



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

Issue: Health care delivery in the U.S. remains 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 do their payments depend significantly on patient outcomes.

The Affordable Care Act (ACA) established ACOs as a key component of its delivery system reform initiatives in Medicare. The federal government is incentivizing and rewarding 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. Medicare's efforts dovetail with and reinforce similar private sector efforts, including those by employers, to transform the payment and delivery for health care away from fee-for-service toward accountability, outcomes, and performance.

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.

CMS [recently announced](#) the 2015 performance year results for the Medicare Shared Savings Program and the Pioneer ACO Model that show physicians, hospitals, and health care providers participating in ACOs continue to make significant improvements in the quality of care for Medicare beneficiaries, while achieving cost savings. Collectively, Medicare ACOs have generated more than \$1.29 billion in total Medicare savings since 2012.

Position: The National Business Group on Health, representing approximately 419 large employers (including 72 of the Fortune 100) who voluntarily provide coverage for 55 million Americans, strongly supports market transitions away from fee-for-service (FFS) payment arrangements to those which place a focus on value-based payments, particularly accountable care arrangements that encourage care coordination and provider accountability for population health and believes that the Centers for Medicare and Medicaid Services (CMS) should: 1) maintain high performance standards for quality and efficiency for ACOs; 2) reward ACOs that accept 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:

- 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 (EHRs) for all patients;
- Use registries to track innovative treatments;
- Involve patients and their families in care decisions through shared decision-making; and,
- 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)

- CMS should continue to encourage increased participation by ACOs in two-sided risk models, which are essential to improving patient outcomes and reducing costs associated with unnecessary, wasteful and ineffective care.

ACOs Should Avoid Adverse Competitive Impacts Due to Undue Market Power

- ACOs should avoid anti-competitive behaviors including: preventing payers from steering patients to certain providers; tying contracts for ACO services to private payers purchases of other services from providers outside of the ACOs; requiring exclusivity that discourages providers from contracting with payers outside of ACOs; and restricting payers' ability to make information on cost, quality, efficiency and performance available to enrollees. ACOs with high market shares should receive expedited antitrust reviews by the Federal Trade Commission (FTC) and the Department of Justice (DoJ). The FTC and the DoJ should continue to work with CMS to monitor ACOs for anticompetitive activities.

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.