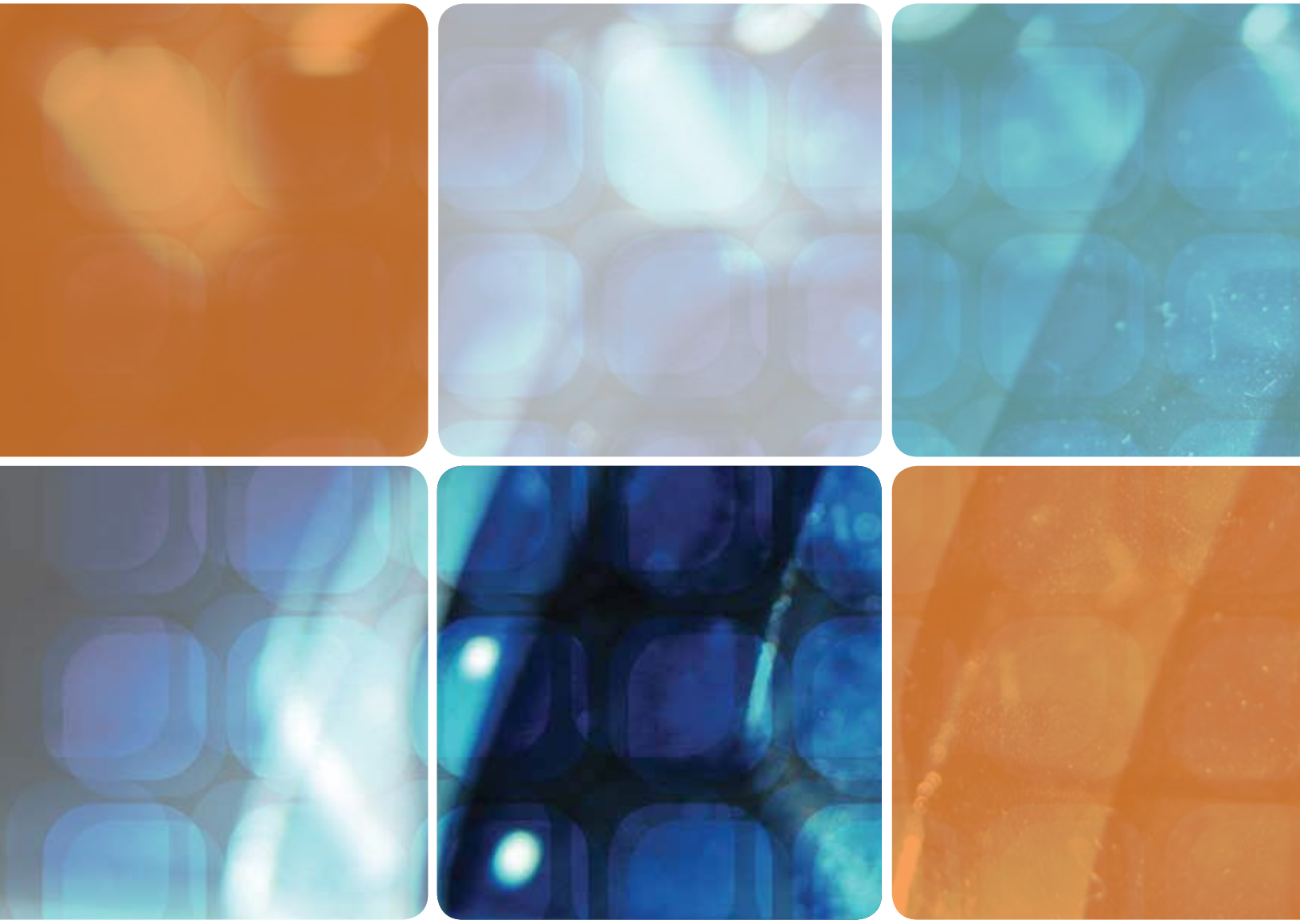

Building ACOs and Outcome Based Contracting in the Commercial Market:

Provider and Payor Perspectives

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Building ACOs and Outcome Based Contracting in the Commercial Market: *Provider and Payor Perspectives*

Contents

Executive Summary

In February 2011, the Taconic Health Information Network and Community (THINC) convened a workgroup (the Workgroup) to identify common ground and critical issues underlying the willingness of health plans and health care providers to collaborate in forming innovative value-based payment arrangements. These arrangements seek to achieve cost savings and improvements in the quality of care by linking payment to the value of care provided or to specified outcomes.

The Workgroup's findings are consistent with what appears to be growing interest and willingness among both providers and commercial health plans nationwide to collaborate in implementing value-based payment models such as accountable care organizations (ACOs). Providers and health plans are being motivated by a growing sense that costs and budgetary constraints will inevitably require significant movement away from the fee-for-service model. In addition, new payment rules and initiatives within the Medicare and Medicaid programs, such as the value-based purchasing program, hospital readmission penalties, bundled payment demonstrations, and the Medicare Shared savings program are motivating providers to develop the kinds of care platforms and information technology capabilities believed necessary to succeed in a value-based payment environment. Likewise, new provisions in the Affordable Care Act are having a significant motivating impact on health plans, such as the new medical loss ratio standards, new rules tying payment to performance under the Medicare Advantage Star Rating System, the federal authority and enhanced state resources to review "unreasonable" premium rate increases, and new laws to support establishment of state-level health insurance exchanges.

While providers see Medicare and Medicaid Program changes as providing the immediate impetus for developing care platforms that can succeed in a value-based payment environment, they also view collaborative value-based payment contracts with commercial payors as a means of (1) aligning commercial market incentives with Medicare and Medicaid payment reform initiatives, and (2) obtaining much needed support in developing the care platforms that are essential for success in a value-based payment environment.

However, the Workgroup has found that the kinds of arrangement that providers and health plans are willing to enter into are largely driven by certain underlying concerns that each has with value-based arrangements. Most significantly, providers are concerned that health plans will not adequately support their efforts to develop care-management platforms and that the terms of their arrangements with payors, such as those relating to the assignment of beneficiaries and the distribution of financial risk, will force them to assume unmanageable and dangerous amounts of risk. Health plans are primarily concerned that value-based arrangements will not lead to better care platforms resulting in cost savings and quality improvements, but instead will give providers market-power advantages that lead to higher costs for payors or the marginalization of the health insurer's role in health care financing. These concerns, combined with historical mistrust between providers and health plans, provide important context for understanding the positions of providers and health plans on issues such as the distribution of financial risk, the assignment of

Although providers and health plans have different concerns, their interests are aligned on many key issues that will play an important role in driving value-based contracting arrangements.

beneficiaries, the validation of quality and financial data, and entering into direct contracts with ACOs.

Although providers and health plans have different concerns, their interests are aligned on many key issues that will play an important role in driving value-based contracting arrangements. For example, plans and providers generally agree that providers will need to develop sophisticated care-management platforms; that successful outcomes based payment programs will require the extensive sharing of clinical and financial information; and that various aspects of a value-based payment model will need to be phased in over time, such as the use of out-come measures and risk sharing by the provider. Additional sources of potential common ground include the following:

- Delegating care-management functions to providers such as complex case management or utilization management.
- The application of existing government value-based payment models to commercial populations.
- Developing consistency in the measures used in value-based payment models.
- Using quality performance thresholds as gateways for payments and penalties under a value-based model.

Collaborating around the challenges that each party will likely encounter in managing populations in the Medicaid and insurance exchange markets.

Based on the Workgroup's findings, this paper reviews factors that are likely to impact the actions of both providers and payors as they begin to consider outcomes based payments. The Workgroup believes this exercise to be an important first step toward identifying and understanding the critical, macro level issues and concerns that will impact the contracting process.

Introduction

In February 2011, the Taconic Health Information Network and Community (THINC) convened a workgroup (the Workgroup) to identify common ground and critical issues underlying the willingness of health plans and health care providers to collaborate in forming innovative value-based payment models. These models would parallel Medicare and Medicaid payment reform and, in particular, shared saving programs with accountable care organizations (ACOs). Such collaborations are referred to throughout this paper as "ACO-contracts" or "ACO contracting" arrangements. The Workgroup facilitated several wide ranging discussions among health plans and providers serving the Hudson Valley. These encounters have given rise to learning on a number of specific points. Perhaps more importantly, they have contributed to a framework of understanding as to the expectations, priorities and needs of the stakeholders. It is hoped that enunciating this framework will contribute to greater understanding among stakeholders as to pathways that might advance their common objectives of delivering high quality and cost-effective care.

In furtherance of this goal, Section II presents certain perspectives gleaned from health care providers and Section III attempts to depict the perspective of health plans. Section IV then draws from these some opportunities for common ground among the providers and health plans.

Provider Perspective

Factors Driving Provider Interest in ACO Contracting

In light of present day conditions, with health care program reimbursement cuts, apparently unsustainable government budget deficits, federal health care access and payment reform attempts, and consensus within the policy community that the government and private sectors must shift away from fee-for-service medicine, many providers have concluded that adoption of value-based payment models are a necessity and will eventually become the dominant form of payment for health care in the United States.

Having reached this conclusion, an increasing number of providers are becoming interested in forming more integrated practices and in developing the capabilities believed necessary to succeed in a value-based payment environment. For many providers, recent changes within the Medicare program are providing the immediate impetus for developing these ca abilities. However, providers have concluded that they can neither cost effectively develop these capabilities nor feasibly implement

Providers view collaborative ACO contracts with commercial payors as a means to both (1) increase their exposure to value-based based payment models that fit the capabilities and advantages of an integrated practice; and (2) obtain much needed support in developing the care platforms that are essential for success in a value-based payment environment.

them without collaboration and support from commercial payors. Providers view collaborative ACO contracts with commercial payors as a means to both (1) increase their exposure to value-based based payment models that fit the capabilities and advantages of an integrated practice; and (2) obtain much needed support in developing the care platforms that are essential for success in a value-based payment environment. Both of these ACO contracting objectives are discussed below, following a general description of the value-based payment models and specific examples of some that are taking shape within the Medicare program.

Value-Based Payment Models and the Changing Medicare Landscape

In a value-based payment model, some portion of the payment rate a provider receives from the payor is tied to the provider's success in satisfying a defined set of performance criteria relating to quality, efficiency, and/or utilization. Payment models vary significantly in their breadth and design, but all seek to achieve cost savings and improvements in the quality of care by linking payment to the value of care provided or to specified outcomes (readmission rate reduced, process measures realized, costs for an episode of care or period of time at or below an expected amount). To perform optimally under such a model, many providers have concluded that they will need to change the balance among the incentives driving institutional and practitioner behavior within their organizations, develop more sophisticated and robust information technology capabilities, and integrate various aspects of their clinical and administrative operations

Many new Medicare programs and initiatives, most of which stem from payment methodological changes called for in the Affordable Care Act (ACA), embrace attributes of value-based payment. Some of these programs, such as the Medicare Shared Savings Program (MSSP) and Pioneer Pilot Demonstration for ACOs, are optional programs that embrace comprehensive approaches to value-based payment. Others, such as new rules relating to hospital readmission penalties and payment penalties tied to hospital-acquired conditions are mandatory and less comprehensive in the care paths that they attempt to influence. However, collectively, these programs are prompting many providers to plan for or to begin the development of capabilities which they hope will enable their organizations to succeed in a value-based payment environment.

Knowing that Medicare often sets a benchmark for the commercial market, a summary review of Medicare programs with outcomes or value-based payment attributes can be instructive as to the range of opportunities available to payors and providers in the commercial context.

- **Medicare Shared Savings Program (MSSP).** Widely viewed as the centerpiece of the government's effort to transition Medicare to a value-based payment model, the MSSP seeks to encourage formation, and operation in the delivery of care to Medicare beneficiaries, of Accountable Care Organizations (as defined under the ACA) by promising to share with the ACO, relative to persons attributed to the ACO's primary care providers, a percentage of Part A and Part B savings Medicare realizes in excess of a pre-determined savings benchmark. ACOs that are participating in the MSSP and meet certain quality performance targets are eligible to share in such savings up to a specified limit. Beginning in either year 1 or year 3 of the MSSP contract period (depending on the program path initially selected by the ACO), the ACO must also share in any losses realized by Medicare when the Part A and Part B costs of Medicare beneficiaries, attributed to the ACO's primary care physicians, exceed the expenditure benchmark.[2]

- **Pioneer ACO Pilot Program.** The Pioneer ACO Pilot Program is a modified version of the MSSP intended for providers that already have experience under value-based payment models. Participating ACOs will have several options under which they can gain more in

[2] ACA Sec. 3022; 76 Fed. Reg. 19,528 (April 7, 2011).

shared savings (via a greater percentage of the savings and a higher cap) but will be exposed to more in shared losses than MSSP ACOs. Moreover, Pioneer ACOs that successfully realize savings during years 1 and 2 can elect for a percentage of their Medicare reimbursement to be provided under a capitation-like model beginning in year 3.[3]

- **Penalties for Hospital Readmissions.** Beginning in 2012, Medicare will reduce payments to hospitals with higher-than-expected readmission rates for heart failure, heart attack, and pneumonia. This rate reduction will be 1 percent in 2012, 2 percent in 2013, and 3 percent in 2014. The ACA expands the list of conditions subject to the penalty in future years.[4]

- **Hospital-Acquired Conditions.** CMS no longer permits federal Medicare funds or pays for hospital inpatient services associated with certain reasonably preventable hospital-acquired conditions (HACs) and hospitals in the top quartile with respect to HACs will experience a 1 percent reduction in the base DRG payment.[5]

- **Hospital Value-Based Purchasing Program.** CMS will use savings originating from reductions in base DRG payments to fund a bonus pool that it will use to reward hospitals that perform above average on a variety of performance measures or show significant performance improvement from the previous year. Initially, CMS will evaluate performance using process measures associated with five health conditions (heart attack, heart failure, pneumonia, surgeries and healthcare associated infections). However, CMS intends to quickly begin transitioning to outcome measures. The cases being measured to calculate FY2013 DRG payment reduction occur in 2012.[6]

- **Medicare Bundled Payment Demonstration.** The ACA calls for both Medicare and Medicaid bundled payment demonstrations. Under the Medicare bundled payment demonstration, CMS will issue bundled payments for episodes of care beginning three days prior to a hospitalization and ending within either 30 or 90 days post discharge. These payments will cover services performed by hospitals and physicians, and may also cover those performed by nursing homes, rehabilitation facilities, home health agencies and other provider entities.[7]

The effect of several new Medicare payment programs will be to incentivize hospitals to become involved with the post-discharge care path in order to avoid penalties or disallowances.

To perform well in the above-described programs, as well as in other demonstrations and CMS initiatives, providers will need to revise and in some cases redefine their business models and build care-management platforms that enable greater coordination among physicians, hospitals, and other providers. For example, Medicare "carrots and sticks" around hospital-acquired conditions and rates of theoretically unnecessary readmissions are going to drive change within the hospital over the next several years as hospitals adjust to managing risks for which they were not previously responsible.

[3] CMS Innovations Center, Pioneer ACO Model Webpage, available at http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/

[4] ACA Sec. 3025.

[5] ACA Sec. 3008. See also CMS Hospital-Acquired Conditions Webpage, available at http://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp

[6] ACA Sec. 3001; 76 Fed. Reg. 26,490 (May 6, 2011).

[7] ACA Sec. 3023.

Hospitals see these payment programs as requiring them to align with community physicians and to evolve the payment methodologies in use within hospital-affiliated medical groups. The effect of several new Medicare payment programs will be to incentivize hospitals to become involved with the post-discharge care path in order to avoid penalties or disallowances. Commercial payor versions of these programs could well be contemplated.

Alignment of Incentives and Functions Across Payors

As they begin to respond to Medicare's value-based payments programs, provider interest in aligning incentives and functions across payors through ACO contracting is increasing. Providers that are building new care-management platforms for Medicare purposes are beginning to seek contract and incentive arrangements with commercial health plans that are in alignment with the government payment methodologies. Such alignment is seen as necessary to minimize the administrative burden and the possibility of conflicting incentives that can arise when dealing with different payment systems. There is also the practical need to have the bulk of a provider organization's book of business subject to the same "rules of the game" to promote adherence. Finally, providers have some concern that commercial payors may "free ride" their care-management efforts without assuming portions of the operational costs.

Support Transitioning to a Value-Based Payment Environment

Providers frequently lack certain capabilities needed for the care-management platforms essential for success in a value-based payment environment. They view commercial payors as vehicles for accessing certain resources and operational support in this area. Most significantly, many providers presently lack access to the utilization management, prescription drug and other claims data seen as necessary to identify targets for intensive care management. Access to actionable data is also seen as a prerequisite to the development of care-management pathways that can succeed against current and future quality metrics, and as important ammunition in discussions with physicians, nurses and administrators around new performance goals. Electronic health records (EHRs) may provide a new dimension to data analytics; however, in the near future care management will continue to rely on the traditional claims data analysis and utilization management reporting that commercial payors have experience delivering.

Providers are interested in partnering with health plans to gain access to payor data that can be effectively deployed in creating new care-management systems.

Providers are interested in partnering with health plans to gain access to payor data that can be effectively deployed in creating new care-management systems. Effective care management is highly dependent on identifying and managing those beneficiaries that have had multiple emergency room visits or inpatient stays, are on multiple medications, and/or have one or more chronic conditions. For many providers, past claims data is the best foundation for the necessary analytics. Again, in the future, EHR data will be integrated into this analysis. However, at this juncture the management that providers will be required to undertake to succeed under Medicare's readmissions penalty and other risk-reward programs will need to be informed by claims history.

In addition to data and analytics, providers are also looking to health plans for funding to support the infrastructure and workforce costs associated with building and sustaining new care-management platforms. Most providers anticipate that efforts to build these platforms and align incentives with value-based payment models will be costly and difficult, and would appreciate financial support for those efforts from all sources, including the commercial health plans that stand to benefit from

them. For example, funding may be needed to contract with the professionals, such as case managers, social workers, nutritionists, and home health workers, who can coordinate care between settings and facilitate the provision of care at the least-costly effective setting. Interest in ACO contracting is somewhat driven by the prospect of receiving interim as well as "back end" funding support from commercial health plans for such networks of practitioners.

Provider Concerns with ACO Contracting in the Commercial Market

Providers see the process of developing and administering the care-management systems that will enable them to function effectively in a value-based payment environment as costly and fraught with risk. One risk they foresee is the possibility that health plans might "free ride" on their efforts to develop care-management platforms in conjunction with changes in the Medicare and Medicaid programs. Providers fear that commercial payors will not "play ball" by offering their own value-based incentives and support programs to foster the development and success of new care-management platforms.

Providers see the process of developing and administering the care-management systems that will enable them to function effectively in a value-based payment environment as costly and fraught with risk.

Even if health plans do "play ball," providers recognize that building the infrastructure for effective care management does not guarantee success and some face questions regarding how such infrastructure should be designed and developed, including questions relating to the types of information that should be collected and reported, the governing structure of the provider organization or network, workforce composition, the nature and extent of clinical integration, and the extent to which commercial payors can be trusted to evaluate performance fairly and accurately, among others. These uncertainties, together with the more general concerns one would expect of any organization venturing into new territory, will cause some providers to move forward at a cautious pace and minimize risk during the initial years of an ACO contract. The specific issues and concerns that providers have identified as vital to successful ACO contracting are influencing providers' desire to move cautiously into this new territory.

Specific issues that providers identified as critical to successful ACO contracting with health plans include the appropriate degree of exposure to down-side risk; the methodology payors will use to assign beneficiaries to the ACO; the process for validating quality measures; the methodologies to be used to calculate value-based payments; and the ability and willingness of commercial payors to provide timely, actionable utilization and claims-based data. Each of these issues is discussed below.

Exposure to Downside Risk

A number of ACO providers operating new care-management platforms would like to test-run and refine their platforms against ACO contracting standards before exposing themselves to down-side risk under a performance-based contract. Furthermore, they see the costs associated with building and operating a care-management infrastructure as risky in themselves, and more than enough risk to bear in the first year of an outcomes -based contract. This is especially true in the Hudson Valley where few providers currently operate the types of care-management platforms essential for success in a value-based payment environment.

For these reasons, many providers will insist on tiered risk models that reflect the gradual ramping up of risk-exposure over time based on the operational and financial capabilities of their organization or network. For example, a provider might share risk

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around inpatient care services early in the contract period and then gradually expand its risk profile over time to include other services such as ambulatory care and pharmacy usage. Mechanisms can be built into outcomes-based payor contracts that would enable the parties to adjust the provider's risk sharing requirements at various points during the contracting period.

Providers are also seeking protection against excessive losses under performance-based payment models, and assurance that such models appropriately account for the complexity of cases they see. Some providers have proposed, as protection against excessive losses, adding safeguards into the ACO contract such as an option to revise performance metrics or terminate the contract before the end of the term if losses exceed a specified amount.

Attribution Methodology

While providers have differing views regarding acceptable methods for assigning or attributing beneficiaries to the contracting entity or ACO, some major concerns regarding attribution were identified. Most significantly, a few providers expressed a strong preference for attribution methodologies where the ACO learns the identities of its participating beneficiaries at the beginning of each risk-evaluation period (prospective attribution) as opposed to at the end of each risk-evaluation period (retrospective attribution). These providers see prospective attribution as necessary in order to effectively target and focus the care-management efforts of the ACO. For this reason, many providers believe that a decision by CMS to use retrospective attribution in the MSSP would discourage provider participation in the MSSP. Nonetheless, one provider informed the Workgroup that, if necessary, it could manage different attribution methodologies, such as retrospective application under the MSSP and prospective attribution under a health plan ACO contract.

Some providers are also concerned that if CMS restricts the applicability of an MSSP ACO's performance efforts to beneficiaries that are assignable only to a primary care physician, it will hamper efforts to form ACOs with commercial payors. Many provider groups are worried that they do not currently have enough beneficiaries assigned to primary care physicians to form an ACO and, given the primary care physician shortage, they will not be able to ramp up. For these reasons, a subset of providers are likely to insist on the use of attribution methodologies that allow beneficiaries to be assigned to both primary care physicians and a limited number of non-surgical specialists.

In addition, some providers have expressed concerns about the potential for frequent utilization of non-ACO providers by Medicare beneficiaries, which could limit the number of beneficiaries assignable to an MSSP ACO. In the Hudson Valley, there is concern about out-migration to academic medical centers in New York City. There is also concern about the large number of retirees who migrate south each winter and receive substantial medical services while away. Providers will be interested in making sure that the rules regarding the amount of services a beneficiary must receive from his or her primary ACO physician in order to be eligible for ACO membership are tailored to the medical use patterns of the health plan's beneficiaries.

Validation of Quality Measures and Calculation of Payments

While providers are interested in collaborating with health plans in the development and day-to-day management of care-management systems, there are concerns among some that payors will not fairly and objectively score ACOs on performance and calculate payments and losses under the applicable risk model. Health plans have similar concerns

about provider quality data measurement which, according to some Workgroup participants, results in very few health plans accepting provider reporting of quality measures produced by EHRs. To allay these concerns both providers and health plans are interested in finding ways to validate quality measures that promote accuracy and fairness but are not unduly burdensome. In striking this balance, parties will have to carefully consider the types of protections that should be built into the validation process, such as whether to use independent auditors, the degree and frequency of information sharing, and whether and to what extent processes for measuring quality and calculating payments and losses should be standardized.

Provision of Timely and Actionable Data

As discussed above, providers are looking for payor partners that can provide data and reports relevant to many different aspects of the operation of the care-management platform such as reports relating to emergency room and inpatient admissions, variations in practice patterns, utilization of services, predictive modeling around high risk patients, and the identities of beneficiaries assigned to the ACO. The ability and willingness of payors to share such information with providers on a frequent or close to real-time basis is viewed by many providers as an essential element of outcomes-based contracting.

Payor Perspective

Factors Driving Payor Interest in ACO Contracting

Health plans participating in the project have long understood that better care management, properly developed, supported, and incentivized through value-based payment models, can lead to significant reductions in the growth of health care costs. These plans recognize that accomplishing the goals of value-based payment would provide a check on premium growth that could result in a significant competitive advantage for health plans that have successfully implemented such models. While previous efforts to effectuate this type of change, such as the managed care efforts of the 1990s, were not successful, many commercial plans have concluded that present conditions offer a unique opportunity to explore a new generation of managed care models such as outcomes-based contracting. Similar to providers, health plans have concluded that they must prepare for the possibility that these new payment models will gain traction in the marketplace, and no commercial plan wants to fail to gain the quality and cost advantages that its competitors might experience.

Health plans participating in the project have long understood that better care management, properly developed, supported, and incentivized through value-based payment models, can lead to significant reductions in the growth of health care costs.

While many of the same conditions giving rise to provider interest in outcomes-based contracting are motivating the interests of commercial plans (e.g., growing alarm over medical cost trends), new provisions in the ACA are also having a significant motivating impact on health plans. Most significantly, commercial plans view value-based contracting as potentially helpful to their efforts to respond to four changing areas of law:

New law restricting the percentage of health plan premium that a plan may use to pay for its administrative expenses including cost focused utilization management, as opposed to medical and quality expenses, through application of a standard known as the "medical loss ratio";

- New law that modifies the payment amount a Medicare Advantage plan receives from CMS based on the plan's performance rating under the Medicare Advantage Star Rating System;
- New law providing the federal authority and enhanced state resources to review "unreasonable" rate increases; and
- New law establishing state-level health insurance exchanges with the power to determine what are qualified health plans.

Collectively, these requirements incentivize health plans to reduce administrative costs borne by the plan, improve the quality of the health care services plans offer, slow the rate of medical cost growth, and develop products that appeal to consumers who will be shopping for health insurance through the exchanges. Each of these changes in law, and their impact on the willingness of plans to engage in ACO contracting, are described below.

Medical Loss Ratio

Many health plans see ACO contracting as a way to reduce the proportion of commercial premium revenues they spend on services that are subject to penalties under the medical loss ratio (MLR) provisions of the ACA. The MLR provisions penalize health plans that spend less than 80 percent or 85 percent[8] of their commercial premium revenues on health care services and quality improvement, or conversely, spend more than 15 percent or 20 percent of their premium revenues on administrative services and profits. Health plans that do not meet these MLR percentage thresholds must pay rebates to their members.[9]

Health plans see ACO contracts that effectively align the incentives of health plans and providers around value-based payment models as creating a new collaborative dynamic in which providers can be trusted to play a more active role in utilization management, case management and other related functions traditionally performed by health plans. Because these functions are primarily intended to control costs they are generally classified as administrative services under the MLR provisions, therefore, delegating them to providers can greatly improve a health plan's ability to comply with the MLR. Health plans can compensate ACO providers for these services indirectly under a capitation or global payment model without adversely affecting their medical loss ratio.

Many health plans see ACO contracting as a way to reduce the proportion of commercial premium revenues they spend on services that are subject to penalties under the medical loss ratio provisions of the ACA.

Medicare Advantage Star Rating System

Insurance carriers that administer Medicare Advantage Plans (MA Plans) see ACOs and certain forms of value-based contracting as potentially benefiting their MA Plans by improving the score that the plans receive from CMS under the Medicare Advantage Star Rating System. The ACA has heightened the importance of performance ratings under the Star Rating System by reducing the base payment amounts awarded to MA Plans and tying bonus

[8] Small group plans must spend 80% of premium revenues on health services whereas large group plans must spend 85%.

[9] ACA Sec. 1001; 75 Fed. Reg. 74,864 (Dec. 1, 2010).

payments to performance under the Star Rating System. Beginning in 2012, MA Plans that earn a four- or the maximum five-star rating will receive a 1.5 percent bonus in Medicare payments, and this percentage will increase to 5 percent by 2014.[10] Health plans see the quality metrics used by CMS to evaluate MA Plans under the Star Rating System, such as the HEDIS claims-based measures, as aligning well with the quality metrics that would likely be incorporated into an ACO contract. The Medicare Star Rating System generally focuses on performance in the following areas: beneficiary satisfaction, management of chronic conditions, preventive services, and health plan responsiveness and care.

Mandatory Review of Proposed Premium Rate Increases

A new law in the ACA requiring commercial health plans to provide regulators with justification for "unreasonable" premium increases may also lead commercial health plans to explore value-based payment methodologies. Commercial health plans operating in the small group and individual insurance markets must report proposed annual premium rate increase above a threshold percentage (initially 10 percent beginning in September 2011) to state or federal regulators. State insurance regulators will review the information reported, with the federal government serving as a fallback for states that lack the capacity to perform such reviews. Although the ACA does not empower regulators to reject proposed premium increases on the basis of such reports, many states have such powers under separate laws. In response to this reporting requirement and the possibility that it could lead to enforceable limits on premium rate increases in at least some states, many health plans are exploring the potential cost savings achievable through value-based payment methodologies as a means of controlling rate inflation.[11]

[10] These provisions can be found in the reconciliation bill amending the ACA. See Sec. 1102 of the Health Care and Education Reconciliation Act (P.L. 111-152).

[11] ACA Sec. 1003; 76 Fed. Reg. 29,964 (May 23, 2011).

Health Insurance Exchanges

Because they require health plans to compete directly for consumer business, rather than competing for the business of employers and other intermediaries, many within the health insurance industry believe that the state-level health benefit exchanges established under the ACA will result in significant shifts in the competitive dynamics affecting health insurance companies.[12] While there is uncertainty and differing opinion as to how health plans should prepare themselves for business in the exchanges, some health plans believe that contracts with ACOs could help them compete in this new environment. Some see ACO contracts, and joint marketing with local ACO providers, as a way of appealing to consumers who will be comparing and shopping for health insurance coverage on the exchanges. Others believe that price competition stemming from direct-to-consumer marketing through the exchanges will drive the exploration of value-based models. In addition, there is speculation that some states may require health plans to use value-based payment models as a precondition for participating in their exchanges.

Payor Concerns with ACO Contracting

Some health plans also see ACO contracting as a risky pursuit and are weary. Health plan concerns generally fall into two categories: (1) that these newly conceived value-based payment models will, despite the time and effort they require, fail to bring about the cost savings and quality improvements that they are designed to accomplish; or (2) that such models will give providers advantages that will result in higher costs for payors or the marginalization of the health insurer's role in health care financing. These two general concerns are the prism through which health plans are likely to view ACO contracting efforts, and are manifested in the issues that plans have identified as critical with regard to ACO contracting.

[12] See ACA Sec. 1311 (requiring states to establish health benefit exchanges).

Specific issues that health plans have identified as being critical to successful value-based contracting with providers include disintermediation, the attribution methodology for assigning beneficiaries to an arrangement, provider readiness to participate in care management, provider willingness to share risk, the selection and validation of quality measures, provider market power, and the size of the provider network. Each of these issues is discussed below.

Although there is little concern that disintermediation would arise in the short term since very few providers have the capability to effectively manage insurance risk, it is likely factoring into the value-based contracting strategies of some health plans.

Disintermediation

Health plans have expressed concern regarding the possibility that a mainstream shift to value-based payment models will give rise to integrated risk-bearing provider organizations that develop the capabilities to manage financial risk entirely on their own and ultimately decide to do so, thereby circumventing health plans. This scenario is often referred to as disintermediation. Although there is little concern that disintermediation would arise in the short term since very few providers have the capability to effectively manage insurance risk, it is likely factoring into the value-based contracting strategies of some health plans.

If health plans pursue value-based contracts, they do not merely want to be conduits that providers use to transition to becoming licensed insurance entities. They want to maintain their relevance over the long term. Some health plans may seek to protect themselves from disintermediation by focusing their value-based contracting on individual physicians or physician groups. Where permitted by law, they may become involved in the provision of care. Although it is presently unclear how this concern regarding disintermediation will influence health plan utilization of value-based contracting, it underscores the importance of devising contracts that facilitate the building of trusting relationships between the parties.

Attribution Methodology

Health plans are concerned that allowing ACOs to use specialists as a basis for assigning beneficiaries to the ACO will undermine the role of the primary care physician as the centerpiece of integrated care management and will perpetuate the over-use of specialists. Some health plans advocate, as an alternative to using specialists, using nurse practitioners and physician assistants as a secondary basis of assignment when there are not enough primary care physicians available. Notwithstanding these concerns, at least one health plan servicing the Hudson Valley has expressed a willingness to allow the utilization of certain types of non-surgical specialists as a basis for covered person assignment.

In addition, some health plans have concerns about attribution methodologies that base assignment on whether the beneficiary received a plurality of his or her primary care (measured by total charges) from the ACO, such as the proposed methodology for the MSSP. Their concern is that a plurality standard, by itself, may result in the assignment of beneficiaries that do not have strong ties to the ACO. One prominent health plan trade association has suggested adding an additional threshold requirement to the attribution methodology that would exclude beneficiaries who satisfy the plurality requirement but are not using the ACO enough to exceed a threshold percentage of total charges or encounters.[13]

Provider Readiness

Health plans want to pursue certain forms of value-based contracts only with providers that have

[13] See June 6, 2011 letter from Carmella Bocchino and Joni Hong to Donald Berwick, sent on behalf of America's Health Insurance Plans (AHIP), regarding the proposed rule implementing the MSSP.

baseline capabilities relating to care management, governance, and information technology. These capabilities reflect many of the requirements for eligibility in the MSSP. The MSSP ACO must have governance and management structures through which it can develop and operationalize care paths, bind providers to alternative payment methodologies, and promote care pathways and best practices; it must demonstrate a significant level of clinical integration; and it must have information technology systems that can collect and deploy information to improve quality and control utilization. For example, desired information technology functions would likely include the ability to access disease registries to support performance on quality measures, produce quality alerts at the time of care, and collect quality data. Electronic health records, by themselves, will not always provide these information technology capabilities.

The America's Health Insurance Plans (AHIP), an industry trade organization that advocates the interests of large health insurance companies, provided a list of the "critical tools" its constituents believe are necessary for delivery system reform in a recent letter to CMS.[14] This list reflects capabilities that providers and plans would develop in collaboration. However, it is instructive as to the types of capabilities that health plans will find desirable in ACOs and other provider groupings that they may be interested in contracting with. The list includes the following items relating to provider readiness:

- **Population health management—**Availability of timely data to identify patients at risk, and opportunities to improve the health outcomes of individuals who routinely access the health care system as well as those who do not;
- **Disease and case management—**Case managers and other personnel to help coordinate and navigate care for patients with specific acute or chronic conditions across multiple providers and settings;
- **Treatment decision support—**Sophisticated IT infrastructures to provide real-time access of key data at the point of care and condition-specific care guidelines;
- **Consumer self-management tools—**Resources and tools to help consumers better manage their own care and adhere to treatment plans and wellness programs designed to their specific conditions;
- **Data supporting provider performance improvement—**Ability to measure, collect, aggregate and analyze information across care and on provider performance, supporting efforts to pinpoint gaps in care and help drive quality improvement.

[M]any health plans are unlikely to accept one-sided risk models, in which providers share in savings but not losses...

Risk sharing

Many health plans believe it is critically important that ACOs be held accountable for losses arising from a failure to control costs so that the incentives of the parties are sufficiently aligned. Therefore, many health plans are unlikely to accept one-sided risk models, in which providers share in savings but not losses, even for a limited time at the beginning of the contract term. This is particularly true of larger plans. Some small plans that serve the Hudson Valley have indicated a preference for focusing on gain-sharing rather than loss-sharing.

The desire of health plans to begin loss-sharing in the first year of the contract term is not necessarily inconsistent with a risk model that gradually ramps

[14] *Id.* at 3.

up risk exposure over time, but such an approach is likely to be resisted by some providers. One health plan that participated in the Workgroup expressed a preference for a two-sided shared savings model at the beginning of the contract period followed by migration to a global risk model, such as capitation. This participant acknowledged that certain medical services would have to be carved out of the capitation model in order to protect ACOs from losses that are beyond the ACO's capacity to control.

> **[M]any health plans are likely to insist that providers agree to processes that are designed to safeguard the accurate collection and reporting of quality data...**

Many health plans also believe that providers should be accountable on the basis of quality measures beginning the first year of the ACO contract term. This means that merely reporting quality information would not be sufficient. Their preference is to predicate bonuses or shared savings on meeting quality metrics.

Selection and Validation of Quality Measures

Health plans believe that quality in a value-based system should be evaluated by measuring health outcomes (outcome measures) as opposed to measuring the ACO's compliance with clinical processes associated with best practices (process measures). However, because outcome measures are still under development and not currently in widespread use, health plans are generally agreeable to using a combination of process and outcome measures at the beginning of the contact term, subject to the gradual transitioning from process to outcome measurement over the duration of the contract. Health plans are concerned, however, that a reliance on process measures under the MSSP would slow the transition to outcome measures under an ACO contract, since providers will insist on a general alignment of quality measures across payors. Therefore, if the process measures CMS has proposed for the MSSP are adopted, they could generate friction between health plans and providers over the selection of measures. Notwithstanding these concerns, both health plan and providers expect claims-based HEDIS measures to form a key piece of this measurement set.

Similar to the concerns providers expressed about health plans failing to accurately and fairly evaluate performance measures and calculate risk payments, health plans also have concerns about providers failing to accurately and fairly collect and report quality data. For this reason, many health plans are likely to insist that providers agree to processes that are designed to safeguard the accurate collection and reporting of quality data, such as audits conducted internally or by an independent third party.

Market Power

The health insurance industry has significant concerns that the clinical networks formed in response to Medicare and Medicaid changes, such as the MSSP and Pioneer ACO demonstration, will gain market power and force pricing concessions in commercial markets. Although it is unclear how these concerns will impact value-based contracting in the commercial market, health plans are likely to take steps to protect themselves and the industry from ACO market power. For example, some health plans may exhibit a preference for value-based contracting with physicians. Others may refuse to contract with large ACOs or may insist on separate, confidential agreements with each of the ACO's provider organizations in order to block the ACO from sharing reimbursement data that could be used to exercise market power.

Size of Provider Network

The Workgroup found that, for comprehensive, fully integrated ACOs that deploy value-based

payment models across service lines, health plans generally would like to see a minimum of 10,000 assigned individuals or perhaps 8,000 in select circumstances. These minimum thresholds reflect concerns about actuarial certainty and statistical validity around performance measures.

Providers generally recognize the need for such minimum thresholds. However, some providers have expressed concerns that requiring the ACO to have an 8,000 or 10,000 minimum number of assignees would impede ACO contracting in low-population rural areas. Both plans and providers indicated that they were willing to explore innovative approaches to address this problem. For example, one provider suggested creating "virtual ACOs" that pool data among many provider organizations.

Opportunities for Common Ground

Along with the prospect of reducing costs and improving health care quality, the interests of providers and health plans are aligned on many key issues that will play an important role in driving ACO contracting arrangements. Some of this alignment is described in the previous sections. For example, plans and providers generally agree that providers will need to develop sophisticated care-management platforms; that successful outcomes-based payment programs will require the extensive sharing of clinical and financial information; and that various aspects of value-based payment model will need to be phased in over time, such as the use of outcome measures and the amount of risk borne by the provider. Below are brief descriptions of additional sources of potential common ground based on the issues discussed above.

- **Delegating functions from the health plan to the provider.** Delegating care-management functions to providers can both improve the ability of the health plan to comply with its MLR requirements and enhance the ability of providers to construct care-management platforms that spread costs across government and commercial populations. For example, a provider could incorporate a delegated function, such as complex case management or utilization management, into the baseline care-management platform that it uses across payors.
- **Deriving payment models in the commercial market from government-led value-based initiatives.** The application of existing government value-based payment models to commercial populations would provide health plans with an opportunity to benefit from existing care-management platforms and providers with an opportunity to align their medical management efforts across populations. These opportunities are emerging as providers develop care-management platforms aimed at minimizing penalties and payment reductions in Medicare and Medicaid

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that are tied to performance, such as hospital readmissions penalties and value-based purchasing programs. Soon-arriving Medicare and Medicaid demonstration initiatives, such as the bundled payment demonstrations, will create similar opportunities for providers and health plans to collaborate around new value-based payment models.

- **Incorporating widely used standards and measures into value-based payment models.** Adopting common approaches to value-based payment, such as claims-based HEDIS measures and measurement criteria from the Medicare Advantage Star Rating System, would create opportunities for both health plans and providers to minimize administrative and start-up costs associated with value-based payment initiatives.

- **Using quality performance thresholds as gateways for payments and penalties under a value-based model.** Payment models that require providers to meet quality measure targets in order to receive a bonus or avoid a penalty would help to dispel any concerns among consumers or policy makers that value-based models will encourage providers to under-treat patients in order to meet utilization targets. Both providers and health plans recognize that ACOs and other value-based payment initiatives will not succeed unless they appeal to consumers. Therefore, each has an interest in the development of robust quality accountability standards.

- **Collaborating around the challenges that each party will likely encounter in the Medicaid and insurance exchange markets.** Further reductions in Medicaid spending across states and increased price competition on the insurance exchanges will create strong incentives for providers and health plans to collaborate around innovative payment models and care-management platforms that increase the value of each dollar spent on care. Both parties are looking for ways to operate sustainably within these markets.

Conclusion

The Workgroup findings described in this paper provide important insights into the factors likely to have an impact on the actions of both providers and payors as they begin to consider outcomes-based payments. By shedding light on the factors that are bringing each party to the bargaining table, and major areas of concern that may need to be addressed during negotiations, it is hoped that this paper will help facilitate the development of new payment models. Nonetheless, the efforts of the Workgroup described in this paper represent only a first step toward identifying and understanding the critical, macro level issues and concerns that will impact the contracting process. While these macro level issues provide important context for understanding the perspectives of the parties, it is the micro-level issues that will ultimately form the basis of each negotiation.

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