

# Creating an ACO: Advice for Employers and Purchasers



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## Introduction

As employers continue to search for strategies to help improve the quality and affordability of the healthcare they purchase, a growing number are becoming interested in accountable care organizations (ACOs). ACOs have the potential to deliver higher-quality, better coordinated care at reduced costs, improving the health of the population for whom they provide care while aligning financial incentives for payers and providers. Some employers, including Intel Corporation and The Boeing Company, have launched ACO pilots working directly with provider systems, while others, like the California Public Employees' Retirement System (CalPERS), are bringing ACOs to their populations through their contracted health plans. Depending on the arrangement, providers serving as ACOs can reap financial gains for improving the health of covered populations while staying within a budget, but may also share financial risk for cost overruns. Employers may also share in savings that come from improving population health.

Yet not every healthcare provider is ready to jump into an arrangement with an employer (or employer and plan) that requires committing to population health improvement targets and to assuming financial risk. And not all employers and other healthcare purchasers are ready either. For these reasons, Catalyst for Payment Reform and the Pacific Business Group on Health developed a set of tools for our member companies and organizations and other purchasers to use when building an ACO with a provider system or their health plan. The tools define ACOs and the basic features that purchasers expect ACOs to have, regardless of the model. They also propose a "glidepath" employers

can follow, starting with offering potential financial rewards to an ACO partner that performs well, and then transitioning into an arrangement that brings both greater potential rewards as well as financial risk.

## What Is an ACO?

An ACO is a type of healthcare delivery and payment system that ties provider reimbursement to quality metrics and to reductions in the total cost of care for an assigned population of patients. At the heart of an ACO is a local provider entity that is responsible for all of the healthcare and related expenditures of a defined population of patients. An ACO's ability to align incentives for providers to improve quality while controlling healthcare spending will vary drastically depending on program design and implementation. There are a variety of channels through which employers can make ACOs accessible to their covered populations.

*Health plan–developed ACO employers can gain access to an ACO through their health plan.* Depending on the specifics of the arrangements, the employer may or may not share directly in the savings generated by the ACO.

*Jointly developed ACO between health plans and employer.* Employers (typically self-funded) can work with their health plans to create an ACO with specific healthcare designs, a tailored network of healthcare providers, trend management or cost-savings goals, population quality and utilization measures, and performance guarantees for healthcare quality. The plan and employer may share in the initial cost of development as well as the distribution

of any savings.

*Direct contracting with an ACO.* Employers also have the option to contract directly with an existing or forming ACO. In this scenario, the employer bypasses its health plan to contract directly with the ACO for care. The contract could be applied to total healthcare services or to specific healthcare services (eg, chronic illness).

### Features Every ACO Should Possess

While there are many models of ACOs in the works, few contain all of the features that employers and other healthcare purchasers value most. Below, we outline these key features.

#### *Networks, quality, and efficiency*

When creating or entering into a contract with an ACO, employers should be choosy about the providers included, insisting that the ACO select providers based on quality and efficiency. The point of an ACO strategy is to improve quality and reduce costs. An ACO must be able to measure and report on patient outcomes and demonstrate that it is improving the quality of care

and reducing costs.

#### *Patient-centered, coordinated care*

ACOs promise to improve the quality of healthcare, largely through better care coordination. A purchaser shouldn't work with any provider system that can't support targeted care management; a key piece of this is physician involvement with patients in shared decision making. Online data management is essential to track care management and performance. ACOs should provide individuals who have multiple chronic conditions with a shared care plan accessible electronically to all providers or members of the care team (including patient and family). Delivery system elements should include use of qualified health professionals to deliver coordinated patient education and health maintenance support that engages the member in self-care, self-management, and risk reduction. Patients must be included in the care process and be given ready access to their health information.

#### *Aligned provider payment policies*

Ideally, ACOs will be subject to a shared-risk payment arrangement in which any savings will be distributed based on meet-

**Table 1. ACO Models**

Contracting Models	Examples	Results
<b>Health plan-based ACO</b> <ul style="list-style-type: none"> <li>Likely to rely on existing health plan provider contracts</li> <li>Narrow network design or Primary Care Medical Home configuration</li> <li>Physician group oriented</li> <li>Insured or self-funded (ASO fees may apply)</li> </ul>	Anthem Blue Cross & HealthCare Partners (California) <ul style="list-style-type: none"> <li>Prospectively attributed population</li> <li>Insured PPO</li> <li>Per member per month (PMPM) fee + financial risk-sharing subject to a quality threshold</li> </ul>	\$4.7 million savings in the first 6 months of 2013 <sup>1</sup> <p>Utilization savings:</p> <ul style="list-style-type: none"> <li>Hospital inpatient days, -18%</li> <li>Inpatient admissions, -4%</li> <li>Outpatient visits (including ED visits), -4%</li> </ul> <p>Quality measures:</p> <ul style="list-style-type: none"> <li>Diabetes LDL, +7.5%</li> <li>Cholesterol management for heart disease patients, +3.8%</li> </ul>
<b>Jointly developed ACO</b> <ul style="list-style-type: none"> <li>Employer-designed requirements</li> <li>Tailored network</li> <li>Includes physician group and/or hospital collaboration</li> <li>Gain-sharing or risk-sharing options</li> </ul>	CalPERS, Blue Shield of California, Hill Physicians Medical Group, and Dignity Health (California) <ul style="list-style-type: none"> <li>Insured HMO with capitated medical group</li> <li>Zero percent trend target with gain-sharing</li> </ul>	Gross savings of \$105 million, 2010-2013 <sup>2</sup> <p>Utilization savings:</p> <ul style="list-style-type: none"> <li>Hospital inpatient days, -16%</li> <li>Length of stay, -15%</li> </ul>
<b>Employer-direct contracting</b> <ul style="list-style-type: none"> <li>Employer-designed requirements</li> <li>Tailored network</li> <li>Risk-sharing or full-risk options</li> <li>Data sharing between ACO, health plan, and TPA for claims and enrollment information</li> </ul>	Intel Corporation & Presbyterian Health Systems (New Mexico) <ul style="list-style-type: none"> <li>Self-funded population with select high-cost conditions</li> <li>Shared risk with negotiated target PMPM cost and P4P with a tiered bonus structure linked to quality performance</li> </ul> The Boeing Company & Providence Health and Services, Swedish Health Services, and University of Washington Medicine <ul style="list-style-type: none"> <li>Embedded management program of high-risk population</li> <li>Shared savings</li> <li>Performance guarantees for quality measures</li> </ul>	Not yet reported/early stage

ACO indicates accountable care organization; ACO, administrative services only; CalPERS, California Public Employees' Retirement System; ED, emergency department; HMO, health maintenance organization; LDL, low-density lipoprotein; P4P, pay for performance; TPA, third party administrator.



**Table 2. A Glidepath Toward Shared Risk and Population Management**

	Year 1	Year 2	Year 3
<b>Beginning with shared savings</b>	FFS payments with yearly bonus payment against a medical budget, and quality standards	Reduced FFS payments, yearly reconciliation against a medical budget, and quality standards	Global PMPM with increasing risk-sharing arrangement
<b>Beginning with shared risk</b>	Reduced FFS payments yearly; reconciliation against a medical budget and quality standards	Global PMPM with increasing risk-sharing arrangement	Global PMPM with full risk-sharing arrangement
<b>Beginning with population-based payment</b>	Global PMPM with increasing risk-sharing arrangement	Global PMPM with increasing risk-sharing arrangement	Global PMPM with full risk-sharing arrangement

FFS indicates fee-for-service; PMPM, per member per month.

ing medical cost and quality goals. Furthermore, ACOs should promote payment for value, not volume, such that primary care and specialty providers share in performance incentives.

*Competition and transparency*

ACOs must support competition and transparency, providing consumers with information about the relative performance, cost, and efficiency of individual providers and facilities within the ACO. ACOs should make information regarding provider financial arrangements available to the public. ACOs must also refrain from contractual nondisclosure provisions that preclude community-level quality and efficiency measurement, comparative performance reporting, or access to price and quality information by consumers. ACOs should disclose medical loss ratios (the percent of premium dollar that goes directly to medical services) consistent with the recommendations of the National Association of Insurance Commissioners.

**The Glidepath: Evolution Toward Shared Risk and Population Management**

As an initial step, we propose that employers and providers maintain existing fee-for-service payments with shared savings. In the absence of prior experience with risk-bearing contracts, this initial model can be implemented in preparation for evolving to a risk-sharing arrangement. The ACO should achieve a minimum savings rate (eg, 2%) before any savings are distributed. To achieve savings, benchmarks should be created each performance year based on historical claims data. After no more than 2 years of being paid under a shared-savings arrangement, the ACO should transition to a shared-risk arrangement.

**Under the shared-risk arrangement, health plans and/or employers will continue to pay the ACO on a fee-for-service basis.** Payers may choose to withhold a portion of the fee-for-service payment to fund the shared-savings arrangement, with the potential benefit of additional membership volume to offset the fee reduction from the initial reduction. Savings or losses should be determined by comparison to a predetermined bench-

mark on a retrospective basis annually. The ACO must achieve a predetermined minimum savings rate (eg, 2%) before any savings are distributed. The employer and ACO should agree upon a clearly defined measure of the ACO’s cost savings prior to the start of a contract.

**The ACO should be able to share up to a predetermined percent of the savings** (eg, 60%) above the minimum saving rate, if 100% of the quality standards are met. If the ACO does not reach cost targets, the ACO should be responsible for a predetermined percent of losses (eg, 60%). Losses can be capped with a sliding rate, for example, starting at a minimum of 8% of the ACO’s medical cost benchmark in year 1, ramping up to 15% by year 3, consistent with the level of the withhold on fee-for-service claims.

**Finally, the ACO should transition to a population-based payment model.** In this final phase, health plans and/or employers should pay the ACO with a combination of fee-for-service and population-based payment methods. Payers will reduce fee-for-service payments by a predetermined percentage (eg, 50%) and combine them with a monthly population-based payment based on a predetermined percentage (eg, 50%) of the ACO’s expected costs. The ACO should be eligible to share in any savings only if it reduces costs by at least a predetermined amount (eg, 3%). As the ACO achieves savings goals, the proportion of risk share can increase to move eventually to a full risk-sharing payment model. The ACO’s ability to manage risk successfully should determine the pace of the transition from shared savings to full risk-sharing.

ACOs are a relatively new and grand experiment. A recent study reports that there are over 600 ACOs nationwide, with about half holding commercial contracts.<sup>5</sup> As the volume of ACOs grows, it is increasingly important that the expectations for performance remain high to assure that both public and private purchasers can

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harness better value for their healthcare spending. We hope that by following these guidelines, employers will find that ACOs produce the higher-value care we all desperately seek.

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