

# ACTION MEMO

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## KEY ELEMENTS TO CONSIDER IN ACO AGREEMENTS<sup>1</sup>

Accountable Care Organizations (ACOs) continue to emerge as a model in value-based (versus traditional fee-for-service) care, as payers, purchasers and providers explore various structures to deliver high-quality care under attractive, affordable insurance products for individual and group customers in commercial markets and government programs. While the long-term viability and transformative nature of the ACO approach is still developing, the purpose of this document is to enumerate, at a high level, aspects to consider when preparing to enter into an effective ACO agreement.

Effective ACO agreements drive transformational achievement. These agreements can incentivize ongoing improvements in quality, no matter the starting point of the organization; enable deployment of and improve access to attractive and affordable insurance products; reduce total health care spending (yielding savings for patients and purchasers) and expand patient access, via a variety of modalities and at tolerable out-of-pocket costs, to preventive and ongoing chronic disease care. In addition, effective ACO agreements can drive Alternative Payment Model-incentive components of the Medicare Access and CHIP Reauthorization Act, specifically basing a meaningful component of payment on quality measures; using certified Electronic Health Record (“EHR”) technology, and including an element of financial risk with the potential for monetary loss.

This document reflects the robust experience of the Task Force membership, and is intended to be educational in nature. It is not intended to be comprehensive. The document does not represent an agreement among HCTTF members or any mandated or mutually agreed contract element and is not binding on HCTTF Member organizations. Nor does it encompass all variations of contracting.

For purposes of this document, the Task Force considers an ACO to be any group of providers who contract to provide covered services to health plan members where components of the relationship include concern for contracting for the patient experience, quality of care, and cost for a specified population – whether that population is assigned through a formal attribution process or through traditional insurance product selection. Included in our ACO designation are the principles of the patient-centered medical home<sup>2</sup> with its emphasis on comprehensive primary care, which provides a foundation for a successful ACO.

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<sup>1</sup> The Health Care Transformation Task Force (HCTTF) is a group of private sector stakeholders convening to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – currently including patients, payers, providers and purchasers – we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care and reduced costs. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020. We strive to provide a critical mass of policy, operational and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation. This document represents the latest thinking of the Task Force on this topic.

<sup>2</sup> M. Bailit and C. Hugs, *The Patient-Centered Medical Home: A Purchaser Guide - Understanding the Model and Taking Action*, Patient-Centered Primary Care Collaborative, 2008.



Additionally, the elements presented here have been organized in accordance with the well-known concept of the Triple Aim: 1) Improving the patient experience of care, 2) lowering per capita costs, and 3) improving population health. Within each section, elements are organized according to importance: those most likely to yield the greatest transformation are listed first.

## SECTION 1: PATIENT EXPERIENCE AND ACCESS

### PATIENT CENTEREDNESS

Contracts must incorporate strategies for delivering patient-centered care including:

- Patient acknowledgement of a primary care relationship with a specific provider.
  - Shared care planning/collaborative care, which includes goal-setting, decision-making, monitoring, and advanced care planning measured by engagement rates.
- Coordination and communication, including:
  - Referrals for specialists, test and procedures include defined follow-up mechanisms;
  - Between transitions of care;
  - Ensuring communication across providers; and,
  - Ensuring communication between providers and patients.
- Access to timely care, including:
  - Increased 24/7 patient, family and caregiver access (in-person visits, telephone, on-line and telemedicine consultation) to providers who know the patient and have access to the patient's EHR; and,
  - Easy scheduling of appointments, including same-day availability based on medical need and acuity.
- Best practice models of care management, particularly those for high-cost, high-need patients, that:
  - Take a holistic, person-focused and family-centered approach to health including its behavioral, social, and physical aspects; and,
  - Emphasize care coordination across providers and have robust primary care capabilities at their center.

**DESIGNATED PATIENT POPULATION** (net of all cost-of-care contracts between the payer and provider, such as HMO, PPO, Bundles)

When determining the size of the covered population, contracts should include sufficient or adequate enrolled members to support clinical transformation within the practice and mitigate overall risk due to natural variation. The primary objective of any attribution model should be to allow patients to become active participants in their care while enabling providers to be held accountable for the appropriate



patients. “Sufficient” or “adequate” population sizes will vary based on the different patient populations on which an ACO chooses to focus.

In commercial markets, insurance product selection (or enrollment) can serve as a form of self-attribution to a specific set of providers or health system. For models where an attribution process is utilized at the patient level to encourage more accountability on the part of frontline providers, we set forth below our step-wise methodology for yearly (or monthly, in some cases) attribution to, or within the delivery system as articulated in earlier Task Force materials.

In order of supremacy:

- Patient has chosen a Primary Care Provider (PCP) in the current or previous year(s);
- Patient has never chosen a PCP, and had a visit with that PCP in current or previous year; and,
- Patient has not chosen a PCP, and is then attributed to a PCP based on plurality of primary care services in the previous year.

## INFORMATION EXCHANGE

Robust health information exchange is critical to ACO models, as information drives accountability across the ACO and the population it serves. ACO agreements should support:

- Standards-based interoperability across providers.
- Two-way communication between providers and patients, which should include:
  - Patient ability to view, download, and transmit their own medical information;
  - Patient ability to add information or correct information in their medical record; and,
  - Ability for patients to communicate electronically with care team (e.g., secure email, remote monitoring, etc.).
- Specific provider strategies (such as a patient portal) for communicating to patients as well as providing information about patient rights and opportunities for redress/recourse and second opinions.
- Commitment to quality improvement based on clinical outcomes data and patient-reported outcomes and experience data.
- Transparency through public reporting of consumer friendly information about quality, cost and payment/financial incentives (including both provider and patient-oriented incentives).
- Leadership commitment to patient and caregiver engagement, inclusive of:
  - Incorporation of patients and caregivers into care teams, bodies tasked with care design/redesign, and governance and oversight bodies;
  - Designation of management positions responsible for patient and caregiver engagement; and,
  - Dedication of specific resources to promoting patient and caregiver engagement.



## SECTION 2: FINANCIAL STRUCTURES

Contracts should reduce the total cost of care for the benefit of the covered population, while meeting quality standards, including patient experience of care.

### FINANCIAL MODEL

For ACOs to achieve the full potential of better and more affordable care delivery, contracts should transition to payments that involve the assumption of greater financial risk – including full, two-sided risk, which facilitate continuous improvements in efficiency and total cost. Fundamental changes to the underlying payment mechanics that move away from a pure fee-for-service payment are needed to complement the move to higher levels of performance risk and can incorporate a variety of approaches, including prospective bundled payments, prepayment, and capitation (full or partial). Consideration should be given to how value-based payments are passed through to the individual provider level and the portion of total payment that is linked to quality and efficiency in order to meaningfully incentivize provider improvement.

Financial structures should advance improved care, improved quality and lower cost. Contracts should offer one of two statistically sound, fully transparent, financial models, designed so that all providers can participate.

- One model should be based on historical claims, thereby moving high-cost providers into structures that decrease costs.
- The second model should be based on community-ratings with local costs/trends.
- For either model, health status should be considered and prospective targets should be set; industry standard risk adjustment models such as the Hierarchical Conditions Categories (HCC) should be utilized and continuously improved.
- In both models, methods to mitigate outlier high-cost or high-trend cases should be considered.

The contract should clearly state the division of financial responsibility between purchaser, payer, and provider and patient, consistent with the following.

- As ACOs accept more financial risk and demonstrate high quality care and improved patient experience of care, contracts should allow ACOs to better facilitate prospectively-attributed patient receipt of care in appropriate settings. There is a need to support stronger patient engagement and education regarding covered services, available providers and facilities, and treatment options, including notification and appeals processes.
- Payment policies that determine the site of care for patients should be waived, or set aside, when replaced with a patient-centered care team approach that demonstrates care coordination and delivery of high quality, high value care.



- Fundamental changes to the underlying payment systems to complement the move to higher levels of performance risk, including changes in bundled payments, prepayment, and capitation, should be pursued. Modifications to underlying payment systems, including payment policies, should be accompanied with appropriate quality criteria, consumer protections and transparency to both internal and external stakeholders.
- Contracts should include provisions to monitor for unintended consequences and effects on site of care determinations to the extent that any services are excluded from shared risk calculations.
- Decision-making methodologies, such as information/decision-support tools about treatment options and tools to encourage seeking care in high-value, high-quality sites and/or high-value, high-quality providers, must be provided to patients and providers.

#### **BENCHMARK/GLOBAL BUDGET**

Benchmarks should be based on a mutually-agreed upon methodology, and should reflect either historical cost of attributed patients in early years or regional cost trends, or a mix of the two approaches, depending on the maturity of the market and the delivery system. Benchmarks should transition to the regional cost-trend approach, providing time for the organizations to make this transition.

While low-cost ACOs can still reduce spending, in the long term, a benchmark based solely on historical spending is not sustainable. The benchmark methodology should take into account how efficient ACOs are when entering the program and maintaining reductions in cost. Conversely, higher-cost ACOs may need to begin with a historical spending approach and, as they decrease spending and improve patient care, transition to a regional benchmark. This means that ACOs will not always be held to the same benchmark standard.

Quality measurement (addressed in more detail in a subsequent section) should be a component of the financial structure, including patient-reported outcome measures and/or patient-generated data. Savings/gains-sharing should be determined by meeting a consistent, parsimonious set of quality standards.

#### **PERFORMANCE PERIOD**

Contracts should span multiple years such that they create program stability, and provide ACOs with the necessary time to achieve the desired quality, experience and financial outcomes.

Longer contracts allow more time to “ramp up” and invest in new programs and processes, savings/losses to be based more on actual performance rather than natural variation in utilization,



increases in spending to be better absorbed, operational consistency/planning, and more time to transition from up-side to down-side risk.

Contracts should include explicit provisions around the performance targets during initial performance years and how and if targets may change in subsequent years.

Ability to terminate the contract, outside of the performance period, should be addressed with appropriate protections for both parties and provisions for continuity of care for affected patients.

### **CONTRACT REVIEWS AND PERIODIC ADJUSTMENTS**

Contracts should include planned, periodic reviews that allow for providers and payers to assess the overall impact of the arrangement, and to revise them as necessary.

Trigger events may include, for example:

- Change in regulatory environment;
- Changes in care options, new technology or covered services (e.g., high-cost drug/device approvals);
- Changes in benefit design (co-pays, deductibles, etc.); and,
- Major market changes (e.g., when benchmarked against evolving neighbor markets or dynamics due to mergers/acquisition activity).

Contracts should strive for continuing reductions in overall health care spending and spur adoption of practices and technology that advance the triple-aim. Periodic adjustments may be needed to accommodate cost changes (decreasing or increasing) from, for example:

- Significant changes in medical practice, new technology, or workforce distribution;
- Changes to any indices (e.g. inflation) to which a benchmark may be tied;
- Risk adjustment for the attributed population using industry standard models, such as the HCC model, with mutually agreed upon prevention mechanisms for coding intensity; and,
- Significant changes in size of at-risk, attributed population, as this can alter risk corridors or financial protection requirements.

Contracts should include triggers and process for amendment and termination, including, for example, defining breach, establishing shared savings/shared losses under partial contract performance, and close-out procedures.

Patients assigned to the ACO should be notified of significant modifications to contracts affecting clinical care model requirements, out-of-pocket cost sharing, utilization management processes, access to participating providers/suppliers, or quality reporting requirements.



### **DATA ACCESS AND REPORTING**

Access to data is essential to ACO performance. Contracts should include, at a minimum, access to a routine (e.g. monthly download) flat file, in accordance with state and federal law, containing unedited attributed patient/beneficiary claims data, which includes co-pay and deductible information. (Timely API access to claims feeds is preferred.) As drug risk management is incorporated into contracts, access to prescription drug claims data increases in importance.

Contracts should address other aspects of data access including data sharing from provider to payer, and the sharing of information beyond claims data. Contracts should allow for full ACO access to data, consistent with state and federal law.

Prospective patients and patients assigned to the ACO should be notified that their data will be shared with the ACO and its participating providers.

## **SECTION 3: QUALITY OF CARE**

### **CLINICAL MANAGEMENT/MODEL OF CARE**

Contracts should articulate the design of the clinical model. The first step is to establish whether the ACO will be solely responsible for clinical management, or whether there will be shared responsibilities with the health plan/payer, including any needed delegation of care, case and disease management authorities.

Whether solely the purview of the ACO or a shared arrangement, contracts should identify the respective responsibilities for care management, acknowledge the existing capacity (or plans to expand capacity) to coordinate care through an interdisciplinary team structure that includes practitioners with the necessary areas of expertise, and appropriate staffing to meet the needs of complex patients, have mechanisms to evaluate patient satisfaction with access and quality of care, including (within the benefit design) choice of providers and choice in care settings. Plans for the clinical care model should detail the ACOs leadership structure, and identify who is responsible for overseeing/implementing key elements of the clinical care model, including, for example, care management, care coordination, transition calls, mechanisms to evaluate quality of care, and utilization of health information technology.



Contracts should articulate plans for electronic exchange of patient records across providers/suppliers; between patients/caregivers and providers/suppliers; and with other providers in the community to help assure continuity of care. Plans for electronic exchange of patient health information should also articulate current and planned capacity to ensure patient and caregiver on-line access to personal health information/electronic health records and ability for patients and providers/suppliers to communicate electronically (e.g., via secure messaging).

### **QUALITY MEASUREMENT**

Contracts should include a mutually agreed upon, parsimonious set of high-impact, high-value measures, consistent across payers, that:

- Monitor population outcomes (readmissions, ambulatory sensitive admissions, etc.) (measures for payment) (patient-reported outcomes/experience);
- Increase transparency and allow consumers and purchasers to compare and evaluate quality outcomes on multiple levels including at the organization-, practice- and individual provider-level; and,
- Ensures there is no under-utilization of medically necessary services (measures for monitoring/public accountability).

Preference will be given to established measure sets and patient reported outcomes, with flexibility to include innovative and mutually agreed upon variations. Incentives should be structured in a way that encourages ACOs to contribute to and refine existing quality measures.

Quality measurement benchmarking methodologies should incentivize improvement over prior performance (historical performance) in addition to achievement relative to industry standards (absolute performance).

Contracts should include consistent quality reporting programs with measures that are maintained for at least three years to provide the stability and time necessary for meaningful evaluations. Newly-developed reporting systems (benchmarks, reporting tools, reporting methods) and quality measures without adequate or valid sample sets should fall under a payment-for-reporting structure for the first two years. Shared savings pay-outs should reflect quality improvement and be allocated accordingly.

### **OTHER KEY CONTRACT COMPONENTS**

#### **Compliance**

The ACO should comply with relevant state and federal health laws and regulations including, where necessary or appropriate: parameters of a Clinically Integrated Network for relevant Safe Harbor protections, federal and state waivers for bundled payments, risk-based structures and the like, State insurance regulatory requirements, antitrust laws, and fraud and abuse laws. The ACO should also





create compliance standards, with appropriate monitoring processes, to ensure there is no stinting with respect to high quality patient care.

### **Operational Leadership and Representation**

Contracts should provide for collaborative leadership structures that include adequate representation of stakeholders in key decision-making. Stakeholders include, for example, ACO participants, payers and purchasers, beneficiaries, patients, public programs, and consumer advocates.

Contracts should encourage leadership approaches that emphasize transparency and collaboration, such as

- A shared communications strategy to align patient communication from the various provider groups involved; and,
- Articulating responsibilities of each side (payer/provider).

Parties to the contract should have governance structures that promote accountability, without limiting flexibility.

### **Health Information Technology**

ACOs must require that their providers use health information technology for clinical decision support, clinical integration and information exchange. It should expect participating providers to:

- Implement clinical decision support;
- Enable electronic communications with patients;
- Enable patient ability to view, download, and transmit personal health information electronically;
- Share information with other providers and contribute to a longitudinal health record for each patient; and,
- Share clinical information with each patient, and collect patient-reported information about health risks, health status, and patient experience.