



Raising the Bar

Standards for Accountable Care Organizations to Truly Improve Health Care Quality and Affordability in the United States

ISSUE BRIEF

INTRODUCTION

Health care costs continue to rise at an unsustainable rate while the quality of care delivered in this country varies dramatically. All stakeholders – including purchasers of health care – continue to experience this pain. The Affordable Care Act placed a big bet on Accountable Care Organizations (ACOs) as one of the new care delivery and payment models that will transform health care. According to the “Triple Aim,” a goal of the Centers for Medicare and Medicaid Services (CMS), this transformation should improve population health, quality and the patient experience and lower the cost of care.

But can ACOs deliver this long overdue, fundamental transformation? What will define an ACO? What should it be accountable for? For ACOs to transform health care rather than merely replace the status quo, purchasers, payers and regulators need to adopt clear, robust ACO standards and monitor whether these standards are met. ACOs may also prove to be an ideal “test laboratory” for other reforms such as patient-centered medical homes and bundled payments (payments based on episodes of care).

This issue brief outlines the standards that health care purchasers support. It provides a roadmap for purchasers and policymakers to help implement those standards. The brief begins with an overview of ACOs.

WHAT IS AN ACO?

An ACO is a provider entity that is responsible for the health care and related expenditures for a defined population of patients. The concept builds upon past experience with HMO staff models, as well as medical groups and hospitals that contract with health plans on a full or partial risk basis. The 2010 Affordable Care Act included a new Medicare Shared Saving Program, beginning in 2012, that “promotes accountability for a patient population and coordinates items and services ... and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” This has prompted many existing provider organizations to declare themselves to be ACOs and hospitals (and potentially health plans) to acquire physician practices to position themselves for the new Medicare program.

An ACO can take many different forms as a provider entity, including but not limited to:

- A medical group (primary care or multi-specialty);
- An independent physician association (IPA);
- An integrated delivery system comprised of doctors, a hospital(s) and potentially other service providers.

To the extent that an ACO is defined more narrowly, for example, as a medical group, it must establish contractual relationships with a hospital and ancillary providers to offer a continuum of care.

EMERGING ACO MODELS

As illustrated in Appendix 1, there is no single model for accountable care. Rather, there is a continuum of risk and opportunity that reflects variable levels of consumer and provider engagement, entailing varying degrees of benefit design innovation and provider payment reform. Currently, ACOs are generally not available as a standalone product, though several ACO-like entities, pilots and products do exist.

Examples of current ACO-like organizations include the provider organizations of Geisinger Health System and Kaiser Permanente. Several ACO pilots are underway such as Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract program, and the collaborations between UnitedHealthcare and Tucson Medical Center, and Anthem Blue Cross with Monarch Healthcare and HealthCare Partners in California.

Many California medical groups assert that they provide ACO-like services. In reality however, many such organizations are not financially integrated with hospitals nor are they accountable for quality and financial standards described later in this issue brief.

Within HMO insurance products, many accept full capitation for professional and facility services; however, few operate with the degree of transparency about these arrangements that we recommend later in this brief. Health plans could contract with higher performing providers and establish gain-sharing rules for favorable financial performance

that results from care redesign and improved efficiencies. For example, in 2010, CalPERS initiated such a pilot with Blue Shield of California, Hill Physicians Medical Group and Catholic Healthcare West that has generated notable cost savings from reduced emergency department use, readmissions and hospital days.

Among PPO and consumer-directed health plan products, most health plans contract with providers as individuals, not as organized systems, and few medical group organizations are structured to meet specific quality targets. Many cannot legally accept financial risk. Arguably, some plans' narrow network offerings may distinguish providers based on clinical performance. But it is difficult to make these entities responsible for the total health of a given population of "attributed" patients since employees are free to seek care outside the network.

ACO STANDARD TO IMPROVE QUALITY AND CONTROL COSTS

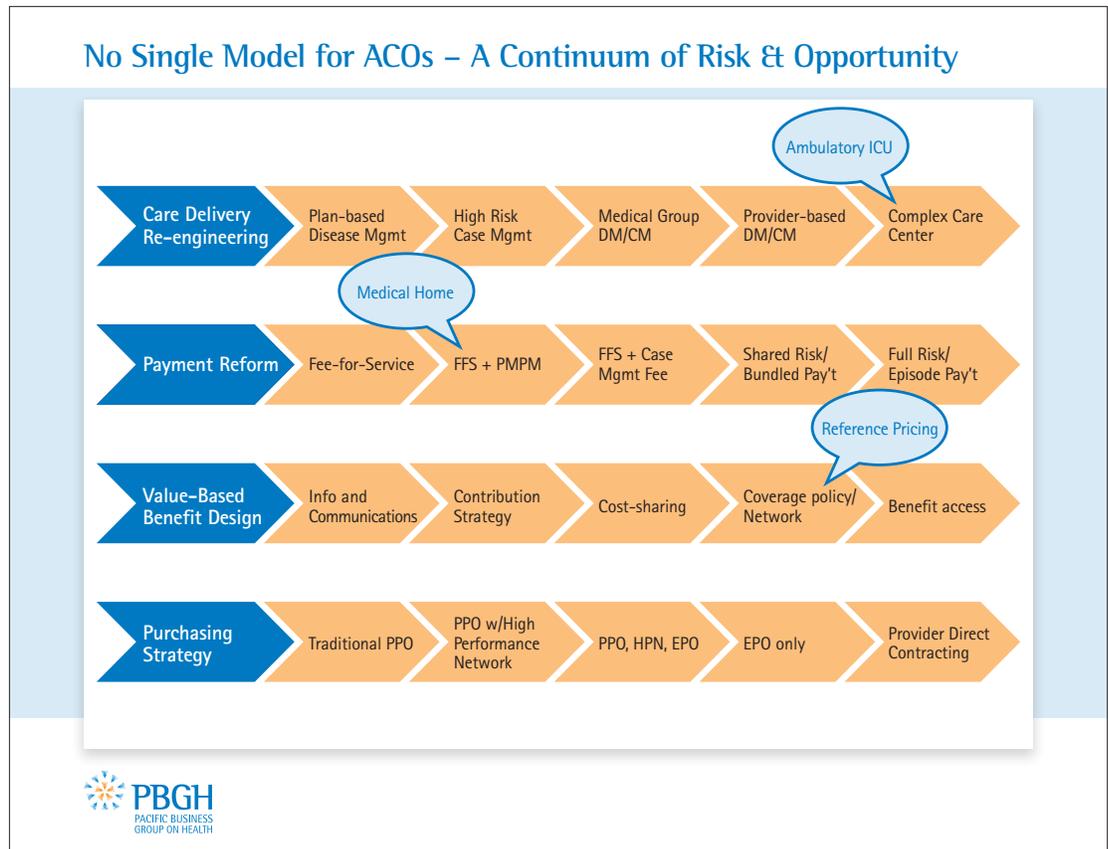
In line with the Triple Aim, ACOs have real potential to improve the health of individuals and populations, improve the patient experience and lower the cost of care. Now - as regulations and payment arrangements are being defined - is the time to set high standards and to align ACO regulations with other legislation and Affordable Care Act implementation processes. Purchasers and policymakers alike should require that ACOs meet the following standards to deliver meaningful reform.

1. ACOs must be transparent

Consumers and purchasers should be able to assess the clinical and financial performance of providers who participate in an ACO as well as the overall performance of the ACO

APPENDIX 1

There is no single model for accountable care; rather there is a continuum of risk and opportunity. The diagram below describes some of the potential levers to drive care redesign and payment reform and potential actions purchasers can undertake to maximize value differentiation in benefit design.



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- Feature ACO-designated groups as part of a tiered provider network, with reduced cost-sharing incentives or contribution strategies for members to elect such a network.
 - Promote incentive alignment in payments to providers through shared saving incentives or bundled payment for episodes of care.
 - Discuss opportunities to participate in multi-payer collaboratives that align commercial provider payments and care delivery with innovations being undertaken for the Medicare Shared Saving Program.
 - Support health plan efforts to redesign payment and promote transparency among their provider networks.
4. Expand the current portfolio of performance measures that are applicable to ACOs and meaningful to consumers and purchasers so they can better assess value.
 5. Support specific regulatory approaches that assure that the proliferation of ACOs leads to improved value for purchasers and consumers. More detail about these specific regulatory approaches can be found at www.pbgh.org/news-and-publications/pbgh-legislative-commentary.

NEXT STEPS FOR POLICYMAKERS

Policymakers and regulators can play a critical role achieving the promise of health care reform, if they hold ACOs to the standards described in this issue brief. Policymakers can:

1. Monitor key “red flags” that would indicate an ACO’s market power has led to increased prices and take corrective action when this occurs. Establish a set of explicit and exacting criteria for any safe harbors from antitrust enforcement actions.
2. Support a competitive marketplace by requiring a high level of quality and financial transparency, including robust evaluation of quality and cost. Choose minimum thresholds that support meaningful quality improvement and cost containment. For example, a high bar should be set for provider gain-sharing and bonus qualification.
3. Offer higher Medicare bonus opportunities for public-private collaboratives to offset providers’ efforts to shift costs to private payers in response to public payment levels.

THE ROAD AHEAD

There is widespread agreement that we need new approaches for care delivery. ACOs have the potential to improve the quality and affordability of health care, but they need to be properly structured and sufficiently accountable. The principles outlined in this issue brief are intended to support value-differentiating strategies for ACO design that leads to true innovation rather than incremental and uncertain improvement. In the long run, purchasers hope that ACOs coupled with other strategies such as value-based benefit design will bring about the improvements in quality and affordability articulated in the Triple Aim.

enterprise. ACOs must be required to disclose a “dashboard” of measures at the provider, site and service line levels. They must be required to contribute each to regional or national comparative reporting and analysis efforts.

SEVEN PURCHASER PRINCIPLES FOR ACOs

- ACOs must be transparent
- ACOs must be outcomes-focused
- ACOs must be patient-centered
- ACOs must pay for quality, not quantity
- ACOs must address affordability and contain costs
- ACOs must support a competitive marketplace
- ACOs must demonstrate meaningful use of health information technology

2. ACOs must be outcomes-focused

ACOs must apply metrics that hold providers accountable for evidence-based care that improves health outcomes and structure payment policies to recognize high performers. ACOs must use a robust measurement dashboard that is outcomes-focused and patient-centered. For example, to qualify for bonus payments, an ACO could be required to demonstrate that at least 80 percent of its providers, including subcontractors and ancillary providers, meet the in-force Stage 2 and 3 Meaningful Use criteria for Health IT adoption and quality outcomes reporting. By investing in health IT infrastructure, ACOs can also advance quality reporting from clinical registries

and electronic health records. For example, ACOs could distinguish themselves by collecting and publishing outcomes data on key population segments, such as patients undergoing elective surgery and management of complex chronic illness. The metrics should include benchmarks and performance thresholds for each of the following:

- Clinical outcomes
- Functional status
- Appropriateness
- Patient experience
- Care coordination and care transitions
- Cost
- Resource use

3. ACOs must be patient-centered

ACOs must use a patient-centered, team-based approach to care delivery and member engagement that supports shared decision-making between patients and providers. ACOs should require that individuals with multiple chronic conditions have a shared care plan that is accessible electronically to all providers or members of the care team (including patient and family). Delivery system elements should include use of qualified health professionals to deliver coordinated patient education and health maintenance support that engages the member in self-care, self-management and risk reduction. Patients must be included in the care process and be given ready access to their health information.

4. ACOs must pay providers for quality, not quantity

ACOs must structure provider payment to support evidence-based care and reward performance. Such payment should also

address workforce issues and support primary care availability. ACOs should also seek to assure that providers receive the same financial signals regardless of payer (public or private). Specific methods could include risk-adjusted, episode payment or bundling, gainsharing and shared risk with the goal of allocating at least 20 percent of provider compensation to performance-based rewards. ACOs should also implement non-payment for “never events,” errors and inappropriate use, holding the patient harmless.

5. ACOs must address affordability and contain costs

ACOs must hold providers accountable for stewardship of health care resources by managing the cost trend increase to Consumer Price Index (CPI) plus one percent. ACOs must demonstrate sound fiscal policies and financial management practices that assure oversight of risk-based contracts. Eliminating waste should also be a discrete objective, linked to quality and utilization measures such as avoidable hospital readmissions, reduced duplication of services and reduced emergency department use.

6. ACOs must support a competitive marketplace

ACOs must support competition and transparency, providing consumers with information about the relative performance, cost and efficiency of providers. ACOs should make information regarding provider financial arrangements available to the public. ACOs must also refrain from contractual non-disclosure provisions that preclude community-level quality and efficiency measurement, consumer access to

information and comparative performance reporting. ACOs and related ownership entities should disclose medical loss ratios (the percent of premium dollar that goes directly to medical services) consistent with recommendations of the National Association of Insurance Commissioners. This number is a good proxy for resource stewardship, financial management and efficiency.

7. ACOs must demonstrate meaningful use of health information technology

ACOs must require that their providers use health information technology for clinical decision support, clinical integration and information exchange. Beyond requiring that a high percentage of participating practitioners meet the Meaningful Use targets as they evolve, ACOs should be capable of exchanging clinical information through the Nationwide Health Information Network (NHIN) structure. It should expect participating providers to:

- Implement clinical decision support;
- Share information with other providers and contribute to a longitudinal health record for each patient;
- Share clinical information with each patient, and collect patient-reported information about health risks, health status, and patient experience.

NEXT STEPS FOR PURCHASERS

To help ensure that ACOs meet the standards outlined above, purchasers can engage in a number of activities.

1. Participate in pilot projects that support accountable care and enforce the principles described above. For example, PBGH’s

Ambulatory Intensive Care Unit (AICU) pilots in Humboldt County and Southern California reflect ACO dimensions such as delivery system redesign and gain-sharing based on financial performance. Under these pilot projects, physician groups are responsible for the quality and cost of care delivered to a distinct group of medically complex and chronically ill patients. Medical groups are compensated with traditional fee-for-service, care management fees and shared savings. PBGH encourages other purchasers to join us to test this approach for more personalized, cost-effective care that focuses on the patient’s overall well-being and care transitions – rather than treating patients who have multiple health care issues on an issue-by-issue basis. The Boeing Company has demonstrated success with this intensive outpatient care program in Seattle.

Other organizations with programs to promote accountability include Safeway Inc. and CalPERS who have introduced reference pricing strategies that encourage consumers to select high-value providers. Safeway’s program entails creating a “shopping experience” for its members by offering price transparency for discrete services such as colonoscopies and certain laboratory tests. CalPERS’ Value Purchasing Benefit Design identifies hospitals that offer joint replacement procedures below a threshold price. Patients using these hospitals have traditional cost-sharing. Patients using more expensive hospitals have a much higher out-of-pocket liability.

2. Engage consumers in using high performance provider networks. Beyond strategic decisions to implement reference pricing benefit strategies, purchasers can use

high performance provider network options or participate in delivery system redesign programs. CalPERS, Union Bank, University of California and Wells Fargo & Company are just a few of the PBGH members using benefit design or contribution strategy to promote selection of plan options with a high performance network. Even without a formal product option, purchasers can support ongoing education of their beneficiaries to encourage use of quality information and understand the value of selecting higher performing providers – both physicians and hospitals.

3. Support policy and advocacy efforts to promote competition and quality.

Purchasers should ensure that ACO regulations support market competition. The Medicare Shared Saving Program regulations should recommend standards that require ACOs to meet transparency requirements that produce provider-level price and quality information that is meaningful to consumers. By actively weighing in on regulations and accreditation standards, purchasers are contributing to the ongoing policy dialogue about accountable care.

4. Partner with provider systems and plans to create your own ACO-like product.

Purchasers can also engage directly with major provider systems in their largest markets to explore opportunities to collaborate. Purchasers can partner with their health plans to design an accountable care strategy that incorporates the lessons of California managed care. Recommendations to purchasers seeking this arrangement include:

- Find out what the plans’ cost and transparency requirements are and encourage them to set a high bar.

About the Pacific Business Group on Health

Founded in 1989, Pacific Business Group on Health (PBGH) is one of the nation's leading non-profit business coalitions focused on health care. We help leverage the power of our 50 large purchaser members who spend 12 billion dollars annually to provide health care coverage to more than 3 million employees, retirees and dependents in California alone. PBGH works on many fronts to improve the quality and affordability of health care, often in close partnership with health insurance plans, physician groups, consumer organizations, and others concerned about our health care system. To learn more please visit www.pbgh.org.

