



Expanding the ACO Concept to Encourage Innovation, Accountability and High Performance and the Value Health Plans Bring to Delivery System Transformation

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BACKGROUND

There is strong support among stakeholders to modernize the delivery and payment system to promote safer, more effective, and more patient-centered care. Incentives in the current fee-for-service reimbursement system have resulted in fragmented, uncoordinated care delivery and have led to significant overuse and waste as they generally reward the number and intensity of services, rather than appropriateness, quality, or cost-effectiveness. Additionally, providers often do not have the tools necessary to enable them to consistently deliver high quality care to patients, while patients do not have the information they need to better manage their health and better partner with clinicians to improve outcomes. The overwhelming consensus that has emerged is that delivery and payment reform are needed to better coordinate patient care across time and settings, and better promote accountability across all stakeholders. Without such reform, patients will continue to receive silo-based care that varies across the country and, in many cases, is not based on the best scientific evidence available.

Creating Accountable Care Organizations

Both the public and private sectors are exploring and implementing innovative care and payment models designed to improve delivery of care and encourage Americans to stay healthy. Among the models receiving increased attention is the concept of Accountable Care

Organizations (ACOs), often defined as organizations of health care providers that agree to be held accountable for the quality, cost and overall care for a defined population of patients and that seek to receive shared savings if they meet certain quality and costs goals.¹ The requirement of meeting quality of care thresholds before any distribution of incentive payments distinguishes ACOs from other payment models.

The Patient Protection and Affordable Care Act (ACA) establishes two ACO programs. Sections 3022 and 10307 direct the Secretary of the U.S. Department of Health and Human Services (HHS) to establish the Medicare Shared Savings Program. This program would allow groups of providers meeting certain criteria to work together to manage and coordinate care (hospital and physician services) for Medicare fee-for-service beneficiaries. As defined by forthcoming rulemaking,² ACOs that meet certain quality standards would be eligible to receive payments based on shared savings. Entities that can participate in the program include group practices, networks of individual practices, partnerships or joint ventures, hospitals employing professionals and “other entities determined

¹ Organizations define ACOs in different ways. For example, the Robert Wood Johnson Foundation defines an ACO as a network of doctors and hospitals who are together responsible for providing high-quality care to patients. The Urban Institute defines an ACO as a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population.

² CMS has indicated that it will provide more program details in a Notice of Proposed Rulemaking to be released this fall. See <http://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf>.

by the Secretary.” The Secretary may give preference to ACOs that are participating in similar arrangements with private payers.³

The ACA provisions – along with a growing number of pilots and collaborative efforts, and extensive commentary and numerous conferences on the subject – have resulted in ACOs receiving increased attention in policy and delivery system communities. ACOs are attractive to many entities that see them as mechanisms to enhance quality of care for consumers, improve patient experience, and address rising costs through their emphasis on performance measurement, aligned incentives, delivery system redesign, and accountability for care provided.

At the same time, recent reports and policy experts have raised concerns that increased levels of provider affiliation that will result as more providers join ACOs could have the unintended consequence of reducing competition and increasing costs for consumers.⁴ Questions also have been raised about the extent to which providers are equipped to assume the levels of financial and operational risk likely to exist under some ACO models. These issues as well as others relating to the operation of ACOs need to be fully considered and addressed to protect consumers and ensure that intended goals will be met.

Achieving the Promise of Accountable Care

As new models are designed and implemented, physicians, hospitals, health plans, employers and consumers will need to work together to take advantage of opportunities as well as address challenges. These stakeholders also will need to work closely with HHS which is faced with developing regulations that are aimed at promoting accountability for patient

populations and encouraging investments for high quality and efficient service delivery.

To best meet this nation’s goals, we recommend that regulators take three key steps:

- ▶ **Present a regulatory framework that encourages a range of delivery models and builds on existing collaborations and innovation;**
- ▶ **Weigh key issues to ensure that intended quality and cost goals are met; and**
- ▶ **Establish requirements that increase the likelihood of an ACO’s success.**

The remainder of this paper addresses each of these items. The first section provides an overview of different structural models that can, if implemented appropriately, help achieve quality and cost goals, and improve patient experience. The second section identifies key issues that need to be addressed as models are designed and implemented. The third section outlines requirements that ACOs should meet to help ensure the success of ACOs. A final section of the paper provides a high-level summary of how health plans can assist stakeholders in transforming the system into one that is more accountable and patient-centric.

PRESENTING A REGULATORY FRAMEWORK THAT ENCOURAGES A RANGE OF DELIVERY MODELS AND BUILDS ON EXISTING COLLABORATIONS AND INNOVATION

As HHS implements the Medicare Shared Savings Program, it should encourage a range of different delivery models that have preliminarily demonstrated effectiveness and efficiency,⁵ and build on existing collaborations and innovation. A one-size-fits-all approach to delivery and payment reform is not likely to result in any long-term success for a number of reasons. Models need to vary based on a variety of

³ In addition to the Medicare Shared Savings Program, Section 2706 of ACA directs the Secretary to establish a pediatric ACO demonstration project. The demonstration would authorize participating states to allow pediatric medical providers that meet specified requirements to be recognized as an ACO and receive incentive payments.

⁴ Berenson, Ginsburg and Kemper. “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform.” *Health Affairs* 29, No. 4 (2010); MacGillis, Alec, “Are bigger health-care networks better or just creating a monopoly?,” *The Washington Post*, August 16, 2010; Robert Wood Johnson Foundation. *Health Policy Brief: Accountable Care Organizations.* *Health Affairs* (July 27, 2010), www.healthaffairs.org/healthpolicybriefs. See also McClellan, M. et al., *A National Strategy to Put Accountable Care Into Practice.* *Health Affairs* 20, No. 5 (2010).

⁵ The value of exploring many different models is supported by ACA, particularly through the establishment of the Center for Medicare and Medicaid Innovation. This Center is designed to test models that promote care coordination and feature risk-based comprehensive payments, rather than traditional fee-for-service based reimbursement. ACA, Section 3021.

factors, including provider readiness and the diversity of communities. Additionally, the scope, structure and processes of models should evolve over time as needs, technology, sites of service and clinical approaches change and more is learned about current programs' effectiveness in engaging patients and providers, and improving outcomes.

Models that involve different types of providers assuming different degrees of risk should be considered and explored. These models may include fully integrated structures, such as integrated health systems. Under this approach, a single entity employs all or part of its providers, which typically include hospital systems, primary care and specialty physicians, community health centers, specialty facilities and other health-related entities.

They also may include ACOs formed by providers which are not part of an integrated health system via contractual relationships (e.g., virtual ACOs). This mechanism can allow participating providers to achieve certain levels of vertical as well as horizontal integration with the goal of promoting shared accountability among all participating providers. Providers participating in these types of models could include physician hospital organizations (PHOs), or physician group practices or IPAs that include physicians of a single specialty (e.g., primary care) or multiple specialties.

Other models which regulators may not be as familiar with, but nevertheless should encourage, are those formed by or in partnership with health plans. Health plans already have significant experience testing various delivery and payment reform models. Thus, partnering with such plans will help ease transitions and may minimize initial and ongoing burdens relating to the administration and operation of an ACO. Health plan models that HHS should consider include delivery systems that are owned and supported by health plans as well as ACOs formed by providers in partnership with

health plans that have “high performance networks”.⁶ Providers participating in health plan high performance networks have agreed to measurement and public reporting on performance, assessment of resource use, referrals to other high performing providers, and the exchange of health information with the plan and other providers caring for the same patient. In identifying high quality providers, health plans utilize board certification and more recently, maintenance of certification, practice improvement models, and designations of Centers of Excellence. These plans also offer technical assistance to providers in organizing care, share data analytics, and provide physicians with other decision support tools and ongoing feedback on performance compared to peer groups.

Finally, regulators should encourage alternative approaches that may be effective when providers are not equipped to assume high levels of risk. One possibility is a model that utilizes the following combination of structures/payment arrangements to promote shared accountability and improve outcomes: (1) low intensity, longitudinal care could be managed through a Patient Centered Medical Home (PCMH)⁷ with payment for services on a monthly basis; (2) episodic or emergency response services could be paid on a fee-for-service basis, with cost sharing for patients; and (3) clinical interventions involving hospitalizations and outpatient services could be paid using a global payment.

Individual providers could choose to participate in one or more components of this hybrid approach, or none at all. This type of approach could avoid putting providers at risk for quality and costs associated with patients' care that are beyond their control, but at the same time, still

⁶ High performance networks encourage enrollees to choose network physicians who meet certain quality and efficiency measures. While they differ across health plans, a common model uses tiered-provider levels. For example, the first tier may consist of the high-performing providers; the second tier may consist of the remainder of in-network providers; and the third tier may consist of out-of-network providers. A higher cost sharing level will apply if a patient sees a doctor in the third tier. In some cases, different cost sharing levels may apply for all three tiers.

⁷ PCMHs often concentrate on primary care practice structures (e.g., disease registries, decision support tools, non-traditional methods of communication, such as email, and e-prescribing, EHRs) and process improvements (e.g., referral tracking and same day appointments) that address the needs of individual patients and facilitate their ongoing relationships with their primary care physician. While PCMHs often address the delivery of primary care, they also can focus on managing the care of patients with chronic diseases, such as cancer, diabetes or congestive heart failure. Retaining the same goals of comprehensive, coordinated and accountable care as a primary care PCMH, a specialty or chronic care PCMH (e.g., for oncology care) could encourage appropriate case and disease management, including patient adherence with treatment protocols, and provide incentives to specialty physicians who meet metrics established by their respective medical societies.

hold participants accountable for certain care and costs which are more predictable and easier to manage.

WEIGHING KEY ISSUES TO ENSURE THAT INTENDED QUALITY AND COST GOALS ARE MET

From an operational Standpoint, ACOs, regardless of the structure, need to address numerous issues to be beneficial and effective. Three of the key issues are:

► **Appropriate Assumption of Risk by Providers.**

ACOs can be implemented using various payment arrangements that allow providers to assume differing levels of financial risk.⁸ They generally range from fee-for-service (FFS) with bonuses/shared savings (where no risk is assumed) to full capitation (where all risk is assumed). It is critical that before implementing any of these payment arrangements, ACOs consider the possible implications. For example, a FFS model is likely to provide fewer incentives for providers to eliminate fragmented care, and reduce overuse and misuse of care in the system. While a FFS model may be appropriate in the initial stages of a model's development, payment arrangements that better align incentives would be more effective at eliminating the delivery of fragmented care, and reducing overuse and misuse, as well as waste in the system.

Additionally, based on lessons learned from previous experiences where some physicians were not equipped to handle financial risk and allocation, full capitation arrangements may in some cases result in higher costs for consumers, or adversely impact the financial

security of consumers and businesses. At a minimum, any provider or provider group assuming financial risk should have appropriate levels of experience in performing this function and be subject to certain requirements (e.g., solvency requirements commensurate with the level of risk assumed) that are intended to ensure financial stability. It also is critical that all stakeholders consider alternatives to full capitation arrangements that recognize the limited capacities of some providers to bear and manage risk.

► **Legal Issues Relating to Provider Integration.**

ACOs, by design, involve the participation of multiple providers. Many different types and sizes of providers may participate in ACOs, including large hospital and health systems as well as smaller, independent providers that historically have not been part of large integrated delivery systems. The result may be unprecedented levels of affiliation by providers that could result in increased costs and less provider choice for consumers, as formerly competing providers now engage in joint contracting and pricing through their ACO.⁹

Through workshops, advisory opinions, and speeches, the antitrust enforcement agencies, the Federal Trade Commission (FTC) and Department of Justice (DOJ), have indicated that issues relating to provider clinical integration are high on their priority list.¹⁰ The agencies must remain vigilant in their enforcement of existing law to ensure that such consolidation does not reduce market competition, resulting in higher prices or other consumer harm. The FTC and DOJ also should consider whether they have sufficient investigatory tools and access to price and quality data to identify and evaluate whether particular ACOs may be harming consumers.

Aside from general issues of provider market

⁸These arrangements include:

- **FFS with bonus/shared savings.** Providers would receive payments on a per service basis, and would receive bonus payments for meeting certain metrics. Under this arrangement, providers assume no financial risk.
- **Bundled payments.** A single prospective payment for all providers – including hospitals, physicians and other clinicians – involved in the management of a patient's condition (e.g., coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma). This type of payment arrangement may also be beneficial for cases involving the provision of specialty services (e.g., radiology/imaging services, specialty pharmacy). Under this arrangement, providers share some degree of risk.
- **Global/episode payment.** An all-inclusive payment for a defined set of services, regardless of how much care is actually provided. This approach may be beneficial for procedures and conditions that have a relatively clear beginning and end, or in which an episode can be defined relatively easily (e.g., prenatal care, procedures such as coronary artery bypass surgery, spine surgery or hip replacement). Under this arrangement, providers share risk some degree of risk.
- **Partial capitation.** Providers would receive a percentage of their payments on a fee-for-service basis and the remaining payments through capitation. Under this arrangement, providers share some degree of risk.
- **Full capitation.** Providers receive a fixed payment for each patient, and the payment does not vary with the quantity or intensity of medical services provided. Under this arrangement, providers assume all risk.

⁹Berenson, Ginsburg and Kemper. Unchecked Provider Clout in California Foreshadows Challenges to Health Reform. *Health Affairs* 29, No. 4 (2010); MacGillis, Alec, "Are bigger health-care networks better or just creating a monopoly?," *The Washington Post*, August 16, 2010; Robert Wood Johnson Foundation. Health Policy Brief: Accountable Care Organizations. *Health Affairs* (July 27, 2010), www.healthaffairs.org/healthpolicybriefs. See also McClellan, M. et al., A National Strategy to Put Accountable Care Into Practice. *Health Affairs* 20, No. 5 (2010).

¹⁰For example, in a recent speech, Christine Varney, the DOJ Antitrust Division chief indicated that "antitrust is not an impediment to legitimate clinical integration," and noted that it was working with the FTC to streamline and make more transparent review of such integrated provider networks. Christine A. Varney, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, "Antitrust and Healthcare," Remarks Prepared for the ABA/AHLA Antitrust in Healthcare Conference, Arlington, VA, May 24, 2010.

consolidation, each individual ACO has the possibility of generating benefit or harm to consumers. The FTC and DOJ have addressed this possibility by requiring that providers joining together deliver benefits to consumers through financial or clinical integration. One issue that the agencies may seek to address relates to providers' abilities to treat patients outside of an ACO. "Non-exclusivity" (i.e., the ability to treat patients other than through the ACO) has been a factor in previous agency decisions that particular provider joint ventures are likely to be pro-competitive. The FTC and DOJ should consider when, and under what circumstances, an ACO that requires exclusive participation by its providers will be pro-competitive.

Finally, in addition to the antitrust issues, ACOs will need to fully explore and address the issues raised by the Stark law, the federal Anti-kickback statute, as well as state fraud and abuse laws, among others.

► **Patient choice of providers and accountability for care provided outside an ACO.** Questions have been raised about whether an ACO should be held accountable for any patient's care provided outside of the ACO. Given that many ACOs include most clinical services necessary for coordinated and comprehensive care, including highly specialized care, and that many health plans – which ACOs may choose to partner with – have broad networks, Centers of Excellence and/or national network contracts, ACOs should be held accountable for all care, and for the total costs of all care, provided to their patients.

When appropriate care is not available within the ACO network, patients should have the ability to choose a provider who does not participate in the ACO. Even under these circumstances, ACOs and participating providers should still be held accountable for this care. While it may be challenging for ACOs to effectively influence patient care provided outside the ACO network, doing otherwise would defeat the key goals of ACOs which are focused on comprehensive, patient-centered care.

For full accountability to work operationally, ACOs and participating providers should agree upfront on the methodology for assigning and attributing patients to providers.¹¹ To discourage patients from seeking care outside of an ACO, ACOs could consider developing incentives, such as additional or enhanced services, targeted programs, or lower cost-sharing. Positive patient experience of care also can help ensure that patients do not seek services outside the ACO.

ESTABLISHING REQUIREMENTS THAT INCREASE THE LIKELIHOOD OF AN ACO'S SUCCESS

To best ensure high quality and efficient care delivery, HHS should establish key requirements that ACOs should meet. These requirements are below.

► **Encourage performance that addresses the elements of the "Triple Aim" approach.** The Triple Aim approach, developed by the Institute for Healthcare Improvement, focuses on the following three elements: improved population health, improved patient experience and lower per-capita costs. Addressing these elements, which are consistent with the six dimensions of quality care outlined by the Institute of Medicine (safe, effective, patient-centered, timely, efficient, equitable), will help ensure that patients receive high quality, affordable care, and move the system away from single-service care to more comprehensive care models.

► **Promote patient-centeredness.** According to the Agency for Healthcare Research and Quality, patient-centered approaches to care have been shown to improve patients' health status, lessen patients' symptom burdens, encourage patients to comply with treatment regimens, and reduce the chance of misdiagnosis due to poor communication. Thus, tools that support patient decision-making and consumer education should be promoted to facilitate

¹¹ Attribution refers to the assignment of responsibility for provision of specific health care services and related patient outcomes for a patient to providers. A number of factors should be considered in selecting an approach to patient attribution, including that the approach: (1) is conceptually valid; (2) is feasible; (3) is robust in applications supporting physician measurement; (4) is flexible; and (5) weighs various trade-offs.

self management of health and resources, and improve patients' experiences as they move across the continuum of care.

- ▶ **Emphasize the foundational importance of effective primary care.** As noted previously, patients often receive fragmented, uncoordinated patient care under the current system. Thus, a key focus of any delivery and payment reform model should be to support activities that promote effective primary care, including care coordination, case management, disease prevention and wellness programs. Such activities can delay or prevent the onset of diseases, allow providers to diagnose and treat patients before a disease becomes more serious, and reduce redundant and ineffective care services. Implementing ACOs or other models in conjunction with Patient Centered Medical Homes (either primary care or chronic care based) may be an effective way to support these activities.¹²

While it is important that ACOs recognize the importance of primary care, they, at the same time, should promote appropriate access to and utilization of specialty care. This will help ensure that their networks have an appropriate balance and mix of providers to meet individual patient needs across the health care continuum.

- ▶ **Demonstrate existing infrastructures to produce improvements in population health as well as individual patient outcomes.** Many stakeholders do not have the ability to track clinical information that can be used to improve patient outcomes. ACOs should have advanced health information technology and systems (e.g., through health plans/payers which can provide a 360 degree view of longitudinal care) to improve the health of all individuals. For individuals who do not routinely access the system, ACOs should have the ability to reduce morbidities and health complications by assessing patient risks and developing appropriate care based on those risks. ACOs also should have data that will enable providers within the ACO network to assess missed opportunities to improve care.

For those individuals with acute or chronic conditions, ACOs should have the ability to coordinate care for those patients across different settings and different providers. This would include having the infrastructure in place to allow for the exchange of health information across providers. Additionally, ACOs should have the ability to collect, analyze and report, on an ongoing basis, information on patient outcomes across populations and provider performance to allow for the identification of best practices, and underuse or potential gaps in care.

Finally, ACOs should have the resources and infrastructures necessary to systematically re-design care processes and clinical practice areas to enhance effectiveness and efficiency in a constantly changing environment.

- ▶ **Demonstrate fiscal responsibility through risk management and appropriate risk allocation.** ACOs can allocate financial risk to providers or to other participants, such as health plans. Some providers may not be fully equipped to handle financial risk and allocation. Full assumption of risk by providers may be more likely to adversely impact the financial security of consumers and businesses. If providers decide to assume/share financial risk, they should have to demonstrate that they have the skills, experience and resources necessary to successfully perform risk management activities. They also should be subject to solvency and other requirements (e.g., requirements which health plans are required to meet at the state level), commensurate with the level of risk assumed, to ensure financial stability. If necessary, ACOs should consider the need for stop loss insurance.
- ▶ **Provide flexibility in structure and process.** ACOs should have the ability to make structural and process adjustments as they become more established. For example, an ACO which allows providers to share savings within a fee-for-service arrangement may eventually want to move to an alternative payment arrangement in which providers take on some financial risk for poor quality results; this type of arrangement

¹² PCMHs should be considered as a process improvement tool within the confines of the ACO, subject to its own payment arrangements/incentives.

better aligns incentives and is likely to be more effective at eliminating the delivery of fragmented care, and reduce overuse and misuse as well as waste in the system. This flexibility will be critical given that ACOs may want to make adjustments for a number of reasons, including: ACO operations are not meeting intended goals; an ACO's needs change; technology, sites of service and clinical approaches evolve; and lessons are learned as other ACOs are tested and evaluated.

► **Establish clear standards for accountability.**

Providers participating in ACOs and other similar models should have a clear understanding of the standards under which they will be held accountable. This will better ensure that an ACO and all of its participants are working together to achieve the same quality and cost goals. Measures that should be used to assess physician performance and be the basis for holding ACOs and participating physicians accountable should include evidence-based outcomes, process, and patient experience/satisfaction measures, as well as episode and per capita cost measures. The measures also should be specific to a clinician's specialty, should be meaningful (i.e., demonstrate proficiency), and should address areas such as care effectiveness (e.g., readmissions, complications and functional status), care coordination, and patient safety. ACOs and providers should be assessed both on their individual progress as well as their achievements relative to peers. Requiring that providers pursue Board certification and Maintenance of Certification also should be considered to help ensure that network providers meet certain standards. Finally, ACOs should engage providers as methodologies about how a patient is assigned and attributed to a provider are developed. Appropriate attribution is essential for achieving the goal of patient-centered care and ensuring accountability for a patient's health outcomes.

► **Promote transparency.** Patients often do not have useful information to make informed decisions about providers and treatments. Thus, patients should be provided with information about the goals and

overall purpose of the ACO, what a patient should expect from participation in an ACO, clear and understandable information on their benefits, rights and responsibilities, and information on health care services and possible alternatives. They also should receive useful provider performance data on quality, cost and patient experience based on sophisticated and reliable measures. Benchmarks should be set and a core set of performance measures that may include physician-level HEDIS measures¹³ and patient experience CAHPS measures¹⁴, should be used to allow for meaningful comparisons of providers. As ACOs report provider performance information, they should do so in accordance with the Consumer-Purchaser Disclosure Project's *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs*¹⁵ aimed at promoting consistency, efficiency and fairness of reporting and make physician performance information more accessible and easier for consumers to understand.

ACOs also should ensure that their participating providers have relevant information on administrative processes and quality assessment program methodologies. Providing all of the above information will help give patients confidence that they are receiving high quality care, and help give providers confidence that the processes for holding them accountable for their care are fair.

THE VALUE HEALTH PLANS BRING TO DELIVERY SYSTEM TRANSFORMATION

To ensure the successful operation of ACO and other models, an active partnership between providers and health plans is critical. Health plans are committed to working with providers and others to ensure that patients receive the care they need when they need it. The information in this section illustrates how health plans can support delivery system transformation.

¹³ "Healthcare Effectiveness Data and Information Set" measures developed by the National Committee for Quality Assurance (NCQA).

¹⁴ "Consumer Assessment of Healthcare Providers and Systems" measures developed by the Agency for Healthcare Research and Quality (AHRQ).

¹⁵ <http://healthcaredislosure.org/docs/files/PatientCharter040108.pdf>

► **Facilitating population health management and health risk identification/reduction.** Health plans have data and infrastructures in place that would allow ACOs and their providers to identify opportunities to improve the health status of individuals who routinely access the health care system as well as those who do not.

- For those individuals who do not routinely access the system, health plans perform various outreach activities. For example, using health coaches and care managers, plans remind members to seek preventive health care, such as mammograms, physical examinations and cholesterol screenings; and encourage members to participate in wellness programs that encourage healthy behaviors and an active lifestyle. Plans also have extensive experience in adopting tools (i.e., health risk assessments) that help members assess risk for illness and identify steps that can be taken to reduce risks.
- For individuals with acute or chronic conditions, plans use nurse case managers to perform care and disease management, and coordinate care for individual patients across multiple providers, geographies, and settings. Additionally, plans have experience in assisting patients in adhering to the treatment prescribed by their doctors, providing patients with important resources to help them better manage their care, and designing wellness programs targeted at reducing risk associated with their condition.

The value of these infrastructure are supported by recent research suggesting that health plans can impact quality of care through various tools, including disease management, provider education efforts, patient education efforts, and the development of reminder systems.¹⁶

The capabilities set out above will make plans indispensable in the operation of ACOs. Critically, plans will have data on patient activity both within and outside of the ACO which will be an essential

element for ACOs in population health improvement efforts, member assistance programs and actuarial planning. These capabilities will become even more important if an ACO is structured so that it is held accountable for any care or costs of care that a patient receives outside of the ACO.

► **Providing the advanced IT infrastructure needed for efficiently performing clinical, operational and administrative functions and performing complex data management.** For example, health plans:

- ***Assist clinicians at the point of care.*** Health plans support clinical diagnosis and treatment plan processes by making available to clinicians best practices, and condition-specific guidelines. Additionally, plans have been and will continue to develop IT capabilities (e.g., personal health records or hand-held devices) to perform real-time monitoring and otherwise assist clinical decision-making at the point of care. For example, plans can use information systems and decision support tools to improve patient safety by identifying and notifying a doctor at the point of care if he/she is prescribing a drug that may adversely interact with another drug that another doctor has prescribed for the patient.
- ***Measure and report on physician performance.*** Plans have data capabilities to longitudinally measure, collect, aggregate and analyze information on provider performance, and quickly report back such information to providers. Based on data that may come from multiple sources, including physician, hospital, lab, radiology, durable medical equipment, and home health claims, disease and case management, personal health records, surveys, and medical records, plans also can identify best practices and gaps in care, and develop quality improvement programs to positively impact provider performance and improve patient outcomes.

Aside from reporting performance information to physicians, health plans also use these same

¹⁶ Laurence C. Baker and David S.P. Hopkins, International Journal for Quality in Health Care, "The contribution of health plans and provider organizations to variations in measured plan quality," (March 18, 2010).

capabilities to provide consumers with information allowing them to compare providers based on quality and/or cost measures. Plans' sophisticated tracking of this performance data is critical to promote patient-centered care.

- ***Efficiently administer health insurance.*** Plans have the electronic infrastructures in place to efficiently administer health insurance for providers and members, reduce paperwork and otherwise reduce administrative burdens. Plan online systems allow individual members as well as physicians to verify benefit eligibility, submit claims for payment, and check the status of pending claims. Complex information is reconciled across different systems (i.e., enrollment, eligibility, benefit, claims systems) and made available to individuals and physicians via phone or online.

► **Managing networks to ensure that patients can choose from providers that meet high standards.**

Given that ACOs will be held accountable for care that its network providers deliver, provider network development and management will be a critical activity. If an ACO is structured so that it is held accountable for any care or costs of care that a patient receives outside of the ACO, this function becomes even more important.

Plans can help ensure that consumers have numerous choices by leveraging their existing relationships with a broad and diverse group of providers. Additionally, plans have experience in identifying qualified providers which make them uniquely positioned to develop and manage provider networks for ACOs. For example, health plans:

- ***Perform Credentialing and Other Similar Activities.*** Plans have extensive experience in credentialing providers as well as ensuring that providers are appropriately licensed, accredited, certified, and have not committed malpractice, fraud or other violations.
- ***Identify Centers of Excellence.*** Health plans

review internal data as well as nationally reported data to develop Centers of Excellence (i.e., networks of facilities with strong track records of quality care, health outcomes, and patient satisfaction).

- ***Develop Provider Recognition Programs.*** Health plans have developed physician and hospital recognition programs to acknowledge those providers who meet quality, patient safety, outcomes and patient satisfaction metrics. These programs may offer financial recognition (e.g., an increase in reimbursement) and/or non-financial recognition (e.g., recognition in press releases or websites).
- ***Encourage Adoption of Physician Maintenance of Certification.*** Health plans are developing incentives for network providers to pursue maintenance of certification, a process by which Board-certified physicians complete requirements (in addition to original Board certification), such as continuing medical education, practice performance assessments and/or re-testing.

- **Assuming and managing risk to ensure financial stability.** Health plans have extensive experience in managing risk. They are able to perform this function due to their current infrastructure and capacity to perform continuous quality improvement activities, including pharmacy benefit management services, radiology benefit management services and other activities to determine appropriate services for patient diagnoses based on the best available evidence. Plans also have unique abilities and sophisticated predictive modeling tools to perform risk assessment activities. These tools, for example, allow plans to identify and design programs to help at-risk populations of patients. Finally, health plans are subject to numerous regulatory requirements (e.g., reserve and solvency requirements) that help safeguard the financial security of consumers and business customers even if unforeseen events occur, such as a flu pandemic or similar disaster impacting the health care system

► **Developing products to meet the diverse needs of businesses and consumers.** Health plans currently offer a variety of health care products to businesses and individuals. They have extensive experience in developing multiple, innovative products as well as financing and delivery options that can be tailored to meet the diverse needs of communities.

CONCLUSION: MAKING ACCOUNTABLE HEALTH CARE A REALITY

The passage of the Patient Protection and Affordable Care Act marks the beginning of a new era in health care delivery. The law promotes new delivery and payment models that seek to transform the current system into one that is more patient-centered, holds stakeholder sectors more accountable in their respective roles, and rewards improvements in health care quality and patient outcomes.

Health plans play a critical role in helping the nation make this transformation. Through their efforts to promote delivery system improvement, plans have created, and continue to develop, innovative tools and key infrastructures which are essential for accelerating and successfully achieving any long-term, meaningful change across the system.

As the public sector continues its ACA implementation efforts, it should take into account such health plan innovation. Equally important, the government has to carefully consider the design and implementation of its programs to ensure that issues relating to clinical integration and financial risk are addressed in a way that does not result in unintended harm to consumers.

Health plans stand committed to partnering with the government as well as clinicians, hospitals, consumers and others to most effectively and efficiently address potential challenges, and quickly move toward a health care system that meets the needs of consumers in the 21st century.