



Effective Accountable Care Organizations (ACOs) Must Improve the Quality and Efficiency of Care While Not Unduly Raising Prices for Any Patients or Payers in Their Communities

Issue: Health care delivery in the U.S. is fragmented and biased toward expensive technology and specialist care. Patients often receive unnecessary or duplicative services, insufficient primary and preventive care; and uncoordinated care from multiple providers. Moreover, health care professionals and facilities often have little incentive to manage resources efficiently nor does their payment depend significantly on patients' outcomes.

The Patient Protection and Affordable Care Act envisions ACOs as key to integrating and rationalizing health care delivery. Beginning with Medicare and Medicaid, the federal government will incentivize and reward networks of providers (hospitals, primary care physicians, specialists and potentially other health care professionals) who succeed in coordinating patients' care, controlling costs and improving quality.

While ACOs have great potential, they also could be a wasted opportunity if they merely repackage or relabel existing provider arrangements and ways of delivering care and pose risks they exert undue leverage to increase prices or shift costs to patients and private payers.

Position: The National Business Group on Health, representing over 315 large employers who provide coverage for 55 million Americans, believes that the Centers for Medicare and Medicaid Services (CMS) should: 1) set high performance standards for quality and efficiency for ACOs; 2) pay ACOs in ways that foster full responsibility and accountability for effective and efficient care; and 3) avoid adverse competitive impacts through unwarranted higher costs or cost-shifting to others.

CMS Should Set High Performance Standards for Quality and Efficiency for ACOs

To evaluate the performance of ACOs, we recommend that CMS use:

- National Quality Forum (NQF) endorsed quality measures whenever possible.
- The emerging (Quality Alliance Steering Committee) QASC cost and efficiency measures, as endorsed by the NQF, whenever possible.
- (Consumer Assessment of Providers and Systems) CAHPS measures of patient experience and patient satisfaction with care.

ACOs Should Truly Integrate, Organize and Coordinate Care Delivery and Not Repackage Existing Delivery Modes That Are Not Effective or Efficient

ACOs must:

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- Deliver evidence-based preventive care and primary care services to those who need them, when they need them;
- Have effective patient and/or family-centered medical homes, particularly for those with chronic conditions.
- Foster safe surgical, inpatient and outpatient environments free from health-care acquired infections, medication and/or other errors and all avoidable complications;
- Make care transitions safe;
- Conform care to available evidence;
- Implement clinically integrated information technology (IT) systems that provide relevant information at the point of care, assist in care coordination both in and outside the ACO, share information with other providers, and use electronic health records for all patients;
- Use registries to track innovative treatments; and
- Involve patients and their families in care decisions through shared decision-making
- Promote patient responsibility and accountability for health and wellness

ACOs Must Assume Appropriate Financial Responsibility for Patient Care (Shared Risk as Well as Shared Savings)

- A bonus-only, or shared savings model for ACOs meeting quality and cost growth targets would not fully incentivize ACOs to become more effective and efficient.
- ACOs should share financial risk for losses as well as savings to incentivize them to lower excessive costs and share the burden with Medicare if they fail to meet their targets.

ACOs Should Avoid Adverse Competitive Impacts Due to Undue Market Power

- Specifically, CMS should require existing antitrust review of interested entities as a condition of participation in the ACO program.
- CMS should require transparency in payment methods, pricing, financial incentives, clinical decision making, and administrative processes by all ACO participants
- Entities not passing initial screenings, including those in rural and areas with less competition, may still participate if they make commitments to generate sufficient cost savings or improvements in population health outcomes; they will not add any new exclusivity requirements for providers in the ACOs; nor will they require private payers to negotiate “all or nothing” contracts.

ACOs Must Not Shift Additional Costs onto the Private Sector (Patients, Self-Funded Employers and Private Health Plans)

- Entities that participate in the ACO program must assure that Medicare savings are not due to increased cost shifting.
- CMS should require that ACOs have constant or declining ratios of private payments to Medicare payments for specific services to qualify for shared savings bonuses.