



A Closer Look at ACOs

A series of briefs designed to help advocates understand the basics of Accountable Care Organizations (ACOs) and their potential for improving patient care.

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Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know

What's an ACO?

Since the Affordable Care Act was signed into law, there has been a lot of buzz about Accountable Care Organizations (ACOs). Supporters of ACOs see them as a way to reshape the way health care is delivered. They hope that ACOs will improve health care quality and reduce health care costs by getting providers to work together and focus on the quality of care, not the quantity.

The broad concept of an ACO is not complicated. An ACO is an entity that is made up of health care providers across the continuum of care (including acute care, long-term care, and behavioral and mental health care) that agrees to be held accountable for improving the health of its patients. If patients' health care costs end up being less than would otherwise be expected while health care quality is maintained or improved, the providers get to keep a share of that savings. Providers, therefore, have a financial incentive to work together to improve the health of their patients. A successful ACO should put the patient at the center of all its activities and ensure coordination of care.

An ACO is not an insurance plan. Rather, the ACO model provides for a new way to pay health care providers: Providers that are part of the ACO will continue to be paid by a third party payer, such as Medicare, Medicaid, or a private insurance plan.

While the concept may be straightforward, actually designing an ACO that will benefit health care consumers is difficult. There is no one-size-fits-all model for an ACO, and there are a great many unanswered questions about how they should operate. If they are implemented poorly, ACOs could simply end up limiting access to care, rather than improving quality.

This brief examines some of the key questions facing advocates and policy makers as ACOs take shape, and we suggest how consumer advocates can get involved in answering these questions in a way that benefits patients. Subsequent briefs have examined some of the complexities of ACOs in more detail. These pieces are available on our website at www.familiesusa.org/resources/publications/.

The Promise of ACOs

Although ACOs are not the silver bullet that will fix all the problems within our health care system, they are potentially a powerful tool that could improve the quality of care and change the way providers are paid so that they are encouraged to deliver high-quality, low-cost care.

ACOs aim to fix the fragmentation in our health care system by addressing simultaneously both the way care is delivered (delivery system reform) and the way that it is paid for (payment reform). One of the goals of ACOs is to move the health care system away from a fee-for-service system, in which providers are paid for each service a patient receives, to one focused on delivering the best care at the best price. This is often described as high-value care.

In a fee-for-service system, the more services providers give, the more money they are paid. This creates a powerful incentive to provide more and more services, regardless of whether the services are improving the patient's health. In a value-driven system, providers will be paid based on the quality and cost of the care they provide. Changing the financial incentives that often drive the way providers deliver health care should help ensure that patients receive the right care at the right time in the right setting.

The most important of an ACO's many functions is to bring health care providers and community-based services together to work in a way that meets all the needs of its patient population. The ACO should help bridge the gap in communication that has often existed between providers (for example, between primary care providers and specialists), along the continuum of care (for example, between acute care and long-term care), and between health care providers and community-based services (for example, between doctors and Meals on Wheels programs).

The ACO will also be responsible for helping providers change the way they deliver care. ACOs should develop guidelines for their providers that establish how care should be delivered. ACOs may also give providers health information technology (HIT) that includes electronic health records and decision-support tools that will help providers and patients work together to explore different treatment options to determine which is best for the patient. An ACO will also serve important administrative functions, such as negotiating contracts with insurers, both private insurers and public programs like Medicare and Medicaid.

To deliver on the promise of lower costs through improved patient health, ACOs will have to develop truly *patient-centered* care. The Institute of Medicine has defined patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”¹ Part of providing patient-centered care means ensuring that patients have

access to care when they need it. This means something as practical as being able to see health care providers the same day or on the weekend, rather than having to wait for an appointment and having a condition worsen. It also means providing the support that patients need, such as helping them transition between health care settings (for example, leaving a hospital for home or an assisted living facility). It should include coordination among all the patient's health care providers and among care settings, particularly during transitions between settings. Care coordination should also include coordination among payers, including Medicare, Medicaid, Tricare, and other forms of coverage, as well as coordination of health and social services, such as transportation and nutrition.

The Emerging ACO Landscape

The idea of creating an integrated health care entity is not new. Large health care systems like the Geisinger Health System in Pennsylvania or the Mayo Clinic in Minnesota have provided integrated care across the health care continuum for decades, often to wide acclaim.

What is relatively new is the idea of using payment reform to make a group of providers accountable for the quality of care they provide. Several demonstrations and experiments have tried this model in recent years. Medicare began a demonstration in 2005,² and the Dartmouth Institute and the Brookings Institution are testing ACO models with five different provider groups and private insurance companies in different parts of the country.³

As part of its efforts to promote better quality care and lower costs, the Affordable Care Act gave the development of ACOs a significant boost. The new law created several kinds of ACOs, including the Medicare Shared Savings Program ACO. This is a new type of payment within Medicare that providers can choose to participate in. Under this model, if the ACO lowers Medicare expenditures from year to year and meets quality measurements, the ACO will share in a percentage of the savings. The Centers for Medicare and Medicaid Services (CMS) issued final regulations for the Medicare Shared Savings Program ACO in October 2011.⁴ The program will begin in 2012. The Affordable Care Act also authorizes Medicare to test other types of ACO models. For example, the Center for Medicare and Medicaid Innovation is testing 32 Pioneer ACOs in 18 states.⁵

On the Medicaid side, the new law authorizes a limited Medicaid ACO demonstration. The demonstration allows states to test Medicaid Pediatric ACOs over a five-year period. States are also pursuing Medicaid ACOs through other means, including state plan amendments and waivers. Colorado, for example, began enrolling beneficiaries in its Medicaid ACO model in 2011.⁶

In terms of private insurance, the Affordable Care Act does not explicitly promote the growth of ACOs that serve patients with this type of insurance. However, private insurers have historically adopted many of the payment reforms that have been pioneered by Medicare. If Medicare ACOs are successful, private insurers are likely to follow suit and develop ways to pay ACOs. This is

why the development of Medicare ACOs is so important. In addition, private insurers are showing significant interest in encouraging the development of ACOs or of entities that in some ways resemble ACOs. This interest is understandable, as ACOs have the potential to reduce costs for all payers, including private insurers. However, in some cases, insurers may seek to blur the lines between a provider-based ACO and an insurance company. This concern highlights the need for advocates to push for vigilant patient protections as ACOs develop.

The Role for Advocates

As providers reorganize themselves into ACOs, advocates have an important role to play to make sure that patients' interests and needs are met. This is true for ACOs that are established under Medicare's rules, as well as for those that emerge through Medicaid and the private sector.

Advocates should monitor the development of Medicare ACOs for several reasons. First, and most obviously, these ACOs will serve Medicare beneficiaries, who need access to high-quality care. Secondly, these ACOs will almost certainly include major health care institutions in some areas (large hospital systems, for example). This means that they will serve patients who are not in Medicare but who also need high-quality care. Finally, ACOs that are developed under Medicare rules will likely serve as models for ACOs that are developed to work with other payers, such as private insurers.

In addition, an increasing number of state Medicaid programs and large provider groups and institutions like hospitals are considering establishing new integrated entities. Some of these proposals are actually true ACOs, in which groups of providers across the care spectrum are held accountable by Medicaid or private insurers for quality and get to share in any savings. Other proposals may use the term ACO but are not truly ACOs. Some are forms of primary care case management, in which primary care doctors are given incentives to coordinate care. Others may be closer to new models for health insurance, in which a private insurer takes on a larger role in coordinating care. In still other cases, providers may be consolidating (for example, hospitals purchase physician groups) allegedly to create an ACO, but the necessary accountability mechanisms are yet to be established.

Because ACOs are at such an early stage of development, the most important role advocates can play in the process is to become involved in setting up the rules and in establishing the new entities. This can mean many things. For example:

- If a Medicaid program proposes an ACO, advocates should participate in the planning process to make sure beneficiaries' needs are met.
- If a large hospital system is acquiring a set of other providers and announces it will form an ACO, advocates should demand a voice in establishing consumer protections and rules for accountability.

- When federal and state regulations and policies are proposed in Medicare and Medicaid, advocates should consider submitting comments.
- Advocates should develop relationships with health care administrators, medical societies, insurance commissioners, and health departments, among others, to stay informed about changes to their local health care delivery system.

What follows is a list of key challenges that may be encountered in the ACO development process and how advocates might suggest these challenges be addressed.

Challenges Facing ACOs

Challenge 1:

Developing an ACO that Meets a Community's Needs

What a particular ACO will look like will depend largely on the health care delivery system in that area. ACOs could be any of the following:

- fully integrated health delivery systems,
- large multispecialty group practices that own or have strong affiliations with hospitals,
- physician-hospital organizations,
- physician-only organizations, or
- some combination of these.

For rural areas, because the providers may be spread over a large geographic area, a rural ACO is more likely to be virtual, while an urban one may be located in a physical location. In addition, different tools may need to be used to help rural providers with care coordination, such as telemedicine, which may not be a common tool that is used by urban ACOs.

Whatever form it takes, an ACO must be built on a foundation of primary care. Primary care providers are usually the ideal providers to coordinate patient care. Beyond this, an ACO should organize itself based on the needs of its patient population. For example, if the patient population is older, the ACO should include providers of long-term services and supports and community-based services such as Meals on Wheels. If the ACO treats a largely low-income population, the ACO will need to include safety net providers, such as federally qualified health centers (FQHCs), as well as transportation service providers.

In addition to a strong primary care foundation, ACOs should include a wide range of health care providers and community-based resources (beyond hospitals and doctors) through formal or informal relationships. ACOs must include an adequate and appropriate mix of health care providers and community-based services in order to manage patient care along the full care continuum.

Governance of ACOs is another concern. In most cases, an ACO will have some kind of governing body, such as a board of directors. The governing body should include patients and community-based service providers, as well as participating health care providers. The governing body should allow all ACO participants and the community to take part in the decision-making of the ACO, which will help ensure local accountability.

Issues for Advocates

- ▶ Does the ACO have an adequate and appropriate range of providers and services, including a large primary care capacity?
- ▶ Can the ACO meet the community's health care needs, including cultural and linguistic concerns?
- ▶ Does the governance structure allow adequate participation by community members who are not health care providers?

Challenge 2: Figuring Out Which Patients Are in the ACO

For the ACO model to work, there must be some way for the payer and the ACO to know which patients they are responsible for. Under most models, including the Medicare shared savings program model, beneficiaries will be automatically assigned to an ACO based on which doctors and providers they see. They will not have to enroll affirmatively in an ACO like they have to enroll in a health insurance plan. Rather, if Ms. Smith sees Dr. Jones for most of her care, and Dr. Jones is part of the ACO, then Ms. Smith is considered to be assigned to Dr. Jones's ACO for payment purposes.

However, there are other ways for beneficiaries to become part of an ACO. Some ACOs and payers may allow beneficiaries to explicitly enroll in an ACO. This could either be an active, voluntary choice by the beneficiary, or it could be some kind of automatic process made by the insurer. In some models, the payer could require the beneficiary to select an ACO, similar to selecting a primary care provider within a network. This last option, which is not part of any current Medicare proposal, would have the effect of limiting patients' access to providers and should be explored very carefully, and it should be implemented only after the adequacy of the ACO has been established.

Under any approach, two concerns are paramount: 1) Patients must know that they have been assigned to an ACO, and 2) patients need to know what their rights are regarding leaving the ACO. In most cases, providing patients with a way to opt out of the ACO is a good idea.

Issues for Advocates

- ▶ How will patients know they are part of an ACO? The more direct and personalized the notification is, the better.
- ▶ Are there any limitations on access to providers? If so, what are they, and how can they be overcome?
- ▶ How can a patient leave the ACO?

Challenge 3: Allowing Patients Freedom of Choice of Providers

Under the Medicare Shared Savings Program, patients will be able to see both ACO providers and non-ACO providers. The ACOs will not be like managed care insurance plans where patients can see only providers within their plan's network. However, the ACO will still be held financially accountable for all the care the patient population receives, both from ACO providers and from non-ACO providers.

For patients, this freedom of choice of provider is particularly important if a patient is undergoing a course of treatment with a particular provider. For providers, it should encourage health care providers both inside and outside the ACO to communicate and coordinate care, regardless of whether they share the same financial incentives, because it is in the best interest of the patient.

Some providers have voiced concerns that they should not be accountable for care that patients receive from providers outside the ACO. As a result, some ACO models (those paid by Medicaid and private insurers) may require patients to see providers only within the ACO. In these cases, consumer protections such as requiring adequate networks, ensuring continuity of care, and instituting an easy appeals process to obtain care outside the ACO are essential.

Issues for Advocates

- ▶ Will patients have freedom of choice of provider? Will ACO providers be able to communicate adequately with non-ACO providers?
- ▶ If freedom of choice of provider is limited, ensuring an adequate range of providers within the ACO is even more vital. Advocates need also to build in consumer protections, including protections for ensuring continuity of care and an appeals process.

Challenge 4: Holding ACOs Accountable for Quality

An ACO must be held accountable for the performance quality of its member providers. Without such measurement, beneficiaries, payers, and the public cannot be sure of the quality of care that beneficiaries receive and determine whether that care improves over time. Quality measurement also serves as a check on the temptation to produce short-term savings by limiting care, rather than by improving quality.

Under the Medicare shared savings program regulations, the quality of care that is delivered is linked to the amount of the incentive payment that an ACO can receive. This makes the ACO accountable for the care that its providers deliver. If the ACO providers lower costs and meet minimum quality requirements, the ACO receives an incentive payment. The higher the quality scores, the larger the incentive payment. On the other hand, if the ACO's health care providers do not meet the quality requirements, then the ACO will not receive any incentive payment.

Other ACO models may use different measures of accountability and different formulas for incentive payments. Advocates should make sure that whatever measures and formulas are used, they are rigorous enough to drive quality improvements. Whenever possible, the quality measurements should be standardized across different payers, both to limit the burden on health care providers and to help improve the quality measurement process.

Issues for Advocates

- ▶ Is there rigorous quality measurement in place that evolves over time to ensure that quality is always improving?
- ▶ Is the quality measurement appropriate for the community and for the patients who will be served? For example, consider whether a measurement is suitable for a pediatric versus a geriatric practice; what the appropriate language and cultural standards should be; as well as whether there are particular conditions, like diabetes, that are especially prevalent.
- ▶ Will the formula for incentive payments ensure participation of an adequate range of providers?

Challenge 5: Getting Providers and Patients to Work Better Together

To be successful, ACOs will need to drive a change in the culture both of health care providers and patients. Historically, doctors have not practiced in teams and have not communicated well across the care continuum. At the same time, many patients believe more care is better and the newest technology or medication is always the best, when in fact sometimes less intensive treatment can be more effective. ACOs aim to shift this culture to one where the emphasis is on care coordination and not simply doing more and more of the latest and costliest procedures.

To start the care coordination process, ACOs should explain to patients (through notices and other means) that the provider is part of an ACO and what that means for the patient. Providers should also include patients in the process of developing health care plans that reflect patient preferences and values. ACOs should also develop protocols to use shared decision making that explains the benefits and consequences of each treatment to patients (or their caregivers).

Issues for Advocates

- ▶ As ACOs take shape, look for evidence (through surveys and other means) that providers are working in teams and communicating better with patients and among themselves.
- ▶ Use positions on governing boards to monitor patient involvement in treatment, such as the use of shared decision making.

Challenge 6: Avoiding the Mistakes of Managed Care

Although they are not a form of health insurance, ACOs have some superficial similarities to health maintenance organizations (HMOs) and other managed care. When first conceived, managed care was intended to produce savings because insurers would benefit from reduced health care costs if their members' health was improved through initiatives like case management and better preventive benefits. In some cases, this worked. In many instances, however, insurers found it easier to reduce costs simply by closing provider networks, which limited patients' freedom of choice of provider, and by denying coverage of services. Little attention was paid to improving quality and paying for high-value care. As a result, in the 1990s, there was a significant backlash against managed care from both patients and providers.

Unlike managed care, ACOs are designed to be provider-based. They should use care coordination and quality measurement to improve health care quality and drive down health care costs. The focus should be on providing high-quality care, not limiting access to care.

Taking the responsibility of improving quality while lowering costs out of the hands of a third party, often a large company that has no ties to the community and that is not directly involved with providing health care, and putting it into the hands of a local organization that is made up of the providers who directly provide care to patients is among the most important differences between a managed care plan and an ACO. Nevertheless, there is a risk that poorly designed ACOs could pursue short-term savings by limiting access to care. That is why robust accountability measures are essential. It is also why payers (insurers) need to be kept separate from ACOs.

Issues for Advocates

- ▶ Ensure patients and providers, not insurers, have authority over health care decisions.

Conclusion

The development of ACOs is an important opportunity for health care advocates to participate in the reshaping of our health care system. If done well, ACOs hold the promise of reducing health care costs while improving quality for patients. But they will succeed only if the needs and concerns of patients are continually brought forward as these new entities develop. As ACOs emerge at the state and local level, advocates should inject themselves into the planning processes and ensure that consumers' interests are protected.

Resources

ACO Learning Network, available online at <http://www.acolearningnetwork.org>.

Medicare Shared Savings Program Final Rule, available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>.

Medicare Shared Savings Program Proposed Rule, available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>.

National Committee for Quality Assurance (NCQA), available online at <http://www.ncqa.org/tabid/1312/default.aspx>.

National Quality Forum, available online at <http://www.qualityforum.org/Home.aspx>.

National Quality Measures Clearinghouse, available online at <http://qualitymeasures.ahrq.gov/about/index.aspx>.

¹ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington: National Academy Press, 2001).

² Centers for Medicare and Medicaid Services, *Medicare Physician Group Practice Demonstration* (Washington: Centers for Medicare and Medicaid Services, December 2001), available online at http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf.

³ More information about the Brookings-Dartmouth ACO model is available on the The Dartmouth Institute for Health Policy and Clinical Practice, Center for Population Health, Accountable Care Organizations web page, online at <http://tdi.dartmouth.edu/centers/population-health/policy-core/accountable-care-organizations/>.

⁴ Centers for Medicare and Medicaid Services, Medicare Program; "Medicare Shared Savings Program: Accountable Care Organizations," 76 FR 67802, available online at <https://www.federalregister.gov/articles/2011/11/02/2011-27461/medicare-program-medicare-shared-savings-program-accountable-care-organizations>.

⁵ Center for Medicare and Medicaid Innovation, Pioneer ACO Model, available online at <http://innovations.cms.gov/initiatives/aco/pioneer/>, accessed on February 10, 2012.

⁶ Colorado Department of Health Care Policy and Financing, *Accountable Care Collaborative* (Denver: Colorado Department of Health Care Policy, 2011), available online at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246>.



Putting the Accountability in Accountable Care Organizations: Payment and Quality Measurements

Introduction

Every year, health care in the United States becomes more expensive. Yet despite the growth in health care costs, quality has not kept pace. As a result, people in the United States pay more for their health care but receive lower-quality care than people in other developed countries such as Germany and Japan.

One of the reasons for this is the way we pay for health care. Most insurers pay providers for each health care service they deliver, regardless of the quality. The more care that is delivered, the more the provider is paid. Providers are not usually paid to work together and coordinate a patient's care, nor are they paid to help patients be active participants in their health care (for example, by jointly developing a care plan). This poorly structured payment system has created a highly fragmented health care system that is very inefficient, with duplication of tests, preventable hospitalizations, and poor care for chronic conditions. This inefficiency causes costs to rise even further and leads to more poor-quality care.

To begin to address this problem, the Affordable Care Act included many new initiatives that are designed to change the way health care services are delivered and paid for in Medicare and Medicaid. One of the new models is the Accountable Care Organization (ACO). An ACO is an entity made up of health care providers that agrees to be held accountable not just for lowering the cost of health care, but also for improving health care quality across the continuum of care, including acute care, post-acute care, long-term care, and behavioral and mental health care.

Advocates have an important role to play in helping develop ACOs that are focused on the beneficiary and that are accountable to the community in which they are located. The goal is to improve the care that beneficiaries receive, not simply to create a new way to pay providers. Advocates can work with payers, such as Medicaid and private insurers, or with providers, such as a local hospital, to ensure that there is an appropriate balance between the financial incentives and the accountability measurements that providers must meet. This means ensuring that there is a meaningful link between financial incentives and quality improvement, as well as ensuring that there are adequate and appropriate quality measurements that evolve over time.

When working to strike this balance, advocates will face several key challenges. This brief examines some of the challenges that advocates will face when working with policy makers, insurers, and providers to develop accountability mechanisms for ACOs that ensure that beneficiaries receive high-quality care at a lower cost.

Background

ACOs aim to change the way providers deliver care by changing the financial incentives. There are different payment structures that can be used to encourage providers to lower costs, improve quality, or both. Since the goal of an ACO should be to both lower costs and improve quality, using an accountability payment structure—one in which cost and quality are linked—will be the most effective.¹ Under this kind of payment structure, ACOs will have to lower costs *and* improve quality to receive the financial incentive. This is the payment structure that Medicare will use in the Medicare Shared Savings Program ACO (MSSP ACO).²

In an accountability payment structure like the Medicare Shared Savings Program ACO, providers are rewarded for delivering high-quality care while lowering costs by linking payment to minimum quality performance requirements. If the ACO does not meet minimum quality performance measurements, the ACO does not receive the financial reward. By requiring providers to meet minimum quality measurements to receive payment, payers can ensure that providers do not reduce costs by skimping on needed care.

It is important to note that the Medicare Shared Savings Program ACO is not the only model for paying ACOs. Other payers, such as Medicaid and private insurers, may take a different approach to structuring their payment mechanism for ACOs. For example, either lower cost *or* higher quality could be the focus, and the incentive payment would be structured accordingly. For example, if the ACO lowered health care costs but there was no change in the quality of care, the ACO would still receive the financial incentive.

Payment structures like this are problematic because ACOs could lower costs simply by limiting access to medically necessary care or by providing lower-quality care. In the alternative, if the focus is on quality improvement only, quality may improve, but costs could increase. This could harm consumers in the short term by imposing higher out-of-pocket costs, and over the long term, the system could become financially unsustainable.

Whether the ACO model succeeds in changing the way health care providers deliver care will depend on two key elements: financial incentives and performance requirements. If the financial incentives are not strong enough, providers will not be encouraged to change the way they deliver care. If the performance requirements are not set high enough, then quality will not improve and could even decline.

Discussion

Challenge 1: How Will ACOs Be Paid?

ACOs can be financed through a variety of mechanisms, including shared savings, shared savings and losses, partial capitation, full capitation, or some combination of these. All of these mechanisms can be part of an accountability payment structure.

■ The Shared Savings Model

Initially, the shared savings model is likely to be the most common way to pay ACOs. This is because it is a less drastic change in the way health care providers are paid. Under this model, providers will continue to be paid on a fee-for-service basis. But if the ACO lowers expenditures (generates savings), it will be able to share in a portion of the savings, say 50 percent. (See [Accountable Care Organizations: Determining Shared Savings or Losses](#) for a more complete discussion of this issue.) Because the providers continue to be paid on a fee-for-service basis, there is no financial risk to them: if they do not lower expenditures, they may not receive an incentive payment, but they also will not lose any money.

The incentive payment, in the form of shared savings, is a way to encourage providers to change the way they deliver care, providing higher-quality care at a lower cost but still benefitting financially from doing so. This has been referred to as the “evolutionary,” rather than “revolutionary,” way to change the way health care providers practice, because it moves providers to a new payment and health care delivery system slowly.³

■ The Shared Savings and Shared Losses Model

While the shared savings model has the benefit of slowly moving health care providers to a new system, thereby increasing the likelihood that they will accept the new model, it has been criticized for not doing enough to encourage providers to change their behavior.⁴ Because there is no down side for providers—they are not likely to face any financial consequences if they do not change the way they deliver care—some critics believe that the shared savings model will not be effective in generating real change.⁵ These critics advocate for an alternative payment model, such as a shared savings and shared losses model. Under this approach, providers would continue to be paid on a fee-for-service basis and would be eligible to share in savings if they lowered costs and improved quality, but if they did not lower costs and instead increased costs (generated losses), the ACO would be responsible for paying back a portion of the losses. (See [Accountable Care Organizations: Determining Shared Savings and Losses](#).) This would put the ACO at risk, which would provide a financial incentive to ensure that expenditures did not increase.

■ The Capitation Model

Another payment mechanism that could be used to pay ACOs is capitation. In this model, providers are given a set payment per patient, rather than per service. The payment would be a set dollar amount per patient, regardless of how many health care services the patient received. It would usually be a lump sum payment that would be made each month (often referred to as a per-member per-month payment). Under a **partial capitation** approach, some, but not all, of the health care expenditures would be paid on a per-patient basis, and the remainder would be paid on a fee-for-service basis. Under **full capitation**, all of the health care expenditures would be paid on a per-patient basis.

Capitated payments put providers at the greatest risk: If health care expenditures are greater than the capitated payment, the provider is responsible for the loss and cannot ask the insurer for more money. On the other hand, if expenditures are lower than the capitated payment amount, the provider keeps the entire difference.

While payment models that put providers at financial risk are more likely to induce ACOs to control spending and improve efficiencies, thereby lowering health care expenditures, these benefits may be outweighed by the multiple possibilities for harm to beneficiaries if the capitation model is poorly implemented. For example, health care providers that fail to manage risk may go out of business, which means patients would lose access to their providers.

There are many providers that are currently in a position to take on risk, but there are also many who are not. For example, a large, integrated delivery system such as Kaiser Permanente in California is likely capable of taking on risk. However, an ACO that is made up of solo or small group practices may not be in a position to do so. If an ACO takes on risk through a capitated payment model and is unable to deliver care within the capitated rate, the ACO's providers may have an incentive to deny or restrict medically appropriate care. This is particularly true if the ACO lacks the resources to deliver care in a more efficient manner by, for example, using health information technology.

Rigorous accountability measures, such as those discussed below, can mitigate the potential danger to patients. But the pressure to achieve near-term savings is likely to be even more acute in situations where the ACO is ill-prepared to bear financial risk. As a result, it's important to be cautious about payment models that require the ACO to bear risk, such as capitation. It is vital that protections be built in to ensure that providers do not take on too much risk too fast. For example, some providers may need to become ACOs with a shared savings only payment model and then slowly transition to a risk-bearing payment model, either a shared savings and shared losses model or a capitated payment model. In all cases, the ACO should be evaluated early on to ensure that it can assume risk before it does so.

Issues for Advocates

As advocates work with payers and providers in developing ACOs, there are key questions that must be answered to ensure that the proper payment structure is put in place. A payment structure that incentivizes lowering costs while improving quality of care will be the most effective way to drive change that is in the best interest of patients.

- ▶ What payment model (shared savings, shared savings and shared losses, capitation) will be used to pay the ACO?
- ▶ What is the link between the incentive payment and quality (an accountability-payment structure)?
- ▶ Is the link between the incentive payment and quality strong enough so that quality will not suffer at the expense of lowering health care costs?
- ▶ If the ACO is put at risk, are there adequate protections built in to ensure that providers do not take on too much risk? For example, if the ACO transitions from a shared savings to a shared savings and shared losses model, will there be an evaluation to ensure that the ACO can make the transition?

Challenge 2: How Are ACOs Held Accountable?

Quality improvement must be the hallmark of ACOs. The intent of ACOs is to promote accountability for the care that beneficiaries receive, and quality measurement is a key element of accountability. Without such measurement, it will be very difficult to assess the quality of care that beneficiaries receive and determine whether that care improves over time.

The Institute of Medicine defines quality as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with professional knowledge.”⁶ In other words, did the patient receive the right care at the right time in the right place? The Agency for Healthcare Research and Quality (AHRQ) groups health quality measurements into two categories: 1) health care delivery measures and 2) population health measures.⁷ Health care delivery measures evaluate the performance of doctors, hospitals, and other providers. Population health measures evaluate the performance of the health care system in a community or for groups of people overall. For example, how many children in a community receive all recommended vaccinations?

Within these broad categories are sub-categories of measurement: **process**, **outcome**, and **efficiency** measurements. A **process** measurement determines whether a specific health care service was provided to a patient consistent with clinical guidelines. For example, when a patient with symptoms of a heart attack goes to the emergency room, was he or she given an aspirin? An **outcome** measurement looks at the health status of a patient after he or she has received

health care services. For example, did the patient with diabetes have his or her blood sugar under control six months after a hospitalization? **Efficiency** measurements evaluate the relationship between the cost of care that has been provided and the quality of that care. For example, did the provider use an expensive procedure, such as an MRI, when a less expensive procedure, such as an ultrasound, would have provided equally reliable results?

Quality measurements can be collected for different purposes, including quality improvement, accountability, and/or research. In the ACO context, measurements will be collected for both accountability (determining payment levels) and quality improvement (is the care that's provided getting better over time). It is important to determine the purpose of these measurements to ensure that the proper measures are selected.

■ **Selecting Quality Measurements**

When determining which aspects of quality ACOs should be required to measure and report, it is important to keep three things in mind: 1) the importance of the measurement, 2) the scientific soundness of the measurement, and 3) the feasibility of the measurement.⁸ The measurements should be relevant to all stakeholders—patients, providers, and payers.

Quality measurement should lead to quality improvement. Therefore, results from measurements should be actionable, meaning the provider can use the results from the measurement to make changes that result in improved care. Measurements should be selected because there is evidence that there is a need for the measurement; for example, because quality is consistently low or highly variable across providers. Measuring an area in which providers consistently perform well will not help improve care.

Quality measurements should be adequate and appropriate to the particular patient population. An ACO that predominantly treats children will likely have very different measurements from one that treats an older population. The quality measurements must also be developed in a way that recognizes the current capabilities and limitations of the health care system. For example, less than half of primary care providers use an electronic medical record system, which may limit the number and types of measurements that can be collected and reported.⁹ Nonetheless, the minimum quality requirements must be set high enough to encourage meaningful change but not so high that they are unachievable.

The measurements selected should be reliable and valid, which ensures that the measurement is reproducible and that it truly measures what it is intended to measure. This is particularly important since, in the ACO context, the measurements will determine provider payment and will help inform patient decision making on which provider and ACO to use. It is also important to select measurements that have been tested and for which there is evidence of their appropriateness.

Finally, there must be a way for providers to collect the data to implement the measurement. This data can come from a variety of sources, including claims data, patient files, and surveys. But it should be data that providers and payers can readily access. As more providers implement electronic medical records and other forms of health information technology, it will be easier to collect a wide range of data for a variety of measurements.

When selecting measurements, it may be easier to achieve agreement from providers by selecting consensus measurements—measurements that have been evaluated and endorsed by respected health care organizations, such as the National Quality Forum. It's also important to build in a means to update quality measurements as clinical guidelines change over time. This may require adding or retiring measurements or modifying existing measurements. To limit the burden that data collection would place on providers, Medicare, Medicaid, and private insurers should work together to try to ensure that the requirements are consistent across payers.

For all of the quality measurements that are used, it is important that these measurements include patient and caregiver experiences of care. Measurements of patient and caregiver experiences of care include more than what would be collected by a patient satisfaction survey. Like a satisfaction survey, an experience of care survey does include ratings of the patient's doctor. But it goes further by asking the patient about other aspects of his or her experience, such as whether he or she received instructions about how to take a new medication and understood those instructions. Such measurements provide a good picture of how well ACO providers are engaging patients and their caregivers. They are also more actionable than general satisfaction ratings. If patients consistently state they did not receive care instructions or did not understand them, the health care provider can take the necessary steps to remedy that problem. Experience of care measurements also evaluate whether patients are able to get the care that they need when they need it, and whether the providers are respectful of the patients' values and preferences. All of these are important indicators of whether the ACO providers are delivering patient-centered care, which should be a central focus of ACOs.

Whatever tool is used to measure experiences of care, it should be accessible to all patients, including those with limited English proficiency. And it may be necessary to consider exactly how the survey is given to patients. Surveys can be mailed, conducted by telephone, or available online. But for some populations, none of these methods is ideal, so it may be appropriate to consider doing the survey onsite.

Quality measurements should be used not only to hold ACOs and their providers accountable for the care they deliver, but also to drive quality improvement. ACOs should be required to have a plan to use the quality measurements to improve care. This plan should explain how the measurements will be used to improve patient care, including how the ACO will work with providers that do not appear to be improving.

■ Making Quality Data Useful

In addition to linking payment to quality, ACOs can be held accountable through public reporting of quality measurements and health care expenditures. This information should be publicly reported in a standardized format and be understandable to the typical consumer. The website should also be easy to search so that patients can easily navigate the information. An example of such reporting is the Centers for Medicare and Medicaid Services (CMS) “Hospital Compare” website (<http://www.hospitalcompare.hhs.gov>). Hospital Compare allows patients to compare local hospitals based on a select set of data that hospitals voluntarily report. The measurements include process, outcome, and patient experience of care measurements, among others. Another example is CMS’s “Nursing Home Compare” website (www.medicare.gov/NHCompare). This website provides star ratings in a range of categories, including health inspections, staffing, and quality.

Using an approach similar to the Hospital Compare and Nursing Home Compare websites, which allow patients to search for local providers and compare them, will enable patients to make informed decisions about where to seek care. It will also ensure that ACOs are truly held accountable to beneficiaries. And, just as importantly, it will encourage quality improvement, since it will allow ACOs to compare themselves to other ACOs. In addition, if ACOs report data at the provider (e.g. physician or nurse practitioner) level, it will allow providers to see how they are doing compared to other providers.

While some providers have expressed concern about the burden of quality measurement and reporting, the benefit and importance of quality improvement outweigh any potential burden on providers. Only with robust quality measurement and reporting will beneficiaries, insurers, and the public be able to evaluate how ACOs are performing and be able to guard against skimping on care in pursuit of short-term savings.

A good quality measurement strategy will include a combination of process, outcome, patient experience of care, and efficiency measurements that are appropriate to the patient population and that target areas where improvement is needed. Such measurements may include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) experience of care survey, the number of patients receiving recommended preventive services (such as colorectal cancer screening and flu shots), the rate of hospital-acquired conditions (such as pressure ulcers), and the rate of hospital readmissions within 30 days of discharge.

Issues for Advocates

To ensure that ACOs are not used just as a way to lower costs, advocates will need to encourage adoption of an adequate number and type of quality measurements, including experience of care measurements. Linking the quality measurements to payment and publicly reporting the measurements will hold providers accountable to patients, payers, and the community. Key questions that advocates should ask about quality measurements include the following:

- ▶ What quality and performance measurements will the ACO measure and report on?
- ▶ Are the measurements adequate and appropriate to the ACO's patient population?
- ▶ Do the measurements include patient and caregiver experience of care measurements?
- ▶ Are the minimum quality requirements set high enough to ensure meaningful change among providers and ensure that beneficiaries receive high-quality care?
- ▶ If the ACO has contracts with other payers, is it possible to standardize the measurements across all payers?
- ▶ How will the quality measurements be used to drive improvement among ACO providers?
- ▶ How will the ACO publicly report these measurements?

Conclusion

Accountable Care Organizations must be more than a new way to pay health care providers. Instead, they must be a way to encourage providers to change the way they deliver care by improving quality, by coordinating care, and by offering patient-centered care.

If ACOs are to fulfill their potential to lower costs and improve quality, it is crucial to structure their payment models and quality measurement requirements appropriately. The focus must not be solely on lowering costs—payment models need to be structured in a way that will encourage meaningful change by health care providers. Linking any payment or financial incentive to quality measurements and performance requirements will ensure that providers are lowering health care costs through delivering improved care and not by limiting access to medically necessary care. And publicly reporting the quality measurements and cost information will provide a new level of accountability to patients, the public, and payers.

Resources

ACO Learning Network

<http://www.acolearningnetwork.org/>

Medicare Shared Savings Program Final Rule

<http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

Medicare Shared Savings Program Proposed Rule

<http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>

National Quality Measure Clearinghouse

<http://qualitymeasures.ahrq.gov/about/index.aspx>

National Quality Forum

<http://www.qualityforum.org/Home.aspx>

Endnotes

¹ Engelberg Center for Health Care Reform, The Brookings Institution, *ACO Learning Network Tool Kit* (Washington: Engelberg Center for Health Care Reform, January 2011), available online at <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>.

² The MSSP ACO is one model that advocates, providers, and payers can use when designing an ACO. It is the most clearly defined ACO model to date, with all of its requirements and parameters set out in regulation. However, there are other models in the health care market, including the Brookings Institution and Dartmouth pilots and Colorado Medicaid's Regional Care Collaborative Organizations.

³ Judy Feder and David Cutler, *Achieving Accountable and Affordable Care: Key Health Policy Choices to Move the Health Care System Forward* (Washington: Center for American Progress, December 2010), available online at <http://www.americanprogress.org/issues/2010/12/pdf/affordablecare.pdf>.

⁴ For example, see Medicare Payment Advisory Committee, *Comment on the Centers for Medicare and Medicaid Services (CMS) Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program* (Washington: MedPAC, November 2010), available online at http://www.medpac.gov/documents/11222010_ACO_COMMENT_MedPAC.pdf.

⁵ For example, see Robert A. Berenson, "Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere?," *The American Journal of Managed Care* 16, no. 10 (October 2010), available online at http://www.ajmc.com/media/pdf/AJMC_10oct_Berenson_721to726.pdf.

⁶ K. N. Lohr (Editor), Institute of Medicine, *Medicare: A Strategy for Quality Assurance, vol. 1* (Washington: National Academy Press, 1990).

⁷ Agency for Healthcare Research and Quality, *Tutorial on Quality Measures: Varieties of Measures in NQMC* (Washington: Agency for Healthcare Research and Quality, 2011), available online at <http://www.qualitymeasures.ahrq.gov/tutorial/varieties.aspx>.

⁸ Agency for Healthcare Research and Quality, *Tutorial on Quality Measures: Desirable Attributes of a Quality Measure* (Washington: Agency for Healthcare Research and Quality, 2011), available online at <http://www.qualitymeasures.ahrq.gov/tutorial/attributes.aspx>.

⁹ The Commonwealth Fund, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011* (Washington: The Commonwealth Fund, October 2011), available online at www.commonwealthfund.org.



Accountable Care Organizations: Determining Shared Savings or Losses

As discussed in the accompanying brief, [*Putting the Accountability in Accountable Care Organizations: Payment and Quality Measurements*](#), one of the central challenges to making an Accountable Care Organization (ACO) work is determining whether the ACO in fact saves money. A closely related question is how the incentive payment will be calculated. Answering these questions requires determining the following:

1. the benchmark against which expenditures will be compared,
2. the minimum savings rate,
3. the sharing or loss rate, and
4. how the benchmark will be updated.

1. Determining the Benchmark

The benchmark is what the ACO's expenditures will be compared against to determine if it has generated savings or losses. There are two different ways to calculate the benchmark: the cohort model and the historical expenditure model.

- **Cohort Model**

In the cohort model, the ACO's expenditures are compared to the expenditures of a control population that is located in the same geographic area but that does not receive its care from the ACO. For example, the ACO could be compared to other ACOs in the same region or to non-ACO providers. This is the approach that was used in the Medicare Physician Group Practice demonstration, which is often referred to as the predecessor of ACOs in Medicare.¹

This approach has the benefit of accounting for unexpected increases in utilization of health services in a given area, such as would occur with a flu outbreak or a natural disaster. However, the ACO population and control population may have very different characteristics that risk adjusting cannot adequately account for, such as socioeconomic status. Not adjusting for differences in the patient population characteristics could make it difficult for the ACO to generate savings, or it could result in the ACO sharing in savings that result from factors other than changes in the way the ACO delivered care.

- **Historical Expenditure Model**

Under the historical expenditure model, the benchmark is calculated using the ACO's historical expenditures trended forward to current year dollars. For example, in the Medicare Shared Savings Program ACO (MSSP ACO), the benchmark will be established using the ACO's previous three years of expenditures for the assigned patient population, trended forward using the national growth rate in Medicare Parts A and B.²

While this approach does not account for unexpected increases in utilization, it provides for a more fair comparison, since it compares the ACO to itself and thus mitigates concerns about differences in patient population. Any savings that are generated are more likely to reflect changes in the ACO's practice patterns.

Under either the cohort or the historical expenditure model, determining the benchmark requires establishing the following: 1) the patient population; 2) whether there will be one per-capita benchmark or benchmarks for different categories of beneficiaries or services; and 3) the appropriate adjustments to the benchmark, such as adjusting for patient characteristics or unusually high-cost claims.

- **Determining the Patient Population**

The patient population that is used for the benchmark could be the assigned patient population, a subset of the assigned population, or the entire ACO patient population. Setting the benchmark using the entire patient population has the benefit of determining how the ACO is lowering costs for all of its patients and not just the assigned population. For example, in the case of Medicare, the benchmark would include non-Medicare patients in addition to Medicare beneficiaries. On the other hand, calculating the benchmark for a subset population, for example, patients with three or more chronic conditions, could show whether the ACO is managing care and costs for high-cost patients.

A benchmark based on the assigned population must use either the patient population that would have been assigned to the ACO in the years prior to the ACO's establishment (based on historical expenditure data) or the actual population assigned to the ACO. These two approaches produce different benchmarks because, as experts have found, the patient population changes from year to year by about 25 percent as patients die, move away, or change providers.³

In the MSSP ACO, the benchmark will be determined based on the population that would have been assigned to the ACO during the three years of historical expenditure data that were used to calculate the benchmark. This approach should make the benchmark a reasonable reflection of the ACO's average patient population, and it should indicate the types and levels of expenditures that the ACO generally will have over a period of time. However, it could incentivize the ACO to avoid continuing to treat the high-risk patients that were included in the benchmark calculation in order to lower its expenditures compared to the benchmark.

By contrast, basing the benchmark on the actual assigned patient population is more reflective of the ACO's actual expenditures for the patient population treated. However, it is difficult to implement such a benchmark because it must be adjusted to reflect partial claims data for patients that join or leave the ACO during each year of the agreement period. (The agreement period for the MSSP ACO will be three years, but it can be longer or shorter for other ACOs.)

■ **Determining the Benchmark Category**

The benchmark can be calculated based on utilization (e.g., the number of inpatient hospital days), expenditures (a per-capita expenditure benchmark), or both. In addition, different benchmarks can be established for different categories of beneficiaries.

The MSSP ACO will establish spending levels for patients with end-stage renal disease (ESRD), those with disabilities, those who are dually eligible for Medicare and Medicaid, and non-dually eligible aged patients. However, in other ACOs, benchmarks could be established for categories of services, such as inpatient care, outpatient care, and advanced imaging. Having different benchmarks for different populations or types of services will help the ACO see where it is spending the most and can help target changes in care delivery in those areas by developing improvement programs for the specific service or population.

■ **Adjusting the Benchmark**

The benchmark will also need to be adjusted to reflect the characteristics of the patient population. Without risk adjustment, some ACOs may realize savings simply because they are treating a healthier population than the population that was used to determine the benchmark. It may also be appropriate to adjust the benchmark to minimize the impact of "shock claims," which are unusually high claims that are not likely to occur frequently.⁴ These claims could be excluded or capped at a certain amount or percentage. For example, the MSSP ACO will cap patient claims at approximately \$100,000.

2. Determining the Minimum Savings or Loss Rate

From one year to the next, an ACO will have different levels of expenditures. This could be the result of changes in practice patterns, or it could be due to random variation. To account for random variation, it is necessary to establish a minimum savings or loss rate. This is a percentage above which the ACO would share in savings or pay back losses. As an example, CMS has set the MSSP ACO minimum savings or loss rate of at least 2 percent. Because smaller ACOs are more likely to have random variation, CMS set the minimum savings rates for small MSSP ACOs between 2 and 3.9 percent, with the smallest MSSP ACOs having the higher minimum savings rate.

Example

If an ACO with 5,000 assigned beneficiaries (a small ACO) lowers expenditures by 6 percent during the first agreement period and meets the minimum quality requirements, it would be able to share in 2.1 percent of the savings, because it would be subject to the 3.9 percent minimum savings rate ($6 - 3.9 = 2.1$). If the same ACO lowered expenditures over the same time period by only 3.4 percent, it would not be able to share in savings, because it did not attain the minimum savings rate of 3.9 percent. On the other hand, an ACO that agrees to take on risk (by sharing in savings and losses) whose expenditures increase by 1 percent during the first year of the agreement period would be protected from paying back the difference because its losses were below the minimum loss rate of 2 percent. However, if the same ACO increased expenditures by 4 percent over the same period, it would be required to pay back a portion of those expenditures.

3. Determining the Sharing or Loss Rate

The sharing rate is the percent of the savings that the ACO will receive as an incentive payment. The loss rate is the percent of the losses that the ACO will have to repay to the insurer. Only ACOs that assume risk will have both a sharing rate and a loss rate.

The MSSP ACO will use a 50 percent sharing rate for the ACOs that are in the shared savings only model and a 60 percent sharing rate for ACOs that assume risk. The MSSP ACO loss rate will not exceed 60 percent. In both cases, the ACO's quality score determines its shared savings or loss rate. The higher the ACO's quality score, the higher the savings rate or lower the loss rate.

Example

If an ACO that is a shared savings only model generates \$100,000 in savings above the minimum savings rate and receives the maximum quality score of 100%, it would receive \$50,000 as an incentive payment ($50\% \times 100\% \times \$100,000$). However, if the ACO's quality score is 75%, the ACO would receive only \$37,500 as an incentive payment ($50\% \times 75\% \times \$100,000$).

4. Updating the Benchmark

Any benchmark will need to be updated at regular intervals. The benchmark could be updated annually or at the end of the agreement period. A predetermined flat percentage or dollar amount, general inflation, a national or regional growth rate, or some other factor can be used to update the benchmark. The MSSP ACO benchmark will be updated annually at the beginning of each year of the agreement period using the national growth rate in Medicare Parts A and B.

When updating a benchmark, it may be appropriate to take into consideration investments that an ACO makes to improve quality or efficiency, such as investments in health information technology. It may also be appropriate to update the benchmark to reflect external changes that have affected utilization or the cost of care, such as a recession or natural disaster.

Issues to Watch

▶ Upcoding

Once the benchmark is calculated, the ACO may have an incentive to change its coding practices in ways that would make the patient population appear to be sicker than it previously appeared. This is referred to as “upcoding.” This would allow the ACO to obtain a higher risk adjustment, which would make it easier for the ACO to look as if it created savings, when, in fact, nothing had changed.

More precisely identifying patients’ diagnoses and needs is not a bad thing, of course. A more thorough and accurate diagnosis and description of the patient’s health helps ensure that the patient receives the care that he or she needs. Nonetheless, ACOs should be monitored for this potential problem to ensure that the ACO providers are in fact better identifying patients’ needs and changing the way they deliver care, rather than simply coding claims to increase payment.

▶ Cherrypicking

ACOs may also have an incentive to either get rid of sick patients or to not accept new sick patients and instead pursue relatively healthy patients, a practice that is known as cherrypicking, in an attempt to lower expenditures compared to the benchmark. Because the sickest patients stand to benefit the most from integrated, coordinated care, it is important that these people not be excluded from ACOs. An ACO’s patient population should be monitored over the course of the agreement period, and drastic changes in the population should be investigated to determine if the ACO is engaging in cherrypicking.

▶ Withholding Medically Necessary Care

It’s also important to monitor the care that is delivered by ACO providers to ensure that patients receive the care they need when they need it in the most appropriate setting. ACOs have an incentive to withhold care in an attempt to lower their expenditures from year to year. This may be particularly true if the benchmark is established by service category. For example, if the ACO has a benchmark for inpatient care, it may try to limit the number of inpatient stays, despite the fact that it may be medically necessary for the patients.

Rigorous monitoring of quality and accountability standards, as discussed in the accompanying brief, [*Putting the Accountability in Accountable Care Organizations: Payment and Quality Measurements*](#), is essential to avoiding all of the problems described here.

Endnotes

¹ Centers for Medicare and Medicaid Services, *Medicare Physician Group Practice Demonstration Fact Sheet* (Washington: CMS, July 2011), available online at https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf.

² Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program Final Rule* (Washington: CMS, October 2011), available online at <http://www.federalregister.gov/articles/2011/11/02/2011-27461/medicare-program-medicare-shared-savings-program-accountable-care-organizations>.

³ Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program Proposed Rule* (Washington: CMS, April 2011), p. 19,605, available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>.

⁴ Engelberg Center for Health Care Reform, The Brookings Institution, *ACO Learning Network Tool Kit* (Washington: Engelberg Center for Health Care Reform, January 2011), available online at <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>.



Designing Consumer-Friendly Beneficiary Assignment and Notification Processes for Accountable Care Organizations

Introduction: What Is Beneficiary Assignment?

An Accountable Care Organization is an entity that is made up of health care providers from across the continuum of care (acute care, post-acute care, long-term care, and behavioral and mental health care) that agrees to be held accountable for improving the health of their patients while also lowering the cost of care. ACOs are intended to better coordinate patient care and to engage patients so that they are active participants in their own health care.¹

To determine whether ACOs are improving quality and lowering costs, both the ACO and its payers (whether Medicare, Medicaid, or private insurers) must know which patients the ACO is accountable for. The process that is used to determine which patients an ACO is accountable for is often referred to as “assignment” or “attribution.”

Designing an assignment process that is transparent and easy for beneficiaries to understand is one of the major challenges in developing ACOs. ACOs can succeed only if beneficiaries see them as improving their health care experience. Using a transparent assignment process and providing beneficiaries with adequate notice that they have been assigned to an ACO are important to ensuring patient buy-in and engagement with ACOs and ACO providers.

Advocates have an important role to play in ensuring that ACOs are designed in ways that meet the needs of patients and the community. This brief discusses the challenges advocates will face when developing beneficiary-friendly assignment processes, and it recommends including certain notice requirements and beneficiary protections.

Challenge 1: How Will Beneficiaries Be Assigned to an ACO?

There are two common approaches that will be used to assign patients to ACOs: Beneficiaries can be automatically assigned to an ACO, or they can actively select an ACO. However, ACOs and insurers can design alternative approaches as well.

■ Automatic Assignment

Under this approach, beneficiaries do not select an ACO. Instead, the payer assigns the beneficiary to an ACO. Ideally, the insurer would make the assignment based on where the beneficiary already receives his or her care as determined by claims data. But it is possible that insurers could make assignments based on other criteria, such as which ACO has providers that are accepting patients.

Under the Medicare Shared Savings Program Accountable Care Organization (MSSP ACO), beneficiaries will be automatically assigned based on where they receive their primary care.² For example, if Ms. Smith receives most of her primary care from Dr. Jones, who is part of a MSSP ACO, then the Centers for Medicare and Medicaid Services (CMS) will assign Ms. Smith to that ACO. (CMS would use claims data to determine where Ms. Smith receives her primary care.)

For ACOs that decide to use automatic assignment, it will be necessary to determine which providers will be used to make assignment decisions. ACOs should be built on a foundation of primary care, because primary care providers usually deliver the most care to patients; have ongoing, long-term relationships with patients; and are central to care coordination. As a result, it makes sense to assign patients to ACOs based on who their primary care providers are. In some cases it may be appropriate to limit assignment to primary care physicians only; for example, if the ACO does not include any non-physician providers. In other cases, it may be appropriate to define primary care providers more broadly to include providers other than physicians. For example, in some areas, nurse practitioners and physician assistants provide most of the primary care to patients. This may be especially true in rural areas or at safety net facilities, like federally qualified health centers. But some patients may get their primary care from specialists. Therefore, depending on the patient population and the makeup of ACO providers, it may be appropriate to also make assignment based on certain specialties, such as oncologists and cardiologists, who also have ongoing, long-term relationships with patients and who provide primary care to their patients

Originally, CMS proposed to use only services that are provided by primary care physicians to make assignment determinations. However, in its final MSSP ACO rule, CMS acknowledged that some patients get most of their primary care from specialists or non-physician providers such as physician assistants. As a result, it decided to use a step-wise approach to assignment. Under this approach, CMS will first look at claims data to determine whether the beneficiary

received primary care services from a primary care physician. If so, the beneficiary will be assigned to the ACO that the primary care physician belongs to. If the beneficiary did not receive primary care services from a primary care physician, CMS will determine whether a specialist or a non-physician provider delivered primary care to the beneficiary. If so, the beneficiary will be assigned to the ACO that that provider belongs to.

The MSSP ACO model is an open system: Beneficiaries can still see any provider who accepts Medicare, even those outside the ACO. Under other ACO models, however, insurers could require patients to see only ACO providers, similar to a closed network in an HMO. This restriction could interfere with existing relationships with non-ACO providers and could interrupt ongoing treatment. It could also cause problems with getting patient buy-in if the patient feels that his or her access to providers or medical care is being restricted.

If ACOs use this approach, it is important to build in beneficiary protections to try to eliminate these potential problems. One important protection in a closed model is an easy-to-use opt-out option. For example, beneficiaries should be able to call the insurer's customer service department and request to opt out. Requiring beneficiaries to complete specific forms and then mail the forms to the payer or ACO creates an unnecessary level of complexity that may prevent some beneficiaries from using the opt-out process.

If the insurer does not provide an opt-out process, it is important to have strong care transition protections in place. For example, if a beneficiary is undergoing a course of treatment with a provider who is not part of the ACO, it will be necessary to ensure that this course of treatment is not interrupted. Ideally, the patient should be permitted to continue seeing that provider. At a minimum, the beneficiary should be permitted to finish the course of treatment with his or her current provider.

■ **Beneficiary Selection**

Some ACOs may allow beneficiaries to enroll in the ACOs that the beneficiaries themselves choose rather than using an assignment process. In this case, the enrollment process would likely be similar to the process used when a beneficiary selects a health insurance plan or a primary care provider in an HMO. If such an approach is used, beneficiaries will need to have adequate information to make informed decisions. Insurers should provide beneficiaries with information about which providers are part of the ACO, the ACO's quality ratings, the number and types of complaints or grievances filed against the ACO (if any), the cost-sharing enrollees would pay for services from ACO providers, whether beneficiaries would be required to see only ACO providers, and any other information that will help beneficiaries make the best decisions based on their circumstances and health care needs. This information should be presented in a standardized format that is easy to understand.

Issues for Advocates

- ▶ Does the ACO meet the provider and care needs of the patient population?
- ▶ Will assignment be automatic, or will beneficiaries have to enroll in an ACO?
- ▶ If the insurer assigns beneficiaries to the ACO, will the insurer use claims data to make the assignment?
- ▶ Will beneficiaries be locked into a specific ACO, or will beneficiaries maintain freedom of choice of provider?
- ▶ Will beneficiaries have access to an opt-out process? Is the opt-out process easy to use?
- ▶ If necessary, will there be adequate care transition protections?
- ▶ Which providers will be used to make assignment decisions?
- ▶ If beneficiaries must enroll in an ACO, what information will be provided to help them make an informed decision? How will that information be made available to beneficiaries?

Challenge 2:

Will Assignment Be Retrospective or Prospective?

Assignment to an ACO can be either prospective or retrospective. Under prospective assignment, the patient population is assigned to the ACO at the beginning of the performance period. With retrospective assignment, patients are assigned at the end of the performance period. The performance period is usually the length of time, most likely one year, over which an ACO will be evaluated for quality and costs.

Each approach has advantages and disadvantages. Using retrospective assignment will help ensure that the ACO provides all of its patients with patient-centered, coordinated care, instead of just the assigned population. This is because the ACO will not know which patients are assigned to the ACO until the end of the performance period. Therefore, the ACO will need to manage costs and quality for all of its patients. However, delivering patient-centered, coordinated care will likely require a significant investment both in technology and personnel, and the more patients receive health care services, the greater the investment. Some providers object to retrospective assignment because they will not be able to target services to a select group of patients; for example, the highest-cost patients with the greatest needs, who will likely generate the biggest return on investment.

Prospective assignment, on the other hand, will allow the ACO to know its patient population in advance, which will enable it to design care models that are in the best interest of that specific population. This approach would give the ACO and its providers the ability to target limited resources in the most effective way.

A retrospective approach would provide certainty as to the ACO's expenditures and savings or losses because it would hold the ACO accountable only for the patients seen during the performance period. A prospective approach would likely result in at least some patients being assigned to an ACO who never receive any care from an ACO provider during the performance period. To address this problem, the payer may need to use a reconciliation process at the end of the performance period to determine the exact patient population, which will add an extra layer of administrative complexity and expense.

Prospective assignment makes giving beneficiaries notice of how they've been assigned easier for the ACO and the insurer, since notice can be directed to the patients who the ACO knows are assigned to the ACO. Giving advance notice to beneficiaries is still possible under retrospective assignment, but some beneficiaries who are not ultimately assigned to the ACO may receive this notice, which could be confusing.

CMS originally proposed using retrospective assignment for beneficiaries in the MSSP ACO.³ But in response to the strong concerns expressed by providers, CMS adopted prospective assignment with a reconciliation process in its final MSSP ACO rule. Under this procedure, CMS will preliminarily assign beneficiaries to an ACO prospectively. The ACO will be notified about who these patients are at the beginning of the performance year. This list will let the ACO know which patients are likely to ultimately be assigned to it. CMS will update this list quarterly. At the end of the year, CMS will perform reconciliation, determine which patients meet the criteria for assignment, and officially assign that population to the ACO. This means that the ACO will have a pretty good idea at the beginning of the performance year of which patients it will be held accountable for. However, the final assignment—the actual patients for whom the ACO will be held accountable—will be determined at the end of the performance year.

Advocates should work to ensure that the decisions ACOs make regarding whether to use prospective or retrospective assignment are based on assessing which approach will provide the greatest benefit to enrollees. Retrospective assignment will benefit the most patients, since the ACO will likely provide patient-centered, coordinated care to all of its patients. It is also likely to be easier to administer, since they won't need to perform reconciliation at the end of the performance period when determining the ACO's expenditures.

It is important to note that this decision must also take into account the existing health care system, its capacities, and its limitations. For example, if retrospective assignment would prevent providers from forming ACOs because the up-front investment is too much, it may be best to pursue prospective assignment, as is being done with the MSSP ACO. This will help move the health care system toward better-coordinated, lower-cost care, which will improve care for the assigned beneficiaries (at minimum). However, if a particular health care system is already highly integrated and uses sophisticated health information technology, retrospective assignment may be the better approach, because it will require the ACO to deliver the same high-quality care to all of its patients, not just the assigned population.

Issues for Advocates

- ▶ Which approach would provide the greatest benefit to enrollees?
- ▶ Which approach would work best given the existing health care system in the area?

Challenge 3:

How Will Beneficiaries Be Notified that They Have Been Assigned to an ACO?

ACOs are a model of health care delivery that is designed to put the patient at the center of all its activities and to ensure coordination of care. To meet this goal, patient trust and engagement will be vital. An open and transparent process that includes providing meaningful notice to beneficiaries from the outset is among the best ways to build that trust and begin the process of engaging patients in their care.

In the MSSP ACO, CMS will require providers to use a standardized written notice at the point of care (for example, in the doctor's office) to inform beneficiaries that they are participating in an ACO and to post signs notifying beneficiaries that they are part of an ACO. ACOs also have the option of (but are not required to) notifying beneficiaries in advance that their provider is part of an ACO. CMS will develop educational materials for beneficiaries but will not send a separate notice telling them that they have been assigned to an ACO.

Unfortunately, the process that CMS adopted is not as transparent as it could have been. A better approach would be to provide beneficiaries with two notices: The first would come from their provider explaining that the provider is part of an ACO. The second would come from the insurer explaining that the beneficiary has been assigned to an ACO. The notice from the provider would be made in writing prior to the beneficiary's first appointment with the ACO provider. This advance notice will provide a meaningful first step in the process of patient engagement. Providing notice prior to the point of service will give the patient time to read it carefully and contact the provider with any questions. Waiting to provide notice until the patient is at the point of service will not allow the patient adequate time to read and understand the notice, nor will he or she likely have the time to ask any questions. Providing advance notice can also give the patient information about how to prepare for his or her next appointment, including preparing a list of all medications and health care providers.

Any assignment notice should explain that the beneficiary's provider is a member of an ACO and should clearly explain what this means for the beneficiary. It should include an explanation of beneficiary rights and responsibilities (including the right to see providers outside of the ACO and where to file complaints or grievances), what changes to expect in their care, how they will benefit, the provider's responsibilities and financial incentives, and where they can call to ask questions and get more information. To help build the relationship between the patient and the provider and begin the process of patient engagement, this notice should be made by the provider rather than the insurer.

In addition, at the time that the insurer assigns a beneficiary to an ACO, the insurer should notify the beneficiary in writing of the assignment. The notice should include many of the same elements described above, but it should also include, if appropriate, whether he or she can opt out, and, if so, how and where to do so.

All notices should be written at an appropriate literacy level for the patient population and should be in the beneficiary's primary language. If it is not possible to provide notice in the beneficiary's primary language, the ACO and insurer should provide oral translation using appropriately trained staff or language access services.

Issues for Advocates

- ▶ When will beneficiaries receive notice that their health care provider is a member of an ACO?
- ▶ When will beneficiaries receive notice that they have been assigned to an ACO?
- ▶ What information will be included in the notice?
- ▶ Are the notices written in a way that beneficiaries will understand (in terms of literacy level and language)?

Conclusion

Creating transparency in ACO assignment and notification processes is key to beneficiary buy-in and engagement. Beneficiaries are often wary of change, and if they feel they have been placed into a system not of their choosing and without their permission, they may reject the new system outright.

To avoid these potential problems, policy makers and advocates must work to ensure that beneficiaries and their needs are the focus as ACOs are designed. Designing an open and transparent assignment process with meaningful notice requirements is necessary if ACOs are going to meet their goal of improving care and lowering costs by delivering patient-centered, coordinated care. Advocates have an essential role to play in making sure that the assignment and notification processes meet the needs of patients.

¹ For more information, see Michealle Gady and Marc Steinberg, *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know* (Washington: Families USA, September 2011), available online at <http://familiesusa2.org/assets/pdfs/health-reform/ACO-Basics.pdf>.

² Centers for Medicare and Medicaid Services, "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, CMS-1345-F," *Federal Register* 76, no. 212 (November 2, 2011), available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>.

³ Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program Proposed Rule* (Washington: CMS, April 2011), available online at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>.

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