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The Health Industry Forum

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BRANDEIS UNIVERSITY // THE HELLER SCHOOL FOR SOCIAL POLICY AND MANAGEMENT

THE HEALTH INDUSTRY FORUM

ACOS: IMPLICATIONS FOR CONSUMERS

CO-SPONSORED BY THE AETNA FOUNDATION AND

AMERICA'S HEALTH INSURANCE PLANS

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Table of Contents

Session Title	Speaker(s)	Page
Key Themes		3
ACOs: An Introduction to the Coming Debate	Stuart Altman, Ph.D. <i>Professor of National Health Policy, Brandeis University</i>	4
How Will Consumers Navigate in an Era of ACOs?	Robert Galvin, M.D. <i>CEO of Equity Healthcare, the Blackstone Group</i>	5
	Kristen Sloan <i>Vice President, National Partnership on Women and Children</i>	
Benefit Designs and ACOs: How Will Private Employers and Health Plans Proceed?	John Bertko, F.S.A., M.A.A.A. <i>Senior Fellow, LMI Center for Health Reform</i>	8
	Diane Kiehl, R.N., C.L.T. <i>Executive Director, the Business Health Care Group</i>	
	Steve Lafferty <i>Director of Health Benefits, Target</i>	
	Samuel Nussbaum, M.D. <i>EVP Clinical Health Policy and Chief Medical Officer, WellPoint, Inc.</i>	
	Jeffrey J. Rice, M.D., J.D. <i>Aetna - Accountable Care Solutions, Aetna</i>	
How Will ACOs Engage Patients?	Patricia Goldsmith <i>Executive Vice President/Chief Operating Officer, National Comprehensive Cancer Network</i>	11
	David Howes, M.D. <i>President & CEO, Martin's Point Health Care</i>	
	Dick Salmon, M.D., Ph.D. <i>National Medical Executive Performance Measurement & Improvement, CIGNA</i>	
	John Santa, M.D., M.P.H. <i>Director, Consumer Reports Health Ratings Center</i>	

The Health Industry Forum is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading health care organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US health care system.

Conference presentations and other background materials are available at www.healthforum.brandeis.edu.

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Key Themes

Overview

An important aspect of healthcare reform was adoption of the concept of accountable care organizations (ACOs) and creation of Medicare's new shared savings program for ACOs. While the rules for the new program are still being written, there is great enthusiasm over the potential for ACOs to improve the quality and efficiency of care by more effectively integrating care delivery. Yet amid the initial enthusiasm are significant questions. What are ACOs and to whom are they accountable? What is the consumers' role and what will consumers need to make informed decisions about plans, providers, and treatment options? And will ACOs be able to control costs?

Context

On October 14, 2010, the Health Industry Forum brought together a diverse group of stakeholders to examine the implications of the current move to establish accountable care organizations for consumers. Participants included consumer advocates, employers, health plans, and providers. CMS Administrator Donald Berwick also joined the group and shared his perspectives.

Key Themes

- **There is great enthusiasm for the ACO concept.**

From a clinical perspective, there is strong support for the ACO concept. No one opposes a greater emphasis on managing the health of populations, provider accountability or improved integration of care.

Participants agreed that there is no one-size-fits-all model for ACOs. Some want broad latitude regarding what an ACO can look like and the organizational characteristics needed to become an ACO. Others cautioned against allowing any entity to proclaim itself an ACO. Although many support the framework in the new law, several stakeholder groups recommend requiring detailed rules and possibly a formal certification process for designing organizations as ACOs.

- **ACOs must benefit consumers.**

Too often, changes in healthcare that affect consumers are made without any consumer input. As ACOs take shape, it is important that consumers are at the table and that their voices are heard.

Also important is that ACOs should not just benefit payers and providers; consumers must benefit from the integration of services and from associated cost savings. Even though consumers are dissatisfied with the current delivery system, they recall problems of access and quality with HMOs and are wary of change. There must be clear and compelling benefits for consumers to convince them to give ACOs a chance.

- **Employers and health plans will demand that ACOs deliver savings.**

Employers and health plans recognize that provider quality and patient satisfaction are critical. Still, their overriding focus is on cost, value, and affordability. If ACOs only deliver improved quality but don't lower costs, these stakeholders will not view ACOs as a success.

Provider integration is a principal means for improving outcomes and lowering costs. However, with hospitals buying doctors at an unprecedented pace, many are concerned about further provider consolidation, resulting in higher prices. Others are concerned that if ACOs give consumers free choice of providers and bear no financial risk for medical spending, controlling cost will be impossible. In each panel, participants said that payment reform is essential to align providers' incentives around quality and cost.

Private payers can be more aggressive than Medicare. They can use strategies like soft enrollment to get members into ACOs or use incentives such as tiered co-payments to keep members in lower cost ACOs. Many believe that consumer financial incentives could also be used in commercial and Medicare ACOs to encourage disease management and healthier lifestyles.

- **ACO success will require informed and engaged consumers.**

Historically, consumers have been passive participants in healthcare, letting providers guide decisions. Some believe that the healthcare industry has intentionally controlled information about cost and quality so that consumers have no idea about the value of any given treatment or service. Getting consumers credible information about cost, provider quality, treatment options, and provider incentives will require significant effort.

Along with credible information, healthcare organizations need to do a much better job engaging patients in their own health and wellness. Engaging patients will require multiple types of interventions and coaching, which will require investments in people and technology. Health plans have capabilities in this area and there are many opportunities for plans to partner with delivery systems to support ACO models.

- **The current development of ACOs is a first step in a long-term process.**

While it is easy to be skeptical about the ability of ACOs to transform care and lower costs, most view this model as stage one in a long-term learning process. Even though ACOs won't be perfect, most believe they represent an important opportunity for change and are a far better alternative than the status quo.

ACOs: An Introduction to the Coming Debate

Stuart Altman, Ph.D., Professor of National Health Policy, Brandeis University

Overview

The debate over accountable care organizations (ACOs) is similar to that at the inception of health maintenance organizations (HMOs) in the early 1970s. The idea that an organization will be accountable and will integrate care is appealing, though no one is clear how it will ultimately play out. However, unlike HMOs that restricted consumers' choices or required providers to take significant risks, there are no plans to have ACOs limit choice or have providers take financial risk. This sounds consumer friendly, but will it work? What roles and responsibilities will consumers take on in an ACO world?

Context

Professor Altman framed the discussion for this forum by sharing his observations about similarities and differences between how ACOs are contemplated in the health reform legislation and the HMOs of the 1990s, and by raising questions about the role of consumers as ACOs take shape.

Key Themes

• The emergence of ACOs bears many similarities to the emergence of HMOs.

Professor Altman recounted lessons learned concerning health maintenance organizations in the early 1970s. At that time, he wasn't familiar with Kaiser or with the ideas of integrated delivery or capitation. He found it appealing that an organization would be responsible for maintaining his health, but he admitted, "I didn't have the foggiest idea what an HMO was, but it really sounded good."

The HMO Act of 1973 had a significant impact on healthcare in the United States. It led to new companies and new models of payment and delivery. However, it took a long time to figure out what an HMO is and how it works. Even today, the landscape continues to evolve.

The situation today bears many similarities. As with HMOs, the idea of an accountable care organization is appealing. It is comforting to think about an integrated delivery system and to know that an organization is accountable for your care. However, as with HMOs, no one knows what ACOs really are and how they will work. Who are accountable care organizations accountable to?

• HMOs stalled because of consumer backlash.

HMOs were beginning to really take hold in the mid-1990s when they stalled. This occurred because consumers felt used; they didn't feel like the system was working for them. People felt that employers forced them into HMOs without giving them a choice. The perception was that the employers and providers benefitted, but consumers did not.

"The great managed care environment of the 1990s fell apart to a large extent over the fact that the consumer, the patient, felt used."

— Stuart Altman

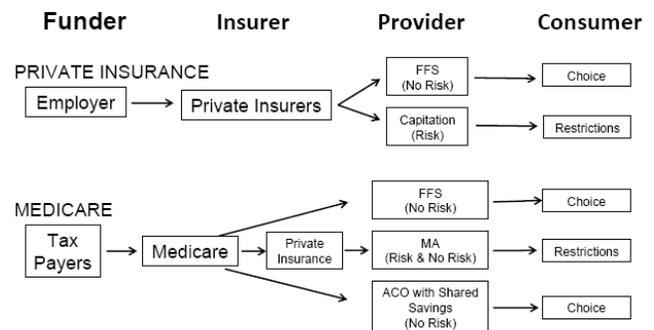
HMOs learned from this backlash and today many have become much more patient-focused organizations. Lessons from this backlash are evident in the creation of ACOs.

• While many uncertainties remain about ACOs, most significant is the role of the consumer.

The diagram below lays out how different insurance options affect providers and consumers. Employers purchase private insurance, and insurers pay providers either fee-for-service (FFS), with no risk to the provider, or on a capitated basis with the provider taking some financial risk. In a FFS model consumers have unlimited choice, with some restrictions in a capitated model.

With Medicare, the situation is similar, though taxpayers fund coverage. Most beneficiaries have FFS coverage. Providers don't take risks and consumers have choice. But about 12 million beneficiaries (25%) participate in Medicare Advantage (MA). Under these plans, providers may take on financial risk and consumers have some restrictions and additional benefits.

The Impact on Providers and Consumers Under Different Insurance Options



ACOs will be a new model under Medicare. The regulations are being written, but the current thinking is that providers won't incur financial risk; they can benefit through shared savings. The idea is not to pressure providers, but to provide incentives. Also, the plan is that ACOs will not impose restrictions on consumers. This avoids the problems HMOs faced in the mid-1990s; however the effects of this design are unknown. The ACO movement raises many questions such as whether patients should have any responsibilities or restrictions and how this new model will improve quality and control cost. At this point, there are many unknowns underlying the hopes that a better system can emerge.

How Will Consumers Navigate in an Era of ACOs?

Presenter: **Kristen Sloan**, Vice President, National Partnership on Women and Children

Responder: **Robert Galvin, M.D.**, CEO of Equity Healthcare, the Blackstone Group

Overview

Consumers want a patient-centered delivery system with higher quality, better coordination, and lower costs. Many consumer advocates believe that ACOs have promise for providing what consumers need. However, having lived through managed care in the 1990s, consumers are wary of changes that limit choices in the name of cost savings alone. Consumers want a voice in defining the ACO requirements. They want choice. They also want full transparency of cost, quality, and gain-sharing arrangements so that they can make informed decisions.

Context

Ms. Sloan shared research on what consumers will want from ACOs and Dr. Galvin offered his perspective on several important considerations that will directly impact their potential success.

Key Takeaways (Sloan)

- **Consumers want improvements in health care but also want their perspectives considered.**

Consumers face considerable challenges in today's healthcare system. They see uncoordinated care, little chronic care management, poor communication, and duplicative care. Consumers don't want the status quo; they want and need a better system.

However, consumers are also wary of changes that do not meet their needs. Historically consumers have not been consulted or engaged in design of new care and payment models. There is often a "disconnect" between what consumers say they need and what payers or policymakers think consumers want.

- **New models like ACOs are promising—if done right.**

Patient-centered models, like ACOs, show promise. Along with potentially lowering the cost of healthcare, they could improve healthcare delivery through better care coordination and other improvements. The key is ensuring that such models "are done right." Research conducted by the National Partnership for Women & Families (NPWF) has identified what consumers say are the most important elements of patient-centered care:

- "Whole person" care.* Consumers want to move away from medicine by body part and towards a team of clinicians who know and understand them.
- Comprehensive communication and coordination.* Consumers support a team treatment approach that is based in primary care. Clinicians must know their

patients and understand the full range of factors affecting ability to get and stay well. Treatment recommendations must align with patients' values.

- Patient support.* Patients want to be active participants in their care and to partner with their providers. They are looking for tools to help them effectively manage their own conditions.

- Ready access.* The key to access is network adequacy so that members of an ACO team are available when the patients need them. Ready access must also take into account the needs that arise from an aging population with physical limitations and cognitive impairments.

- Health information technology (HIT).* Consumers are interested in how HIT (particularly electronic health records) can be used to make healthcare more efficient.

Beyond the way that ACOs coordinate and deliver healthcare, other ACO elements are important to consumers.

- Transparency.* Consumers want to know if their doctor is in an ACO; they want and expect transparent attribution. They also want to know if their doctor has financial incentives related to their treatment, such as shared savings arrangements. Consumers also want transparent quality results. Payment must be linked not just with clinical measures, but to patient-centered metrics like patient experience.

- Appeals.* Consumers need an external appeals process. A credible impartial entity is required to review and resolve complaints quickly and fairly.

- Patient engagement.* Patients want to partner with providers in making shared treatment decisions. Patients need to be active members of ACO governing bodies.

Ultimately, for ACOs to be viewed positively by consumers the benefits can't accrue only to health plans and providers; patients must understand how they benefit.

"If we build a truly patient-centered system in collaboration with consumers, they will embrace it, benefit from it, and help ensure its success."

—Kristen Sloan

Key Takeaways (Galvin)

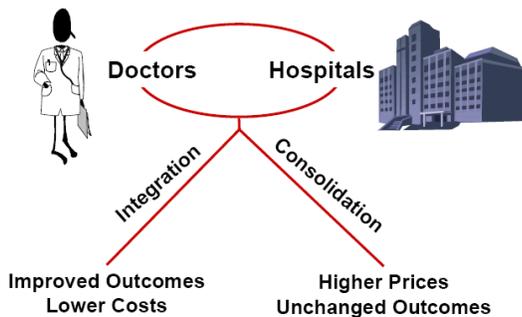
- **Employers will be cautious about incenting employees to join networks that restrict choice.**

Having spent many years at one of the country's largest employers, Dr. Galvin is very sensitive to the issues that employers will face. He likes the notion of accountability residing with providers and anticipates that payment to ACOs will eventually evolve into a global payment.

With providers receiving global payment and being accountable for the health of populations, two key issues will arise:

1. *Convincing people to choose ACOs.* In the wake of the backlash against HMOs, Dr. Galvin believes employers will be reluctant to incent employees to join networks that might be construed as limiting their choices. Dr. Galvin describes employers as having an attitude of "once bitten, twice shy." He believes the government also will have difficulty incenting consumers to move into these networks.
 2. *Managing situations when individuals aren't happy with their ACO.* There will invariably be situations where consumers aren't happy with their ACO and want to seek treatment outside of it. Since ACOs will receive a global payment to cover all of a patient's care, letting individuals go wherever they want will present a challenge. One way to mitigate this situation is to require ACOs to report publicly performance information relevant to consumers at a provider level. This could decrease the number of people wanting to get care outside the ACO. If it doesn't, the ACO will need other ways to convince consumers that the care they need is best provided in the ACO.
- **It is unclear if ACOs will lead to lower costs, which is essential.** As doctors and hospitals become more closely linked, as is shown in the diagram below, it is unclear if integration or consolidation will be the outcome.

ACO's: Integration or Market Dominance?



Integration is the hope for ACOs, with improved outcomes and lower costs. However, with hospitals buying doctors at an unprecedented pace, consolidation

may be the reality, resulting in higher prices. In many markets, ACOs will not be multi-specialty groups or MSOs—they will be physician-hospital organizations. It is not clear if this structure ACO will be able to produce the desired result.

Recently, Dr. Galvin has observed that contrary to his expectations a select number of consolidated organizations are making good progress on outcomes. However, consistent with his expectations, some of these organizations are raising prices dramatically. What he had seen recently at GE was that 70% of cost increases were coming from hospital inpatient and outpatient care, and 70% of that was attributable to pricing. Many of the organizations that had raised prices significantly were planning to become ACOs. As regulations enable doctors and hospitals to come together to deliver care, it inadvertently may enable them to raise prices to private payers. Smart policy is needed to drive seamless and efficient care but not consolidation, which will result in higher prices.

Participant Discussion

- **Creating an ACO.** A participant observed that many commercial ACOs seem to have been created in an ad-hoc manner. There are presently no ACO standards and patients may unknowingly become ACO customers. This could cause considerable consumer concerns. Many believe that ACOs must be regulated to ensure they meet minimum requirements and are reviewed by an independent certification entity.
 - **Alignment of the public and private sectors.** It is important that payment systems, incentives, and quality standards in private health plans are aligned with those of the public sector. If they are not, incentives for delivery system performance will be diluted.
 - **Receiving care outside an ACO.** Conflicts may be inevitable when patients want different care or more care than is provided by an ACO. One participant suggested that processes to provide a "relief valve" when these situations occur should be developed. For example, there might be shared financial responsibility for out of network care between the individual and the ACO.
- Dr. Galvin commented that when people get sick, they get scared. When conventional treatments don't work and patients hear about other treatments from another patient, they will want this treatment. While such instances may be uncommon, they can't be ignored. Under global payment, these rare but costly exceptions have to be anticipated, and policies to resolve them must be developed.
- **Trust and choice.** A physician from a group practice emphasized that his patients are more interested in trust than choice. Having a medical home with a trusted navigator who knows the patient is essential. In this physician's experience, most patients don't want unlimited choice. They want a trusted resource who can

answer, “Who do you recommend?” In addition, it is important that there is transparency of physician incentives and treatment options so that patients can make informed choices. Many agreed that patients must have freedom to select providers based on objective information about cost, quality indicators, and financial arrangements between payers and providers.

- **Consumer-driven guidelines and principles.** One participant suggested that consumer groups develop principles and guidelines to guide and evaluate ACO development. Ms. Sloan agreed and pointed out that consumers need education to help them become true partners in ACO discussions.
- **Patient dumping.** Protections are needed under global payment models so that ACOs cannot dump sick patients.

One idea is that ACOs could be responsible for populations of patients for a multi-year period.

- **Transparency on performance measurement.** In response to a question about the role of transparency in consumer choice, Dr. Galvin said that transparency could be a requirement for providers to receive shared savings payments. In addition, performance measures should be available to consumers at the ACO level or the individual physician level, depending on what consumers need to make informed decisions.

Benefit Design and ACOs: How Will Private Employers and Health Plans Proceed?

Panelists: **John Bertko, F.S.A., M.A.A.A.**, Senior Fellow, LMI Center for Health Reform
Diane Kiehl, R.N., C.L.T., Executive Director, the Business Health Care Group
Steve Lafferty, Director of Health Benefits, Target
Samuel Nussbaum, M.D., EVP Clinical Health Policy and Chief Medical Officer, WellPoint, Inc.
Jeffrey J. Rice, M.D., J.D., Aetna - Accountable Care Solutions, Aetna

Overview

For employers and health plans, the improved integration and quality promised by ACOs is important but not sufficient. These stakeholders want reforms that create cost savings. They are optimistic about the potential for ACOs given the emphasis on accountability and the focus on population health, but believe that payment reform is necessary to drive meaningful delivery system reform. Other key issues include reconciling consumers' desire for broad provider choice with the desire to make providers accountable for the care of specific individuals, and the need for greater transparency to help consumers make educated health care decisions.

Context

The panelists discussed the role of benefit design and incentives in ACOs from the perspective of employers and health plans.

Key Takeaways (Actuary - Bertko)

- **It is important to understand what ACOs are and what they are not.**

Mr. Bertko said that organizations can't merely label themselves as ACOs. There are roughly 100 design elements that must be addressed in order for organizations to truly be an ACO. The key financial aspect of an ACO is an agreement between providers and payers to share gains. Gain sharing might be "bonus only," "symmetric risk" with bonuses and withholds, or "partial capitation." An important lesson from HMOs is that there should be no gain sharing unless certain quality metrics are met.

Mr. Bertko emphasized that ACOs are not HMOs. ACOs are not closed networks nor do they have gatekeepers; enrollees can use any provider they want and don't need permission. Also, ACOs are not fully capitated. They are meant to operate under a prospective budget model that includes all Part A (facility) and Part B (professional and ancillary) costs.

"ACOs are not closed networks. They are not HMOs. They are not gatekeeper models. Patients can go anywhere. ACOs are an alternative."

— John Bertko

- **Benefit design can be used to promote ACO use.**

It won't work to try to force people into ACOs or limit their choice. One approach worth considering is "soft enrollment" where people who use certain doctors and meet certain criteria are enrolled in an ACO unless they opt out.

Analysis of claims data shows that people tend to stay within specific care systems. In PPOs, leakage outside of the network has typically been less than 10%. For Medicare beneficiaries where there is no network, 70-80% of all care is typically delivered within a particular system. It is possible to further increase the proportion of care within a system by increasing primary care capacity, offering extended hours or open scheduling, and taking steps to keep patients out of EDs and hospitals.

For private payers, tiered networks with incentives can be used to steer people to desired providers. For example, an ACO could be viewed as the "prime tier" with the lowest co-pays.

There also may be opportunities to employ value-based insurance design (VBID) principles where patients are incented to select providers or treatment options based on value. While VBID has mainly been used for prescription drugs there are opportunities to extend it for other treatments.

Key Takeaways (Employers - Kiehl and Lafferty)

Ms. Kiehl is the executive director of the Business Health Care Group, a coalition of over 1,000 businesses in southeast Wisconsin that came together to lower their healthcare costs. Mr. Lafferty manages health benefits at Target, one of the country's largest retailers with 340,000 employees in 49 states.

- **Employers want lower healthcare costs and improved employee health.**

The Business Health Care Group was founded because the cost of healthcare for companies in southeastern Wisconsin was 27% higher than elsewhere in the Midwest. It is trying to lower its healthcare costs by: "walking in unison" as a business community; providing transparency on provider cost and quality; promoting accountability by all parties; and educating consumers to help them make more informed decisions.

Target is also working to “bend the cost curve.” Target is concerned about provider inefficiencies, an increase in chronic disease related to employee behavior, and lack of employee engagement in preventive care, which results in high cost claims. To address these concerns, Target is promoting a culture that encourages healthier lifestyles. The company also is exploring benefit design changes to align employees’ incentives with healthy behaviors, and with using centers of excellence and preferred provider networks.

“We are focused on cultural change within our organization . . . and on aligning incentives.”
 — Steve Lafferty

▪ **Employers are interested in the concept of ACOs, but see several challenges.**

Ms. Kiehl emphasized that all stakeholders, including employers and consumers, must participate in the design of this new system. The current trend of health systems buying up providers to lock in market share will not transform the delivery system. Competition is needed to moderate costs and improve quality. In addition, maintaining consumer choice will help hold providers accountable because it places the burden on providers to find ways to keep patients in the ACO voluntarily. This will require that consumers have credible information about provider performance.

Mr. Lafferty indicated that Target is interested in solutions that focus on population health; the company has agreed to participate in ACO and other payment reform pilots.

Employers also want to make sure that their concerns about ACOs are addressed.

—*Reconciling “choice” and “accountability.”* Employers want to satisfy employees by providing broad choice, yet they are concerned that unrestricted choice complicates provider attribution and accountability. Mr. Lafferty indicated that in the longer term, Target may find it necessary to restrict choice to maximize value.

—*Avoiding attempts to lock in market share.* Ms. Kiehl worried that health systems will claim to deliver integrated care just to lock in market share without truly integrating care.

—*Creating new payment models.* Both employer representatives agreed that new payment models are needed that tie payment to outcomes.

—*Increasing transparency.* Consumers need much better tools and information on cost and quality to help them make cost-effective decisions.

Key Takeaways (Health Plans – Rice and Nussbaum)

Representatives from Aetna and WellPoint—two of the country’s largest health plans—offered perspectives on how their organizations are thinking about ACOs.

▪ **ACOs must focus on value and affordability.**

Both health plan representatives emphasized that if ACOs just improve quality but don’t address costs, they won’t be successful.

A challenge shared by Dr. Nussbaum is that consumers are misinformed about what drives healthcare costs. Consumers believe lawsuits, insurance companies, and the government are the reasons for rising costs. However, the biggest factor driving health spending is the rapid growth in payments to physicians and hospitals. Over the past decade deteriorating health status due to behavior (i.e. smoking, obesity) has also contributed.

▪ **ACO success requires payment reform.**

Providers today are set up to optimize their revenue in a fee-for-service environment. Health plan representatives stressed the importance of changing how payment works. Payment must be aligned with quality and outcomes, not volume. Dr. Rice believes that employers, which make the ultimate insurance purchasing decisions, need to be the major driver of payment reform.

Dr. Nussbaum shared data from the Commonwealth Fund indicating that the financial interests and incentives of healthcare providers, as well as lack of financial incentives for integration, are seen as greater barriers to the growth of population-based ACOs than patients’ preferences for open access. Dr. Nussbaum also expressed concern that providers seem to expect that all of the gain in gain-sharing arrangements goes to them.

Dr. Nussbaum mentioned that WellPoint is pursuing other payment reform initiatives in addition to ACOs. These include bundled payments, medical homes, and centers of excellence. WellPoint wants to drive more volume to providers that deliver higher quality at lower cost.

▪ **Health plans’ role is to provide architecture and systems to support ACOs.**

Dr. Nussbaum observed that the ACO development may move activities built by health plans—like care coordination, disease management, and health advocates—into ACOs.

Moreover, he noted, in order for ACOs to have discernable value, they need to foster greater efficiency among participating providers and transparency for consumers. For example, WellPoint is helping providers improve efficiency through a partnership with Availity, a multi-payer portal company that simplifies many administrative tasks for providers, including checking a

patient's eligibility and benefits, and providing information related to utilization management. In addition, WellPoint plans to use the Availity portal to deliver patient-specific information at the point of care, helping to reduce the time physicians spend looking for information and to reduce duplicative tests, resulting in improved quality of care.

Dr. Nussbaum added that WellPoint is working to help doctors spend more time on care and less time on paperwork, at no charge to doctors. WellPoint, for instance, has developed a tool to provide better quality and cost information to its members called Care Comparison. This tool was recently adopted by the entire Blues system.

Initiatives like these, Dr. Nussbaum stressed, combined with reimbursement reforms and a shared commitment to lower the cost of medical care, have the potential to make a real difference in how health care dollars are spent—to reward value over volume.

From Dr. Rice's perspective, health plans will support ACOs with architecture, infrastructure, and systems. This entails both patient and provider applications:

- Patients.* Health plans will develop new plan designs with incentives for patients to select plans based on value; engage in healthy behaviors; and choose efficient providers. Health plans will create networks that encourage participation in ACOs, and will offer health-management tools as well as education. Plans are likely to deliver support in multiple ways including face to face, over the phone, and via the Internet.
- Providers.* Providers will have to compete on value. Aetna envisions helping ACOs with the technology, infrastructure, and care-management capabilities they need.

"The health plan's role is to provide the architecture, systems, and support for Accountable Care Organizations."

— Jeffrey J. Rice

▪ **ACOs may face regulatory issues.**

Dr. Nussbaum said that a number of health plans that have developed limited networks have faced challenges from state regulators. This may be a challenge for ACOs as well.

Also, many opinion leaders see a need for regulations specific to ACOs including standards for primary care capacity, developing a national ACO accreditation

system, and public utility regulation of ACO rates in areas without market competition.

"The recommendation that many opinion leaders make is that for ACOs to be successful, not only do you need insurance design and payment reform, but you need to put regulations around these organizations."

— Samuel Nussbaum

Participant Discussion

- **Provider dilemma.** Even with accurate information on quality and cost, one participant said it is hard to imagine a provider suggesting to a patient that they leave their network to receive higher-quality or lower-cost care elsewhere.
- **Centers of excellence.** Many patients choose not to go to centers of excellence, even if they are higher quality and lower cost. The reasons include not wanting to leave their community and lacking data about the improved quality and outcomes. A participant suggested that detailed outcomes data would sway many people.
- **Long term, high quality/low cost is unlikely.** The view was shared that in the long term, there won't be high-quality/low-cost providers. High-quality providers will have no incentive to price below the market. Like in other industries, high-quality providers will have the ability to command higher prices, often substantially higher.
- **Using information to lower costs and drive value.** A major employer in California recently put a \$30,000 cap on what it would pay for hip and knee replacement surgery. All costs over the cap have to be paid for by the consumer. A result is that some hospitals that have been charging \$60,000 or \$80,000 are lowering their prices to gain or preserve volume.
- **Payment reform and HIT required.** A participant from Massachusetts finds it unimaginable to implement ACOs without payment reform. A lesson from Massachusetts, where some providers are now participating in Blue Cross Blue Shield's Alternative Quality Contract, is that providers will need significant HIT investments to make an ACO work.
- **Patient accountability.** Several participants mentioned that it is not just providers that need to be accountable; patients also must be accountable. This will require changes in patient engagement, education, communication, and transparency. Patients must have access to credible information to make informed decisions.

How Will ACOs Engage Patients?

Panelists: **Patricia Goldsmith**, *Executive Vice President/Chief Operating Officer, National Comprehensive Cancer Network*
David Howes, M.D., *President & CEO, Martin's Point Health Care*
Dick Salmon, M.D., Ph.D., *National Medical Executive Performance Measurement & Improvement, CIGNA*
John Santa, M.D., M.P.H., *Director, Consumer Reports Health Ratings Center*

Overview

Patient engagement is a relatively new focus that is viewed by some as necessary for the successful implementation of ACOs. Improving patient outcomes and population health will require deliberate efforts to engage patients in managing their own health. Panelists discussed interventions to boost patients' confidence in managing their own illnesses and strategies for making information available that would help patients select appropriate providers and treatment options. There is some debate over the role of provider groups versus health plans in making patient engagement a cornerstone of the ACO delivery model. Patient engagement strategies will require continued development and testing to establish successful models.

Context

Panelists, representing consumers, providers, and insurers discussed approaches their organizations have used to engage patients.

Key Takeaways (Healthcare Provider)

Dr. Howes described how his healthcare network modified its culture to engage patients more effectively.

- **Focusing on patient experience has been transformational for Martin's Point Health Care.**

High NCQA rankings and even good patient satisfaction results don't necessarily reflect how patients feel about their healthcare experience. So, about two years ago Martin's Point Health Care in Maine began examining whether patients understood and felt capable of managing their own disease. As a result, Martin's Point has:

- Built medical homes.* Each of Martin's Point's practices will soon be part of a medical home care delivery model.
- Focused on building patient confidence.* More confident patients have better outcomes. Martin's Point has focused its entire organization on boosting patients' confidence in self-management.
- Required that physicians reach out to patients.* In an ACO, it is essential that physicians deliberately construct a process of education and follow-up with each patient. Knowing their patients and determining the proper intervention for each is a key to building patient confidence.

—*Studied best practices.* The best practice in the U.S. comes from CareSouth, where patient confidence levels went from 40% to 100%. CareSouth segmented patients based on their level of confidence and provided specific, repeated interventions for each patient and carefully evaluated each visit and interaction.

Martin's Point is now applying lessons learned from CareSouth, starting with patients with hypertension. Each patient receives an extensive education plan. Initial lessons indicate that:

- **Focusing on patient experience is differentiating.** Martin's Point's hypertension interventions have generated enormous patient loyalty and have differentiated Martin's Point from other providers.
- **Some patients aren't motivated.** Martin's Point has found that despite the organization's best efforts, some patients who need an intervention are not personally accountable. If they don't come in and don't respond, it isn't clear how to engage these individuals in an ACO model.

Key Takeaways (Health Plan)

Dr. Salmon explained how CIGNA Healthcare is working in partnership with providers to accelerate improvements in quality and patient outcomes.

- **CIGNA has developed its own ACO-type model.**

CIGNA insures about 10 million people, most of them in open access plans. Over the past two years CIGNA has developed an ACO-type model called Collaborative Accountable Care. This model is being implemented in ten locations across the country with primary care groups, multi-specialty groups, and integrated delivery systems.

This model is based on IOM and patient-centered medical home (PCMH) principles. It places patients in the center and emphasizes collaboration between CIGNA and providers. CIGNA's goal is to help medical groups be successful through:

- Clinical programs.* CIGNA is open to transferring some case management responsibilities to providers, which are hiring nurses to assume these responsibilities. CIGNA is also working with medical groups to bring patients into disease management programs in ways that feel like extensions of the practice.
- Informatics.* CIGNA is producing patient-specific information for providers that can be used to guide improvements. Informatics also can be used to identify

gaps in care and patients at the highest risk for readmission.

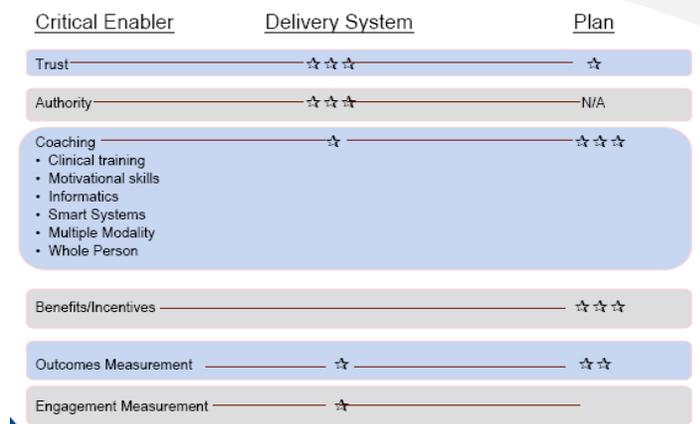
- Management reports.* CIGNA is supporting its Collaborative Accountable Care participants by providing management reports. For the first time, many providers can see how they are performing on quality and cost of care for their patient population.
- Rewards.* Participating providers are paid a monthly PMPM care-management fee. Organizations are eligible for rewards if they improve the medical cost trend, quality, and patient satisfaction. Just controlling cost is not adequate; participants must also improve quality and satisfaction. Rewards for patient experience will be added.

▪ **Engaging patients must take into account the strengths of providers and health plans.**

Dr. Salmon shared ideas on the factors that are necessary to engage patients, and offered perspectives on the capabilities of the delivery system and health plans. He sees the critical enablers in engaging patients as:

- Trust.* Patients must trust the sources of information. Physicians have high levels of trust; plans have less trust. As ACOs evolve insurance risk should remain with health plans in order to preserve trust in providers.
- Authority.* This is about having patients accept clinical recommendations and follow instructions. Currently, patients are more likely to question providers' recommendations than previously. Still, delivery systems have significantly more authority in the eyes of patients than health plans.
- Coaching.* Good coaching that engages patients is a critical skill that requires extensive training. Good coaching, smart systems, and informatics can help produce better patient outcomes. This is an area where health plans have strong capabilities while delivery systems are lagging.
- Administering benefits and incentives.* This includes tiered networks and incentives to go to certain providers. It also entails rewards for healthy behaviors. Health plans have developed capabilities in this area and delivery systems have not.
- Outcomes measurement.* Both delivery systems and plans are just starting to use specific indicators that measure clinical outcomes for specific treatments and services. Plans are slightly ahead.
- Engagement measurement.* Patient engagement measurement focuses on patients' skills and confidence in taking steps to stay well and effectively manage their health conditions. Plans and delivery systems currently lack experience; the delivery system is slightly ahead.

Population Total Health Engagement



Health plans and delivery systems can work together to utilize what they do well in a collaborative fashion and develop and test patient engagement strategies that currently lack evidence.

Key Takeaways (Clinical Information Provider)

Ms. Goldsmith shared how the National Comprehensive Cancer Network (NCCN) is helping consumers make more informed decisions.

▪ **The healthcare system has not found a way to engage the majority of consumers.**

Historically, patients have played a passive role in healthcare. Everyone involved in healthcare agrees that this must change. The challenge is how to do it.

Ms. Goldsmith is concerned that when employers or payers say they want to increase patient accountability, it typically means cost shifting. The theory is that if consumers pay more, they will be more engaged. However, consumers lack information to evaluate what they are purchasing. Currently, consumers have more information about purchasing refrigerators than about making choices regarding cancer treatments.

When consumers are selecting insurance, they typically look just at whether their physician is in the network and the amount of co-payments. This is not engagement in healthcare.

“We have to find better ways to bring consumers into the system and enable them to understand what they are purchasing and what they are receiving.”

— Patricia Goldsmith

▪ **NCCN is helping patients make better decisions about their treatment.**

NCCN is a developer of clinical practice guidelines that have become the standard of care in cancer care across

the world. To date, the organization has focused primarily on producing information for providers. However, about a year ago, NCCN created a new consumer website, www.NCCN.com, as a way to supply patients with credible information on the best treatment plan for each cancer according to its stage. NCCN is publishing its guidelines in a patient-friendly format to help patients understand their treatment options and be able to engage in more informed discussions with their clinicians.

Key Takeaways (Media)

Dr. Santa provided a perspective on how organizations in the media may cover ACOs.

- **The media is excited about the opportunity to furnish consumers with more information.**

Dr. Santa isn't sure how ACOs will work for consumers, but he sees much opportunity for the media. He termed healthcare a "dysfunctional market" that is dominated by industry stakeholders. The industry has controlled information about cost and quality, creating an unlevel "playing field." Consumers have no idea about the value of any given treatment or service.

In Dr. Santa's view, ACOs will be evaluated based on:

- Consumer experience.* This includes how a patient is treated, the culture in a physician's office, and a patient's perception of trust and safety. Patients expect physicians to have their interests in mind. However, greater awareness of physicians' financial incentives and growing perceptions of physician relationships with industry (i.e. drug reps) has caused some patients to question the trust they have placed in physicians.
- Objective information.* Increasingly there is a segment of educated consumers who are hungry for objective information and will use this information to make decisions about providers.

Consumer Union sees opportunities to provide four types of information related to ACOs:

- Who the doctors are.* This includes basic information such as a doctor's name, where they work, and their phone number. While you might think this type of basic information is easily accessible, surprisingly it often is not or is incorrect, causing concerns about credibility. Consumers Union would say this is typical

of an industry that doesn't fairly disclose information to consumers.

- Patient experience data.* Patients believe it is important to get a sense for how others feel about a doctor or a practice. Collecting this data will be a significant undertaking, costing \$50-\$100 million per year.
- Performance data.* Consumers are smart and educated, particularly those who subscribe to *Consumer Reports*. They want data so they can compare their options.
- Cost.* Consumers want a general sense of the cost of physicians' services.

While this type of information won't be used by all consumers, many want such data to make informed comparisons. This will be an important opportunity for organizations like Consumer Union.

Participant Discussion

- **Motivating patients.** If patients aren't motivated, incentives can play a role. Dr. Howes sees nonfinancial incentives as critical. This entails figuring out what matters to a patient, such as watching a child graduate from college.
- **Decreasing variation.** In response to a question about variation in cancer treatment, Ms. Goldsmith said the keys to decreasing variation are alignment of providers' incentives and transparency about cost and quality.
- **Assigning patients.** While most CIGNA members are in open access plans, CIGNA is assigning members to its Collaborative Accountable Care groups. This ensures that these groups are clear about who they are accountable for. Members receive a letter from CIGNA explaining the benefits of their Collaborative Accountable Care group. These letters do not mention the financial arrangements between CIGNA and the provider. Because the providers' bonus is tied to solely to quality and patient satisfaction results, CIGNA is comfortable that its members' interests are taken care of.
- **Transparency may erode trust.** Historically, consumers have trusted providers and accepted their advice. However, increased transparency about quality and cost could lessen consumer trust in some providers.
- **Believing the data.** To change providers' and consumers' behavior, data must be credible. Trusted sources of credible actionable data must be established.