How-To Guide: Accountable Care Organizations

How to Use this Guide

The information in this guide is intended to be used primarily by self-funded purchasers of health care who are interested in understanding more about Accountable Care Organizations and how best to utilize them. This guide outlines the tools CPR and PBGH have created and made available for purchasers who want to begin implementing an ACO strategy.

Tools

- **ACO Health Plan Questionnaire**
- **ACO Request for Information (RFI)**
- **Model ACO Contract**

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Disclaimer: Engaging with an Accountable Care Organization will likely result in individual specific negotiations on various provisions. CPR and PBGH are not providing legal advice or direction on how to address these specific negotiations. The tools provided in this guide are for information purposes only. Before any decisions are made as to whether to use these tools in whole or in part and to understand the legal implications of doing so, purchasers should consult with a qualified legal professional for specific advice.

I. Introduction: Understanding ACOs

An ACO is a type of healthcare delivery and payment system that ties provider reimbursement to quality metrics and reductions in the total cost of care for an attributed population of patients. At the heart of an ACO is a local provider entity that is responsible for all of the health care and related expenditures of a defined group of patients. An ACO's ability to align incentives for providers to improve quality while controlling healthcare spending will vary depending on the program, incentive design and implementation. There is limited evidence to date about what approaches work best so it is essential to experiment and evaluate results and continue to innovate over time.

Based on experience to date, to achieve cost savings while improving quality and the continuity and coordination of patient care, an ACO must support:

A high performance network of providers: ACOs should contain a defined network of providers who have been selected based on their quality, utilization and efficiency. The network shall represent the continuum of care and optimize access to primary care through multiple modalities.

Outcomes-oriented measurement: ACOs should seek to improve health outcomes through improved quality of care and patient experience. The ACO must be able to produce meaningful evidence of its quality and cost improvements though recognized outcomes and utilization measures.

Patient-centered and coordinated care: ACOs should support coordinated care with targeted care management for those who need it. Care should be based on Participant preferences and needs. ACOs should provide care-planning support as well promote physician engagement in shared-decision making with patients.

Cost measurement and savings determination: A primary objective and expectation of ACOs is to reduce overall spending and moderate trend to target CPI or less. To assess cost savings, ACOs should apply a prospective patient attribution model. As a result, the ACO will have a defined patient population for cost and quality measurement and targeted care coordination strategies. Ideally, ACOs will be subject to a shared-risk payment arrangement in which any savings will be distributed based on meeting medical cost and quality goals.

Transparency: Transparency on quality and costs are critical for employers and health plans, patient participants, and participating providers within the ACO. In particular, the ACO must provide consumers with cost and quality information at the individual provider level accounting for patient plan design impacts. Purchasers expect transparency on spending, savings, and savings distribution. Providers will need feedback on their individual performance from both a quality and cost perspective.

Health information technology and administrative infrastructure: The ACO should utilize an advanced IT infrastructure that enables it to manage the health of its population. Specifically, the ACO should enable online data management and communication with Participants, care management, outcomes tracking and performance analysis.

Maintaining market competition: ACOs should not use contract exclusivity and/or non-transparency provisions that reduce competition within the market. Rather, ACO development and growth should advance competition among providers in the market.

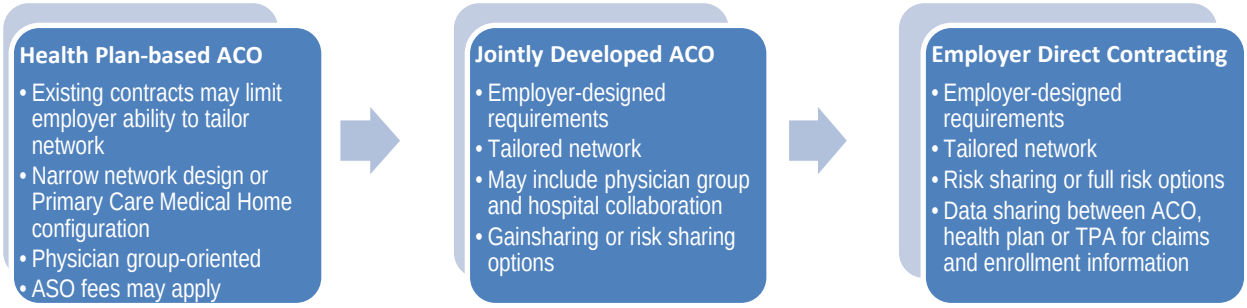
There are a variety of ways an employer or other purchaser can participate in an ACO:

Health Plan-Developed ACO
Employers can gain access to an existing ACO offered by their health plans. A purchaser may elect to access such programs "as-is," which may limit the ability to apply specific quality measures or financial gainsharing terms, which are often dictated by how many employer lives are attributed to the ACO. Additionally, under such programs, a health plan may have an established fee structure that applies either at the population level or is based on enrolled or attributed members. Depending on the specifics of these arrangements and potential additional fees, the employer may or may not share directly in any savings the ACO produces.

Jointly Developed ACO between Health Plan and Employer
A purchaser may also work with a health plan to leverage its existing provider network and/or ACO contracts, but collaborate to establish specific performance criteria and risk-sharing arrangements. The plan and employer may share in the initial cost of development and will also share in the distribution of any savings.

Direct Contracting with an ACO
Employers may contract directly with an existing ACO or work with provider organizations to form an ACO. In this scenario, the employer would bypass its health plan to contract directly for care with the ACO. The contract could encompass all healthcare services or a targeted population (e.g. chronic illness).

The schematic below describes a continuum of benefit programs that may leverage existing or newly developed accountable care organizations. The features listed are intended to be illustrative only.



For a more detailed review of ACOs, see CPR's Action Brief on Accountable Care Organizations here and PBGH's Principles for ACOs here.

II. Assessing Your Options and Selecting a Partner

As reviewed above, there are a variety of forms an ACO can take and there are multiple avenues an employer can take to engage with ACOs. Whether or not to use an ACO and which ACO to use will be a

case-by-case, market-by-market determination. Key issues for an employer to consider include the following:

Member Identification

- Assess potential Participant volume in a given geography
- Analyze current distribution of provider use and provider affiliation with existing provider organizations (through health plan or may need to collect provider NPIs to conduct analysis through an internal data warehouse)
- As needed, arrange for plan to provide historical data and conduct member attribution

Benefit Design

- Assess the current benefit design with respect to:
    - Open or closed network
    - Incentive for provider selection or steerage to a high performance network
    - Incentive for member engagement in health management programs for risk reduction
    - Incentive for member and provider engagement in treatment option decision support
- Determine what types of incentives would support member engagement and/or selection of the ACO network (if offered in a multi-option environment)
    - Copay waivers or coinsurance reduction for use of primary care services
    - Copay waivers or coinsurance reduction for medication adherence
- Determine the degree to which benefit design modification can be administered through an existing health plan relationship and/or the capacity of a third-party administrator if contracting directly with an ACO
- Determine impact on member out-of-pocket expenses if provider payments are shifted from traditional fee-for-service to bundled payments, case management fees, and/or capitated structures

Compliance/Data Analysis/Data Agreements/Security

- Sign data sharing agreements between health plan/medical group/purchaser
- Ensure data exchange process and data security measures are in place
- Analyze data to assess high cost conditions, risk distribution, avoidable services such as readmissions or high-volume emergency department use
- Conduct a legal review of ACO contract terms and fiduciary roles (with or without health plan)
- Confirm state regulations, if any, concerning oversight and licensure of risk-bearing entities

Financial Considerations and Contracting

- Build business case, financial analysis and quantify savings opportunity
- Compare options such as plan-based ASO fee vs direct administration costs
- Determine financial terms:
    - Agree to how reimbursements will be applied (e.g., withholds, added fees, etc.)
    - Determine care management PMPM, if applicable
    - Determine gain sharing levels and risk-sharing terms, including potential upside and downside margins

- Develop financial reserve policy to allocate funds for potential gain-sharing obligations
- Complete a Division of Financial Responsibility document to confirm the responsible parties for payment and categorization of services for risk-sharing reconciliation (e.g., outlier claims, out-of-area claims, transplant services, etc.) and address integration of expenses for carveout services (e.g., use of behavioral health specialty networks and prescription benefit managers, value-add benefits such as travel surgery or Centers of Excellence, etc.)
- Evaluate/discuss need for risk reinsurance policies to protect employer and provider against future liabilities

Implementation

- Review program or service gaps identified through Request for Information (per section below)
- Assess benefit design and potential incentives for steerage
    - Quantify actuarial value of current benefit design offering and cost of copayment or coinsurance differential as incentive
    - Model savings requirement to offset incentive design, weighing premium reductions vs. reduced out-of-pocket costs
    - Consider reducing employee cost share for primary care services while increasing cost-sharing for services that may be subject to overutilization
    - Consider incentives and disincentives for risk reduction, medication adherence and chronic condition management
- Prepare communications plan, including:
    - Draft communication materials as needed (e.g. program description, patient letters, FAQs, etc.)
    - Coordinate communications with health plan and/or ACO, as needed
    - Communicate internally to employees, as needed
    - Prepare FAQs for HR and Customer Service staff

Reporting and Evaluation

- Identify periodic reporting requirements (metrics and frequency) that ACO or health plans need to deliver
- Identify evaluation criteria (e.g. cost, quality metrics, patient satisfaction metrics, etc.)
- Establish baseline performance levels and improvement targets
- Acquire agreement from stakeholders on evaluation criteria

III. Conducting a Request for Information (RFI)

Employer-purchasers can field a Request for Information (RFI) to assess the capabilities of the ACOs in a market or a Health Plan Questionnaire to assess the ACO offerings of their health plan. The RFI and Questionnaire developed by CPR and PBGH will help you assess an ACO on the following categories:

- High-performance networks
- Outcomes-oriented measurement
- Patient-centered care
- Coordinated care

- Cost measurement and savings determination
- Transparency
- Health information technology and administrative infrastructure
- Maintaining market Competition

The RFI and Questionnaire can be used to determine if your health plan offers an ACO that meets your needs as well to determine if any existing ACOs are good partners for direct contracting.

To the extent that implementing an ACO can support broader market reforms and payment redesign, purchasers may wish to utilize CPR's Market Assessment Tool. The assessment presents an opportunity to engage with local providers and health plan(s) to capture data about the size of the market's population, the major stakeholder groups and their percent market share, measures of market concentration among health plans and hospitals, and attitudes toward and readiness to implement delivery and payment reforms.

IV. Implementation Planning and Timeline

The planning cycle to implement an ACO can vary significantly from nine to 18 months. Typically, using a health plan-developed ACO requires less lead time for implementation than direct contracting. A sample implementation plan and timeline are available to purchasers as a separate appendix.

V. Direct Contracting with an ACO

If an employer-purchaser finds an ACO partner with which to contract directly, the Model ACO Contract Language developed by CPR and PBGH can provide a starting point for negotiations. The contract language is designed to assure the ACO meets CPR-PBGH expectations in the RFI and health plan questionnaire categories outlined above.

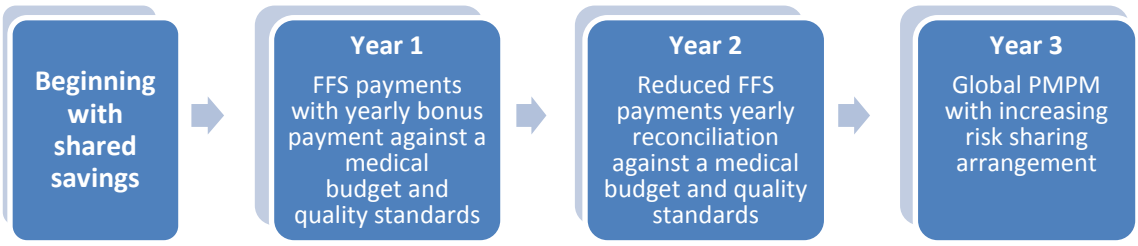
The model contract also specifies a shared-risk payment arrangement. Employers may modify the payment arrangement to match the ACO's capabilities. The contract provides a starting place, but the parties will need to discuss and negotiate 1) the level of risk the ACO bears and 2) the degree to which savings and/or losses are capped.

1) **Determining the level of risk.** Each ACO's capacity to bear risk will be the key factor in determining the payment model for the ACO. If the ACO is not equipped to enter into a shared-risk payment arrangement, an initial period (one year illustrated below, and not to exceed two years) of fee-for-service payments with shared savings can be implemented in preparation for evolving to a risk-sharing arrangement. Recommended guidelines for the transition from shared-savings to a population-based-payment model follow.

   Beginning Shared Savings. For ACOs that are not ready to enter into a shared-risk arrangement, initial payments will be made under fee-for-service at the usual allowable amount. Savings will be determined by comparing costs to benchmarks and will be allocated through a retrospective reconciliation process annually.

The ACO must achieve a minimum savings rate (e.g. 2%) before any savings are distributed by health plan or employer. Benchmarks will be created each performance year based on historical claims data. Medical cost should be case mix-adjusted.

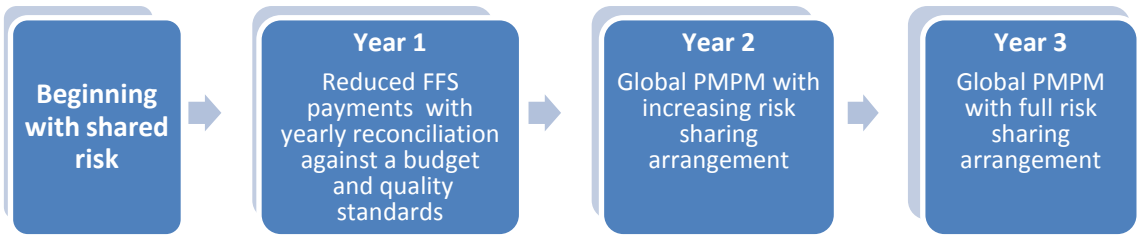
To achieve savings, benchmarks will be created each performance year based on prior year claims data. The ACO will be able to share up to a predetermined percent of the savings (e.g. 50%) above the minimum saving rate if 100% of the quality standards are met. At the discretion of the Company and ACO, the parties may agree to establish stretch targets for select measures for which targeted intervention is a priority, or mutually agreed upon improvement targets significantly above current market performance but with a threshold lower than meeting 100% of the quality standards. Savings will be capped at a specific percent of the benchmark for that given year. Losses can be capped with a sliding rate, such as starting at a minimum of 8% percent of the ACO's medical cost benchmark in year one, ramping up to 15% by year three. After a year of being paid under a shared savings arrangement, the ACO should transition to a shared-risk arrangement.



Transition to Shared Risk. The ACO will continue to be paid on a fee-for-service basis. A withhold on the fee-for-service payment may be implemented to fund the shared savings arrangement, with the potential benefit of additional membership steerage to offset the fee reduction from the withhold. If implementing a withhold, the ACO will be paid a negotiated reduced rate with the potential to earn back the reduction through a two-sided risk arrangement (shared savings and shared risk). Savings or losses will be determined annually by comparison to a predetermined benchmark on a retrospective basis.

A predetermined minimum savings rate (e.g. 2%) must be achieved before any savings are distributed. The employer and ACO shall agree upon a clearly defined measure of the ACO's cost savings prior to the start of a contract. The ACO will be able to share up to a predetermined percent (e.g. 50%) of the savings above the minimum saving rate if 100% of the quality standards are met. Savings can be capped at a predetermined percent (e.g. not more than 15%) of the benchmark for that given year. Medical cost should be case mix adjusted.

The ACO will be able to share up to a predetermined percent of the savings (e.g. 60%) above the minimum saving rate, if 100% of the quality standards are met. If the ACO does not reach cost targets, the ACO will be responsible for a predetermined percent of losses (e.g. 60%). Losses can be capped with a sliding rate, for example starting at a minimum of 8% percent of the ACO's medical cost benchmark in year one, ramping up to 15% by year three, consistent with the level of the withhold on fee-for-service claims.

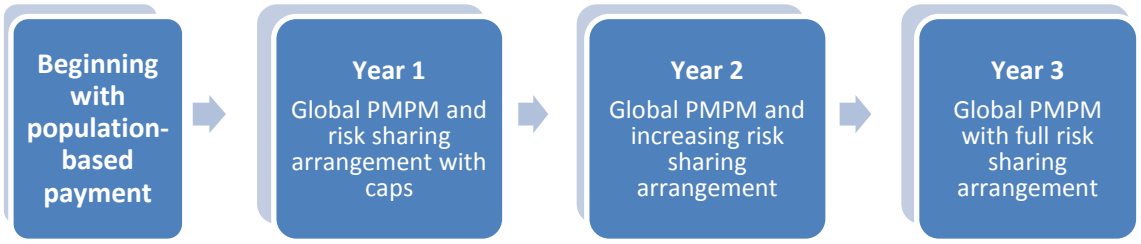


Transition to Population-Based-Payment Model. In this phase, the ACO will receive a combination of fee-for-service and population based payment. Fee-for-service payments will be reduced by a predetermined amount (e.g. 50%) and then combined with a monthly population-based payment based on a predetermined amount (e.g. 50%) of the ACO's expected costs. The ACO will be eligible for shared savings only if costs are reduced by at least a predetermined amount (e.g. 3%). As the ACO achieves savings goals, the proportion of risk share can increase to move eventually to a full-risk-sharing payment model.

If the ACO transitions to a population based-payment model, performance can be measured through a combination of:

- Benchmarks
- Setting a target for spending
- Trending data

The ACO's ability to manage risk successfully will determine the pace of the transition from shared savings to full-risk sharing. The table below outlines the possible transition timeline for ACOs at different levels of readiness to take on financial risk.



2) **Determining losses and/or savings caps.** The CPR-PBGH Model ACO Contract Language includes no limits on an ACO's ability to share in savings or in losses. Depending on the size of the attributed population, employers may want to negotiate these limits in their contract with a specific ACO. Claims volatility may be associated with a smaller population. A downside cap allows an ACO to manage its financial risk, while an upside cap provides an employer with guidance on establishing an appropriate financial reserve for potential payouts.

Capping losses. Imposing a cap on the losses shared entitles the ACO to share in the designated proportion of losses (if any) up to that defined cap. Once the cap is reached, any subsequent losses are solely incurred by the employer. Implementing a cap on losses may

help an ACO in the beginning stages of sharing risk to enter more readily into shared-risk payment arrangements. Losses can be capped on a sliding scale, for example starting at 5-percent of medical costs targets in year one and increasing to 15-percent in year three.

Capping savings. Imposing a cap on the savings shared entitles the ACO to share in the designated proportion of savings (if any) up to that defined cap. Once the cap is reached, any subsequent savings belong exclusively to the employer-purchaser. If a cap on losses is implemented, the employer may want to leverage a cap on savings to offset the risk of the cap on losses.

VI. Health Plan-Developed ACO or Jointly Developed ACO between a Health Plan and Employer

Many health plans have already developed their ACO models, and employer-purchasers may have limited options for creating a customized ACO (especially as compared to a direct contracting situation).

An employer should assess the following elements of the health plan-developed ACO.

- **Member Identification.** An employer, health plan and provider organization must established a mutually agreed upon patient attribution methodology and validate completeness of historical claims, such as capturing the rendering provider NPI at the individual physician, rather than facility or tax ID level.
- **Financing**. Assess whether a health plan is applying additional fees for access to its network, and if so, what portion of such fees is linked to program administration and what portion is linked to performance-based payments to the ACO?
- **Payment reform strategy.** Determine the underlying payment structure between the health plan and provider organization(s), and the extent to which the plan has a progressive strategy towards payment reform that rewards quality and efficiency. Absent a longer term strategy, an ACO relationship may net near-term savings in lower utilization or reduced fee structure, but may not have a sustained framework to drive quality improvement and savings in the later years of the contract.
- **Level of risk.** What level of gain sharing or risk sharing is available?
- **Customization.** What degree of benefit design customization is permitted? How is the program different than a traditional "narrow network" offering.
- **Measures and reporting.** What types of quality (including patient experience), cost and utilization reporting are available?

If an ACO is jointly developed between a health plan and employer, the elements above also apply. Additionally, an employer should consider whether some of the opportunities outlined above in the direct-contracting section are desirable elements to incorporate through a jointly-developed program. Other elements include:

- **Provider Selection**. To what extent can the employer influence the selection of provider partners – both physician organizations and facilities.
- **Provider Network Stability.** Does the health plan have a multi-year contract with the recommended provider organizations that offers rate stability and access for beneficiaries?

- **Provider Disruption and Member Steerage**. What portion of an employer's existing population uses the recommended network and what steerage opportunity exists to promote additional member enrollment or attribution. Are there leveraging opportunities with enrollment through other purchasers in the marketplace and/or through the health plans' other product lines?

With limited ability to guide the design of the ACO, employers working through a health plan may seek to implement specific performance guarantees to ensure ACO alignment with the employer's overall goals. The performance guarantees (Appendix A of the ACO Contract Language) are written to put in place target improvements relative to the prior year experience.

The guarantees cover ACO performance on:

- **Outcomes-oriented quality improvement**
- **Patient-centered care**
- **Cost measurement and savings determination**

VII. Evaluating Results

Regardless of the method of implementing the ACO, all employers should evaluate quality outcomes, patient experience, utilization, cost trends and savings. The ACO should provide employers with evaluation results on a quarterly basis and reconciliation on an annual basis to track progress on achieving the employer's overall expectations outlined in Section I. Specifically, the ACO or Administrator shall report on the following information specific to the Company:

- Total attributed membership
- Cost, utilization and defined quality indicators
- Total spend, PMPM, per admission, and per episode for a list of defined services
- Overall reduction in total spend compared to prior year (total savings)
- Average reduction in PMPM compared to prior year (when applicable)
- Break down of total payment distribution of any savings

Specific language requiring evaluation on the above topics is outlined the Model ACO Contract.