- **Savings Decreased in the ACOs that Switched to Downside Risk.** The 17 ACOs that made the shift to downside risk in 2016 had generated net savings for Medicare in both 2015 and 2016, but savings per beneficiary decreased by 39% in 2016. Only 340,000 beneficiaries participated in these ACOs in 2016, an 11% decrease from 2015. Medicare received a total of \$33 million in net savings from these ACOs in 2016.

- **Savings Increased in ACOs That Did Not Switch to Downside Risk.** In contrast, the 127 ACOs that started in Track 1 in 2012-13 and stayed in Track 1 in 2016 had a small net loss in 2015, but generated net savings per beneficiary in 2016. Although the average savings per beneficiary in these ACOs was less than half as much as those in the downside risk track, they had more than 2.7 million assigned beneficiaries, 8 times as many as the downside risk ACOs. As a result, Medicare received a total of \$111 million in net savings from these upside-only ACOs in 2016, more than three times as much as from the ACOs that switched to downside risk.

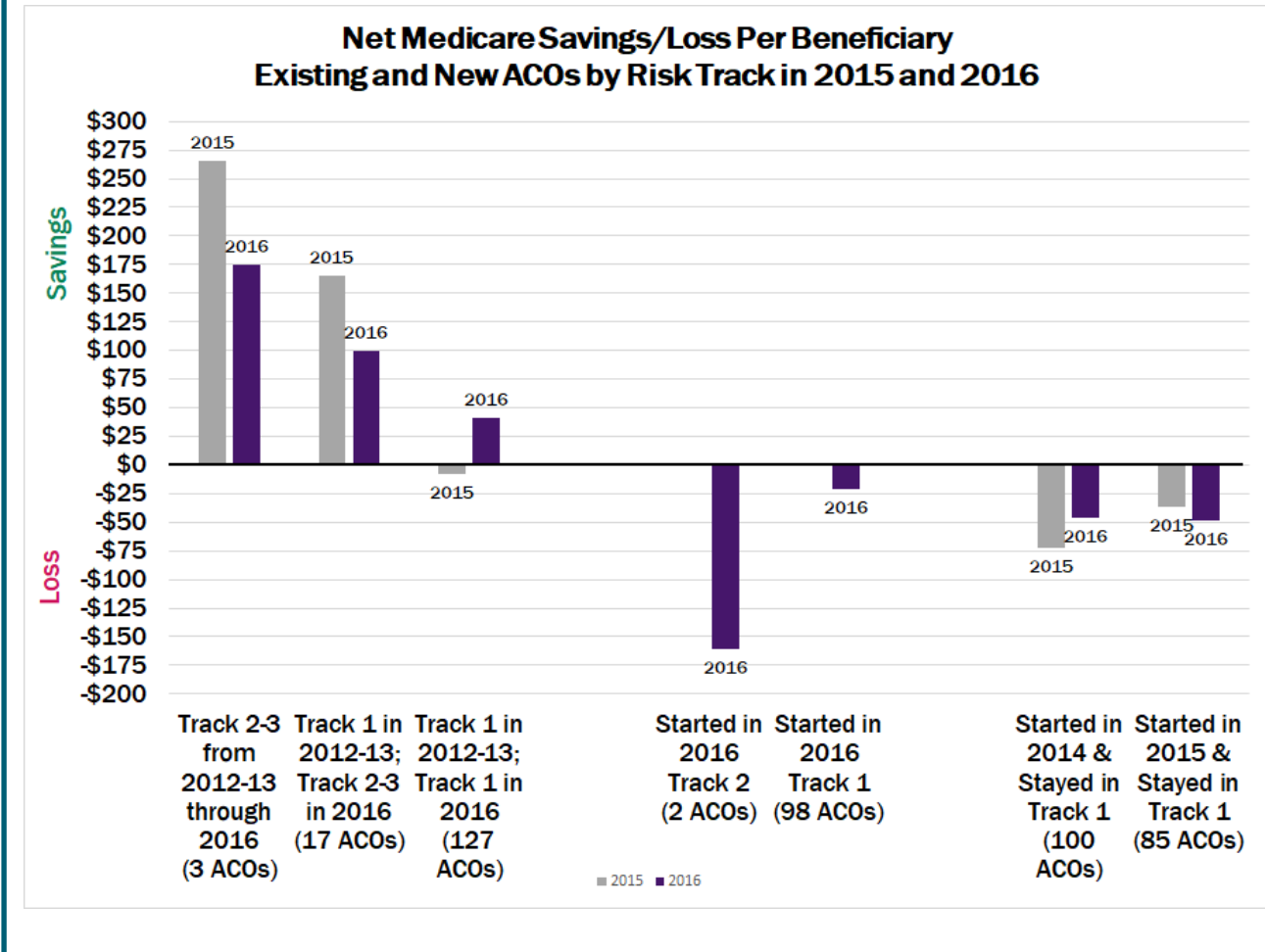
As shown in Figure 7, the only ACOs that generated any net savings in 2016 were the 147 that started in 2012 or 2013; collectively, they generated \$152 million in net savings for Medicare in 2016. In contrast, the 285 ACOs that started in 2014 or later created \$191 million in net losses for Medicare in 2016. This includes the two ACOs that started in the downside risk Track 2 in 2016; they increased Medicare spending by \$161 per beneficiary. (The best performers on a per-beneficiary basis were the 3 ACOs that started in the downside risk tracks in 2012-2013, but they served only 36,000 beneficiaries and generated only \$6 million in net savings in 2016, a 41% reduction from the prior year.)

Many of the current Track 1 ACOs have signaled that they would likely leave the program altogether rather than take on downside risk. Some people have accused these ACOs as being unwilling to make the move to true "value-based payment." In reality, leaving the program would be a very rational and appropriate response in light of the serious flaws in the risk adjustment and benchmarking methodologies CMS uses in the ACO program. Moreover, no matter how good the risk adjustment and benchmarking system is, there will still be random variations in total Medicare spending from year to year that could result in significant financial penalties through no fault of the ACO.

Most ACOs, particularly those formed by small physician practices, do not have the financial reserves necessary to pay millions of dollars in risk-based penalties to CMS. Most of the money Medicare spends on patients goes to hospitals, skilled nursing facilities, and drug manufacturers, not to physician practices. If a physician-led ACO accepted downside risk and had to repay CMS 4% of total Medicare spending, that could represent 25% or more of the physician practices' total revenue. A loss that large could force the physician practices out of business, harming patient access to care.

Requiring ACOs to accept downside risk would likely cause both CMS and Medicare beneficiaries to lose more than they would gain. In 2018, over 80% of the 561 MSSP ACOs are in the upside-only Track 1. If a large fraction of those ACOs were to exit the program, Medicare spending could increase even more than it has to date. Moreover, if the MSSP is truly enabling ACOs to improve the quality of care for the Medicare beneficiaries assigned to them, more than 7 million beneficiaries could be harmed if those ACOs leave the program.

FIGURE 7



## Alternatives to Requiring Downside Risk for ACOs

Requiring ACOs to accept downside risk is not the only option available for increasing savings in the Medicare Shared Savings Program. Other options include:

- Option 1: Drop ACOs from the program if they haven't achieved savings after two years.** 79 of the 410 ACOs that were in Track 1 in 2016 had been in the MSSP for at least two years and had spending levels higher than their assigned benchmarks in both 2015 and 2014. Fewer than half of these ACOs generated savings in 2016 and none of them produced cumulative net savings over the three-year period. If the ACOs that had failed to achieve savings in both 2014 and 2015 had been dropped from the program at the end of 2015, Medicare would have received net savings of \$120 million from the remaining 331 Track 1 ACOs in 2016, four times as much as the \$33 million it received from the 22 ACOs with downside risk.
- Option 2: Reduce shared savings payments to those ACOs that incur large losses before generating savings.** In 2016, 21 Track 1 ACOs received \$96 million in shared savings payments even though they had experienced a net cumulative loss over the 2014-

2015 period. Eliminating these payments would have enabled Medicare to receive \$24 million in net savings in the Track 1 program in 2016 instead of the loss it actually experienced that year.

- Option 3: Reduce the shared savings rate for Track 1 ACOs.** There is no clear rationale for the 50% shared savings rate in Track 1. Although on average, the Track 1 ACOs have reduced Medicare spending every year, the shared savings payments CMS has paid to them exceeded the net savings Medicare received. If the shared savings rate had been reduced to 40% in 2016 instead of 50%, the net savings for Medicare from the Track 1 ACOs would have been greater than the savings from the ACOs in the downside risk tracks in 2016.
- Option 4: Allow ACOs to take accountability for the specific types of spending they can control, rather than total Medicare spending.** The real problem with asking ACOs to accept downside risk is not that there is a risk of losses *per se*, but the fact that the risk is being applied to *total spending* on the patients. No ACO can possibly control all of the reasons that *total spending* on ACO patients might increase, and neither HCCs nor any other risk adjustment or benchmarking methodology can accurately estimate the total

amount of healthcare spending and services a group of ACO patients will need. Rather than trying to adjust the *percentage of total spending* for which the ACO will be at risk, it would make more sense to adjust the *types of spending* for which it will be at risk. In the private sector, when a physician practice or health system signs a capitation or other risk-based contract with a commercial health plan, it doesn't take risk for every possible type of spending. Most of these contracts include a "Division of Financial Responsibility" that describes in detail what aspects of spending the physician practice or health system will be responsible for, and what aspects the health plan will remain at risk for. CMS could do the same thing in the Medicare Shared Savings Program. Instead of "tracks" that differ only on the amount of risk the ACO will take, CMS could define tracks based on the range of services for which the ACO would be at risk. (More detail on how multiple "levels" of ACOs could be created to address different subsets of services is available in the Center for Healthcare Quality and Payment Reform report *How to Create an Accountable Care Organization*, available at [www.CHQPR.org](http://www.CHQPR.org).)

## The Flaws in Risk-Based Population Payment Models

All of these options, however, implicitly assume that continuing to pay ACOs using some form of "shared savings," "shared risk," or similar "population-based payment" is a fundamentally good idea that simply needs to be tweaked. Unfortunately, these approaches fail to address the real problems in fee-for-service payment and they create significant new risks of patient harm.

The Medicare Shared Savings Program is merely a variant of the many pay-for-performance schemes that research has repeatedly shown are ineffective in improving quality or controlling costs. The concept is rooted in the mistaken notion that physicians need financial incentives to stop delivering and ordering unnecessary services. Moreover, the Medicare Shared Savings Program makes no distinction between necessary and unnecessary services, so physicians in an upside-only ACO could receive a financial bonus for withholding *necessary* care, and physicians in a downside-risk ACO could be penalized for delivering the care patients need.

The 31 quality measures in the Medicare Shared Savings Program don't even come close to protecting patients from stinting on care. For example, because of the high cost of cancer drugs, withholding expensive treatments from cancer patients who are assigned to an ACO could make the difference between whether the ACO receives a shared savings bonus or pays a penalty to CMS. However, none of the ACO quality measures assesses whether patients with cancer are receiving evidence-based care. In fact, none of the data that are available about ACOs enable anyone outside of CMS and the ACOs, including patients, to determine exactly how the ACOs that are achieving savings are doing so.

The biggest problem with the current fee-for-service payment system is not that it lacks financial risk or incentives for quality. The problem is there aren't fees at all for many high-value services that would improve patient outcomes and reduce total spending. For example, the Medicare program does not pay for palliative care services outside of hospice, and it does not pay for transportation to a primary care physician for a patient who cannot walk or drive, even though those kinds of services could significantly reduce the number of expensive ED visits and hospitalizations.

The Medicare Shared Savings Program does nothing directly to address this – every physician, hospital, skilled nursing facility, home health agency, and other provider is paid exactly the same way they always have been. The only way an ACO can receive additional payments beyond standard fee-for-service payments is if an impossible-to-understand benchmark calculation by CMS concludes that the total spending on the ACO's assigned patients is lower than would otherwise have been expected. If CMS determines that the ACO is eligible for a shared savings bonus, the payment will arrive as much as a year or more after care was delivered, with no assurance that it will be adequate to cover the costs of any services the ACO delivered the previous year in order to achieve savings. This means that an ACO that incurs the costs of delivering unreimbursed services is taking significant financial risk to do so, even if the ACO is in the "upside only" Track 1 program.

Multiple studies have shown that as much as 30% of healthcare spending is unnecessary or avoidable, which means it should be possible to significantly reduce Medicare spending without harming patients. The fact that the Medicare Shared Savings Program has produced gross savings of less than 1% each year and net savings of less than 1% even in the downside risk track is a clear indication that the current approach is fundamentally flawed.

This small amount of savings might be acceptable if ACOs had been able to dramatically improve quality. But the data indicate that despite whatever improvements ACOs have made, many patients are not receiving the care they need, at least on the measures that have been defined by CMS. For example, in most of the ACOs in 2016, including the downside risk ACOs, one-third or more of the patients who should have had breast cancer screening or colon cancer screening did not receive it, and 15% or more of diabetic patients had blood sugar levels that were higher than the recommended range.

The fact that measures of the quality of care in ACOs are better than national averages does not mean that every patient is receiving high quality care. Many ACOs are delivering very high-quality care, and some are doing so at below average costs, but others are not. In the Medicare Shared Savings Program, ACOs can receive bonuses even if large segments of their patients are not receiving recommended care. Conversely, if an ACO dramatically improves the quality of care without increasing spending, it will receive no reward in the MSSP.

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## Creating a Patient-Centered Payment System

The high and growing cost of America's healthcare system is increasingly limiting the country's ability to address many other important needs, it is affecting the nation's competitiveness in the world economy, and it is creating financial problems and limiting access to care for growing numbers of citizens. Health *insurance* will never be affordable unless the cost of health care is reduced. It is clear that a radically different approach to healthcare payment and delivery is needed.

Rather than trying to rescue the flawed shared savings model, or trying to turn physician practices into insurance companies without giving them the tools and financial reserves they would need to succeed, CMS and other payers should instead focus on implementing *Patient-Centered Alternative Payment Models*. A Patient-Centered APM would:

- Enable a patient to have a specific healthcare need or group of needs addressed by a team of providers who have agreed to work together to achieve specific, feasible outcomes for that need;
- Enable a patient to select which provider team to use based on (1) the quality standards and outcomes that each provider team commits to achieve for that patient and (2) the total amount that the patient and Medicare or other payers will pay for all of the services the patient will receive with respect to the need that is being addressed;
- Give the team of providers adequate resources and sufficient flexibility to deliver the most appropriate combination of high-quality services to achieve the best outcomes possible based on the nature and severity of the patient's need; and
- Hold the team of providers accountable for eliminating unnecessary services, for meeting evidence-based quality standards in the delivery of care, and for achieving good outcomes for their patients.

Physicians and other providers who want to work together through Accountable Care Organizations could use Patient-Centered APMs as a way of overcoming the barriers in fee-for-service payment that each individual care provider currently faces. Even if the ACO views itself as one large coordinated entity managing care for a population of patients, most patient care will be delivered by small teams of providers focused on specific patient needs. Patient-Centered APMs could provide a mechanism for the ACO to ensure that each team has the resources it needs to deliver the care patients need and that each team takes accountability for the aspects of overall spending and quality that it can control.

However, physicians, hospitals, and other providers should not be forced to form or join ACOs in order to be paid appropriately to deliver the care their patients need. Many patients do not want or need a large ACO in order to receive high quality care; what they need is for the physicians, hospitals, and other providers who care for them to be paid in a way that supports the best possible outcomes at the lowest possible cost for the specific health problem(s) the patient is experiencing at the time.

Creating a Patient-Centered Payment System is the best way to help all Medicare beneficiaries to receive high-value care and to achieve the maximum savings for Medicare and its beneficiaries. More details on how to create a Patient-Centered Payment System are contained in the Center for Healthcare Quality and Payment Reform's report *Why Value-Based Payment Isn't Working, and How to Fix It*, which is available at [www.CHQPR.org](http://www.CHQPR.org).