



**ACCOUNTABLE CARE ORGANIZATIONS AND
FEDERAL HEALTHCARE REFORM:
A Search for New Payment Models that will Provide
Better Care, Improve Health Outcomes and Reduce Costs**

Prepared for Con Alma Health Foundation
and its Blueprint for Health New Mexico Advisory Network

By

Southwest Women's Law Center

Jane Wishner, JD, Executive Director

Kyle Marie Stock, JD, Reproductive Justice and Health Law Fellow

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The mission of the Southwest Women's Law Center is to increase opportunities for women and girls in New Mexico. The Southwest Women's Law Center engages in systemic legal and policy advocacy to address gender discrimination and disproportionate poverty among women and their families, and to increase access to comprehensive healthcare services for women and girls. The Center has been actively engaged in implementation of the Affordable Care Act in New Mexico since its adoption in March 2010. The Center's goals are to ensure that implementation of the Affordable Care Act maximizes healthcare coverage and access to healthcare services among women and girls throughout the state, and that systems are developed so that the law benefits the most vulnerable and hard-to-reach populations in New Mexico. *Con Alma Health Foundation provided funding for this paper.*

1410 Coal Avenue SW
Albuquerque, New Mexico 87104
505.244.0502 | Fax 505.244.0506
www.swwomenslaw.org

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In 2011, the W.K. Kellogg Foundation awarded Con Alma Health Foundation a strategic planning grant to help New Mexico ensure the successful implementation of the Patient Protection and Affordable Care Act (the “Affordable Care Act” or the “ACA”).ⁱ Con Alma Health Foundation convened a Blueprint for Health New Mexico Advisory Network (“Blueprint for Health New Mexico”) to help develop that strategic plan. This paper provides a preliminary analysis of Accountable Care Organizations – a relatively new healthcare payment model contained in the Affordable Care Act. The purpose of this paper is to assist the Blueprint for Health New Mexico address the issue of payment reform to improve healthcare access and healthcare quality for New Mexicans as the ACA is implemented in New Mexico.

I. EXECUTIVE SUMMARY

Accountable Care Organizations (“ACOs”) represent a new payment model for health care services that are designed, in theory, to lead to better quality care for patients and lower costs. There is no single definition of an ACO. In general, ACO payment models create financial incentives for groups of health care providers to form an Accountable Care Organization. The ACO would be responsible for coordinating patient care and would be held accountable – by the payer – for health outcomes of a particular group of patients. Under an ACO payment model, the ACO providers could share in savings from the care they provide, share some of the risk if costs of care are higher, or some combination of shared savings and risk. ACOs are still in the early developmental stage, but the Affordable Care Act created a significant ACO initiative in Medicare – the Medicare Shared Savings Program – and, as a result, ACOs have become a hot topic among providers and insurers.

It is important to clarify what people mean when they are talking about creating an Accountable Care Organization. ACO models differ widely and the term “ACO” means different things to different people. Providers and payers have direct financial interests in the structure and payment policies of an ACO and thus the details can be intensely debated and controversial. Patients have a huge interest in how ACOs are structured and implemented – since they are supposed to offer better quality care and improve health outcomes – but generally do not have a seat at the table when ACOs are established. Indeed, patients may not know if they are receiving care under an ACO payment arrangement or – even if they do know – may not be able to determine whether they should seek another provider who is not part of an ACO. Patients may be concerned if healthcare providers have an incentive to save costs on their care. Patients, their families and their caregivers will need to understand how the financial incentives in an ACO payment system will improve the quality of healthcare the patients receive, and not lead to the withholding of care or the restriction of patients’ access to appropriate healthcare.

The Affordable Care Act contains two explicit ACO initiatives and an opportunity to create other ACO payment models:

1. **Medicare Shared Savings Program.** The primary ACO initiative in the Affordable Care Act is called the "**Medicare Shared Savings Program.**" (ACA § 3022). The Medicare Shared Savings Program is optional for providers and includes both a shared savings and shared risk component. The proposed regulations contain significant requirements for care coordination and patient-centered quality measures. The program will begin in 2012 and providers in New Mexico will have an opportunity to create Accountable Care Organizations and apply to participate in the Program for at least three years.

2. **Pediatric Accountable Care Organization Demonstration Project.** The Affordable Care Act also authorizes the establishment of a **Pediatric Accountable Care Organization Demonstration Project** (ACA § 2706) to run from January 1, 2012 through December 31, 2016. The Pediatric ACO Demonstration Project would operate under **Medicaid and Children's Health Insurance ("CHIP") programs** operated by states. The Centers for Medicare and Medicaid Services ("CMS") has not yet announced its plans for creating the Pediatric ACO Demonstration Project.

3. **Centers for Medicare and Medicaid Services Innovation Center and ACOs.** The Affordable Care Act established a Center for Medicare and Medicaid Innovation within CMS ("CMS Innovation Center")(ACA § 3021). The CMS Innovation Center can pilot other ACO models in the Medicaid and Medicare programs. In May 2011, the CMS Innovation Center announced the creation of a **Pioneer Accountable Care Organization Model**. Organizations that participate in the Pioneer ACO Model will not be allowed to participate in the Medicare Shared Savings Program. **Presbyterian Healthcare Services has applied to participate in the Pioneer ACO Model.** Other providers in New Mexico, including Hidalgo Medical Services, are interested in developing small primary care ACO models, which potentially could be considered by the CMS Innovation Center.

ACO models are also being developed outside the specific initiatives in the Affordable Care Act. Private insurers and some self-insured large employers have tried to develop ACOs. Because ACOs involve a complex interplay of legal, regulatory, healthcare financing, healthcare delivery and information technology systems, some companies and associations are developing business strategies to promote specific types of ACOs and/or to provide technical assistance and support to medical providers seeking to establish an ACO.

ACOs are a potential model for improving healthcare outcomes, but they are still in early developmental stages. Moreover, not all ACOs are the same. Because there are significant financial incentives for providers, insurers, Information technology experts, and others to advocate for (or against) particular ACO models, it is important that patients, public health

advocates, community organizations, and community members learn more about quality improvement measures and payment model reform, including ACOs, and participate in the development and implementation of new systems that may be established in their own communities.

The intense debate surrounding ACOs presents an opportunity for public health and community advocates in New Mexico to engage in the important discussions taking place in medical communities around the State regarding how ACOs can be designed so that resources are used more effectively to provide better healthcare and improve health outcomes. This discussion need not be limited to ACOs; other payment models could lead to better care, better health outcomes, more effective delivery systems and better value for healthcare dollars. New Mexico will also need to address how ACOs will impact rural communities, including providers and patients. A focus on payment reform models, in general, and ACOs, in particular, may also be an opportunity for Blueprint for Health New Mexico to have input in the "Medicaid Modernization" effort underway by the New Mexico Human Services Department. State officials have stated that they seek to improve healthcare quality and outcomes in the Medicaid Program while increasing efficiency and value for healthcare dollars.

II. TACKLING THE RISING COST OF HEALTHCARE WHILE IMPROVING HEALTHCARE QUALITY AND HEALTHCARE OUTCOMES: A NEW APPROACH TO AN OLD PROBLEM

Spending more on healthcare does not guarantee that children and families will receive the health care they need or that they will receive the right care at the right time in the right place. According to the World Health Organization's Report, *World Health Statistics 2011*, the United States spends more money on healthcare as a percentage of our gross domestic product than any other country in the world.ⁱⁱ Yet over 50 million Americans – and nearly 450,000 New Mexicans -- remain uninsured.ⁱⁱⁱ There is a widespread belief among health industry experts that the healthcare system in the United States can deliver much higher quality care at lower cost. The Robert Wood Johnson Foundation published a report in 2008 describing the factors leading to the rising cost of healthcare in the United States. The report concluded that: "health care inefficiency, medical technology and health status (particularly obesity) are the primary drivers of rising U.S. health care costs . . . The best evidence indicates medical technology accounts for one-half to two-thirds of spending growth. While medical malpractice insurance and defensive medicine contribute to health costs, they are not large enough factors to significantly contribute to a rise in spending."^{iv}

The assumption underlying ACOs is that spending more money does *not* mean that patients get better care. The Affordable Care Act's focus on ACOs reflects a new approach to addressing an old problem: how can we invest public dollars (primarily in Medicare and to some extent Medicaid) to provide better quality care at lower cost. This was the problem managed care was designed to address in the 1990's. It will take some time before it is known whether ACOs will accomplish this goal, but in the meantime, private payers will likely follow the road that Medicare paves in the development of ACOs.

The idea behind ACOs is to create a system that will improve patient care by creating incentives for providers to join together in an "accountable care organization" to provide high quality integrated care that has been shown to improve health outcomes for patients. ACOs are intended to create incentives for providers to coordinate care, and to avoid unnecessary duplication of services.^v The primary ACO initiative in the Affordable Care Act – the Medicare Shared Savings Program – will apply to fee-for-service Medicare patients. Fee-for-service is considered by many to be one of the most inefficient methods of delivering health care because it values high volume and expensive procedures, is often characterized by fragmented care, and does not take into account health outcomes. Fee-for-service does not usually pay for the coordination of care, only the delivery of services, often by multiple specialists.

Lack of coordination can be bad for patients, families and their caregivers, leading to inconsistent care, overuse of specialists, and patient and family confusion and stress over what care the patient needs. The public reporting, coordinated care, and quality measurement components of ACO models will be important to caregivers, not just patients. The Southwest Women's Law Center is particularly concerned about the support systems and information available to family caregivers, who are usually women. An article written by Debra Ness, the Executive Director of the National Partnership on Women and Families, addressed these issues in an article in the *Journal of the American Society on Aging* entitled "Women, Caregivers, Families and the Affordable Care Act's Bright Promise of Better Care." The article addresses the role that women play in making healthcare decisions for their families and in providing economic support and caregiving to elderly family members.^{vi}

Most ACOs are also expected to use electronic health records to help promote more coordinated care and eliminate unnecessary duplication of services. If a patient sees a provider and presents with certain conditions, if the provider does not have access to prior tests and examinations, she may order the same tests that have already been performed on that patient. Some of the data and information technology requirements of ACO models can be significant and particularly challenging for smaller providers. But they also present an opportunity to better address healthcare disparities, track and promote the delivery of preventive health services, and begin to develop and report data that may enable public health experts to better address the social determinants of health.

ACOs also generally attempt to reward the provision of preventive health services and evidence-based care that has been shown to reduce incidents of disease or injury. The choice of quality measures used by an ACO is particularly significant to providers, patients, families and caregivers.

ACOs are not a panacea and they will evolve over time. But the industry's increasing focus on ACOs -- as a result of the initiatives in the Affordable Care Act -- offer a significant opportunity for communities to have a voice in how these new efforts to restructure healthcare payment systems will ensure that children and their families receive better quality healthcare and greater access to such care.

III. A BRIEF OVERVIEW OF ACCOUNTABLE CARE ORGANIZATIONS.

This section of the policy brief describes the three different ACO programs currently authorized under the ACO, including explaining the controversy around the Medicare Shared Savings Program, describes other ACO and payment reform initiatives that are relevant to improving the health of New Mexico children and their families, and describes some resources that can assist Blueprint for Health New Mexico in developing a patient-centered approach to payment reform that addresses the needs of underserved and diverse communities.

A. ACCOUNTABLE CARE ORGANIZATIONS UNDER THE AFFORDABLE CARE ACT

The term "Accountable Care Organization" is fairly new. Dr. Elliott Fisher, Director of the Center for Health Policy Research at the Dartmouth Medical School is credited with developing the ACO concept. His article, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," published in Health Affairs in December 2006, promoted the ACO concept as a hospital-based structure.^{vii} Today, most ACO initiatives include a significant focus on primary care providers at the center of the system. The Centers for Medicare and Medicaid Services also laid the groundwork for ACOs through its five-year "Physician Group Practice Demonstration" project, which it launched in 2005 in the Medicare fee-for-service program. Ten physician groups (none from New Mexico) participated in The Physician Group Practice Demonstration, which set performance targets and rewarded the physician groups by sharing \$110 million, which accounted for 80% of the savings achieved under the program.^{viii}

Accountable Care Organizations represent a new payment model for health care services that are designed, in theory, to lead to better quality care for patients and lower costs.^{ix} There is no single definition of an ACO. In general, ACO payment models create financial incentives for groups of health care providers to form an Accountable Care Organization. The ACO would be responsible for coordinating patient care and would be held accountable – by the payer – for health outcomes of a particular group of patients. Under an ACO payment model, the ACO providers could share in savings from the care they provide, share some of the risk if costs of care are higher, or some combination of shared savings and risk. ACOs are still in the early developmental stage, but the Affordable Care Act created a significant ACO initiative in Medicare – the Medicare Shared Savings Program – and, as a result, ACOs have become a hot topic among providers and insurers.

It is important to clarify what people mean when they are talking about creating an Accountable Care Organization. ACO models differ widely and the term "ACO" means different things to different people. Providers and payers have direct financial interests in the structure and payment policies of an ACO and thus the details can be intensely debated and controversial. Patients have a huge interest in how ACOs are structured and implemented – since they are supposed to offer better quality care and improve health outcomes – but generally do not have a seat at the table when ACOs are established. Indeed, patients may not even know if they are receiving care under an ACO payment arrangement or – even if they do

know – may not be able to determine whether they should seek another provider who is not part of an ACO. Patients may be concerned if healthcare providers have an incentive to save costs on their care. Patients, their families and their caregivers will need to understand how the financial incentives in an ACO payment system will improve the quality of healthcare the patients receive, and not lead to the withholding of care or the restriction of patients' access to appropriate healthcare.

The Affordable Care Act contains two explicit ACO initiatives and an opportunity to create other ACO payment models:

1. Medicare Shared Savings Program. The primary ACO initiative in the Affordable Care Act is called the "**Medicare Shared Savings Program**" (ACA § 3022). The proposed regulations regarding the ACO Medicare Shared Savings Program were announced by the federal government's Centers for Medicare and Medicaid Services ("CMS") on March 31, 2011, and have triggered significant debate and controversy, particularly among health care providers.^x The Medicare Shared Savings Program will begin in 2012 and providers in New Mexico will have an opportunity to create Accountable Care Organizations and apply to participate in the Program. The Medicare Shared Savings Program is optional for providers and includes both a shared savings and shared risk component. The proposed regulations contain significant requirements for care coordination and patient-centered quality measures that include coordination of care across care settings, such as doctors' offices, hospitals, and long-term care facilities. ACOs may include practitioners who are not physicians, including nurse practitioners and physician assistants.

The 400-page proposed regulations sparked significant controversy. The final regulations will likely change, but for now the March 31, 2011 proposed regulations reflect the best information on how the Medicare Shared Savings Program will work.

The regulations are highly technical. The following is not a legal or technical analysis of the proposed regulations; indeed it omits many important details. Instead it is designed to summarize key elements to provide sufficient background to Blueprint for Health New Mexico regarding how the Medicare Shared Savings Program would work.

The regulations contain several key sections:

- Eligibility and governance of the ACO. Providers will have to create an ACO that has both a formal legal structure recognized under state law and a federal tax ID number. Some existing entities, primarily hospital systems that employ physicians, might qualify as an ACO, but most ACOs will likely be newly organized. All of the ACOs participating providers must have a tax ID number and be enrolled in the Medicare program. Providers include physician assistants, clinical nurse specialists, and nurse practitioners.

- Three-year agreement to participate in the program. ACOs must commit to participating for at least three years and agree to significant data sharing.
- Assignment of Medicare fee-for-service beneficiaries to the ACO. ACOs must serve at least 5,000 fee-for-service Medicare beneficiaries. This requirement may preclude practitioners in rural communities in New Mexico from participating easily in an ACO.
- Quality and other reporting requirements. These critical provisions for patients are addressed in more detail below.
- Determination of shared savings. This is a complicated system for determining whether an ACO would be eligible for shared savings.
- Option to participate in a "two-sided model". ACOs have the option of choosing whether to participate in the one-sided model where the ACO can share in savings but would not be subject to any risk associated with higher costs of the patient population until the third year. An ACO could also choose to participate in the two-sided model, in which it would be eligible for greater shared savings but would also be subject to risk every year it participates in the program.
- Monitoring and termination of ACOs. This includes monitoring ACOs to determine whether they are avoiding at risk beneficiaries who could be costly and whether they are meeting the quality performance standards.
- Coordination with other agencies. This includes addressing significant legal issues surrounding the creation of ACOs and the role of anti-trust laws and anti-kickback and anti-referral laws that apply to medical practices.
- Overlap with other CMS shared savings initiatives. Participants in the Medicare Shared Savings Program cannot participate in other shared savings initiatives.

The Medicare Shared Savings Program will establish a benchmark for how much it would normally cost to pay for a group of fee-for-service patients assigned to the ACO based on the prior three years. Providers will continue to receive payments for services provided but, if they participate in an ACO, they would have the opportunity to share in the savings achieved by the ACO. There must be a minimum of 5,000 Medicare fee-for-service patients assigned to an ACO, which could limit the participation of rural providers in New Mexico. If Medicare pays less than the benchmark amount, the ACO would be eligible (if other requirements are also met) to receive a percentage of the savings. By the third year, the ACO might also be responsible (at risk) for a portion of payments that exceed the benchmark.

Improving healthcare quality is one of the primary purposes of developing the Shared Savings Program. CMS explained in the proposed regulations that its three-fold goal in the Shared Savings Program is to provide "better care for individuals," "better health for populations," and lower growth in expenditures "by eliminating waste and inefficiencies **while not withholding any needed care that helps beneficiaries.**"^{xi} According to CMS, "[a]n ACO will put the beneficiary and family at the center of all its activities. It will honor individual preferences, values, backgrounds, resources, and skills, and it will thoroughly engage people in shared decision-making about diagnostic and therapeutic options."^{xii}

To meet the goal of improving healthcare quality and placing the patient and family at the "center," the proposed regulations require an ACO to meet a minimum standard with respect to 65 quality measures.^{xiii} Those quality measures address the following areas:

1. Patient/Caregiver Experience
2. Care Coordination
3. Patient Safety
4. Preventive Health
5. Services for At-Risk Populations/Frail Elderly Health (which include Diabetes, Heart Failure, Coronary Artery Disease, Hypertension, Chronic Obstructive Pulmonary Disorder and the Frail Elderly).

The proposed regulations also require public reporting of both cost and quality measure data. According to CMS: "Public reporting of ACO cost and quality measure data would improve a beneficiary's ability to make informed health care choices, and facilitate an ACO's ability to improve the quality and efficiency of its care by making available information that enables ACO professionals to assess their performance relative to their peers, and creates incentives for those professionals to improve their performance."^{xiv} From the patients' perspective, adoption of the quality measures and the public reporting and transparency requirements are critical to becoming more engaged in their care and comparing different providers. Providers, however, are concerned about developing the infrastructure needed to meet and report on all of those requirements and, in some cases, question the specific measures being proposed. Most ACOs and their participating providers will have to make a significant upfront investment in order to meet these performance and reporting requirements. Providers who create ACOs are concerned about making sure they will recoup those investments. If the quality measures and public reporting requirements, however, are significantly scaled back, patients will lose the accountability on healthcare quality that would make the ACO model attractive.

For New Mexico, one of the challenges is that, under the proposed regulations, federally qualified health centers and rural community health centers cannot be recognized as ACOs

under the Medicare Shared Savings Program. Although these health centers can participate in an ACO, for a variety of technical reasons, CMS has decided that their patient populations cannot be assigned to an ACO. This is a significant issue for New Mexico because it eliminates a significant population of low-income Medicare patients from participating in the Medicare Shared Savings Program and raises significant concerns about whether the Medicare Shared Savings Program will serve the needs of underserved and low-income communities.

CMS policy has the potential to produce a series of downstream consequences, most notably, the systemic exclusion of the poorest and most underserved patients from the benefits of ACOs and the disincentivization of meaningful FQHC [Federally Qualified Health Center] affiliation agreements with hospitals and specialty groups participating in ACOs. The exclusion of Medicare FQHC patients comes at a time when health centers have experienced explosive growth in the number of Medicare patients served – a doubling of patients over the past decade, even as the number of low-income Medicare beneficiaries grew by less than 10% nationwide.^{xv}

Although the exclusion of patients who receive care in federally qualified health centers and rural community health centers is of significant concern, other low-income Medicare patients in New Mexico could benefit from the Shared Savings Program.

CMS is expected to launch the Medicare Shared Savings Program in 2012 by entering into contracts with Accountable Care Organizations. It is likely that CMS will amend its regulations before entering into those contracts. Blueprint for Health New Mexico could monitor those regulations, seek out providers who intend to create ACOs to participate in the Shared Savings Program, and work with those provider groups to develop systems and structures that will meet the stated goals of the Shared Savings Program: provide better care for patients, better health for populations, and lower expenditures without withholding needed care.

2. Pediatric Accountable Care Organization Demonstration Project. The Affordable Care Act also authorizes the establishment of a **Pediatric Accountable Care Organization Demonstration Project** (ACA § 2706) to run from January 1, 2012 through December 31, 2016. The Pediatric ACO Demonstration Project would operate under Medicaid and Children's Health Insurance ("CHIP") programs operated by states.

Section 2706 of the ACA states that the Secretary of Health and Human Services ("HHS") "shall" establish a Pediatric ACO Demonstration Project to authorize states to allow pediatric medical providers to be recognized as an ACO and receive incentive payments for savings. ACA § 2706(a)(1). HHS has not yet established this Demonstration Project, but under the ACA, it is to begin on January 1, 2012. ACA § 2706(a)(2). States will be allowed to apply to participate in the Demonstration through their Medicaid and CHIP programs. In consultation with HHS, states will be able to establish a minimum level of savings that an ACO must reach in order to receive the shared savings, or "incentive payment." A provider that seeks to be recognized as

an ACO under this Demonstration must commit to participating in the demonstration for at least three years. ACA § 2706(c)(3).

CMS has not yet announced its plans for creating the Pediatric ACO Demonstration Project, but New Mexico could be pro-active in urging CMS to create the Demonstration and develop such a project in the State. The Blueprint for Health New Mexico could investigate the viability of, and interest in, a Pediatric ACO Demonstration Project among providers and Medicaid/CHIP patients. It could also work with the New Mexico Human Services Department ("HSD") to determine whether HSD would be interested in applying to participate in any such project and whether HSD is considering making ACOs part of its Medicaid Modernization planning in general.

3. ***CMS Innovation Center and ACOs.*** The Affordable Care Act established a Center for Medicare and Medicaid Innovation within CMS ("CMS Innovation Center")(ACA § 3021). The CMS Innovation Center can pilot other ACO models in the Medicaid and Medicare programs. In May 2011, the CMS Innovation Center announced the creation of a ***Pioneer Accountable Care Organization Model.***^{xvi} Organizations that participate in the Pioneer ACO Model will not be allowed to participate in the Medicare Shared Savings Program. ***Presbyterian Healthcare Services has applied to participate in the Pioneer ACO Model.***

The Pioneer ACO Model is targeted toward integrated healthcare systems that have already developed some financial accountability and performance incentives. The Pioneer ACO Model will offer participants the opportunity to achieve greater cost savings than the Shared Savings Program, but will also subject them to greater risk. Pioneer ACOs will be required to develop outcomes-based payment arrangements with other payers (not just Medicare) within two years, and are also required to serve at least 15,000 patients instead of the 5,000 patients required in the Shared Savings Program. Patients must be informed that their provider is participating in the Pioneer ACO and have the right to seek care from providers outside the ACO at anytime. According to the CMS Innovation Center, Pioneer ACOs will test models that CMS may later use in the Shared Savings Program.

If Presbyterian Healthcare Services ("PHS") is accepted into the Pioneer ACO model, New Mexico could become an important testing ground for the ACO concept. Blueprint for Health New Mexico could seek to work with PHS to understand more fully PHS' ACO structure, the quality improvements they are targeting, the strengths and weaknesses of the ACO model, and seek information from PHS regarding their outcomes and the impact of the Pioneer ACO Model on healthcare disparities.

B. ACCOUNTABLE CARE ORGANIZATIONS OUTSIDE THE AFFORDABLE CARE ACT

ACO models are also being developed outside the specific initiatives in the Affordable Care Act. In some communities, there are integrated care models that have some of the elements of an ACO. Private insurers and some self-insured large employers have also tried to develop

ACOs. In response to these initiatives and those in the Affordable Care Act, health insurance companies and trade associations have developed expertise and resources to promote ACOs.^{xvii} Because ACOs involve a complex interplay of legal, regulatory, healthcare financing, healthcare delivery and information technology systems, some companies and associations are developing business strategies to promote specific types of ACOs and/or to provide technical assistance and support to medical providers seeking to establish an ACO.

The Commonwealth Fund released a report in July, 2011 addressing private payer ACO models that are being developed to share risk – not just savings -- between payers and providers.^{xviii} The authors raised concerns about the capacity of providers to participate in such risk-sharing arrangements. In their Executive Summary, the authors warned: “[W]hile many providers and payers prepare to participate in ACOs, there is minimal evidence about what it takes for ACOs to succeed, including the payment models – shared-risk or otherwise – that will most appropriately support them.”^{xix} The authors emphasized how early in development these risk-sharing ACO models are, and how different they are in defining shared risk and designing the risk-sharing models. Among other things, they concluded: “Providers do not currently have the infrastructure required to take on and manage risk successfully, though some payers are providing infrastructure and other support to providers.”^{xx}

A totally different approach to ACOs is being developed by Hidalgo Medical Services in Silver City, New Mexico. The “Hidalgo Plan” is based on a primary care model in a Federally Qualified Health Center in a rural community. By necessity, the population base is substantially smaller than the 5,000-beneficiary minimum required for the Medicare Shared Savings Program. Hidalgo Medical Services is proposing a Demonstration Project to the CMS Innovation Center to develop an accountable care plan built on what it calls an Advanced Primary Care Model. It is possible that the Hidalgo Plan could become a catalyst for other federally qualified health centers and rural providers in New Mexico to address smaller-scale ACO models that might work in their communities.

C. NON-ACO MODELS FOR IMPROVING QUALITY AND REDUCING COSTS

Although ACOs appear to be on track to become the next major restructuring of health care delivery and payment systems – like managed care was in the 1990's – other payment models and quality improvement models are also being piloted and are worth consideration by Blueprint for Health New Mexico. A helpful resource is The Robert Wood Johnson Foundation's County Rankings website, which provides county-specific health data for all New Mexico counties.^{xxi}

In Albuquerque, the Albuquerque Coalition for Health Care Quality has received funding from the Robert Wood Johnson Foundation (“RWJF”) to increase health care quality by bringing together the major stakeholders in the healthcare system in the community. The RWJF initiative is called “Aligning Forces for Quality” and is designed to address the same issues that ACOs are supposed to address: improving health care quality while lowering costs.

Albuquerque is one of only 16 communities in the country to receive funding from RWJF for its Aligning Forces for Quality Initiative.^{xxii}

On August 23, 2011, the CMS Innovation Center announced another payment reform initiative designed to contain costs while improving health care quality: the Bundled Payments Initiative. Bundled payments are designed to address an “episode” of care related to all treatment provided to a patient for a particular medical condition – regardless of how many providers are involved in that treatment. Instead of paying separately for each service provided, the payments will be “bundled” and create incentives to coordinate care. The Initiative announced by CMS would apply to patients who are in the hospital or recently discharged. It is a voluntary program designed to promote care coordination and reduce costs.^{xxiii}

D. STRENGTHENING THE ROLE OF PATIENTS AND THEIR FAMILIES IN ACCOUNTABLE CARE ORGANIZATIONS AND OTHER PAYMENT REFORM MODELS: THE CAMPAIGN FOR BETTER CARE

Whether small (the Hidalgo Plan), large (Presbyterian’s application to become a Pioneer ACO), or what will become the most common (Medicare Shared Savings ACOs), communities, patients and their families should have an opportunity to participate in the planning and implementation of ACOs and other payment reform models that may be developed over the next several years. Whatever payment models are used, there is significant change coming as the ACA is implemented, Medicaid is expanded, and tax credit subsidies are available to tens of thousands of New Mexicans to participate in commercial health insurance plans offered through a Health Insurance Exchange.

The Campaign for Better Care is a consumer advocacy campaign led by the National Partnership on Women and Families, Community Catalyst, the Leadership Conference on Civil and Human Rights, and the National Health Law Program, that advocates for high-quality, comprehensive, and coordinated care.^{xxiv} The Campaign for Better Care focuses on the healthcare needs of older, chronically ill patients, in the belief that if we can improve healthcare quality and care for the most vulnerable individuals who need to access the healthcare system on a regular basis, then we can improve the quality of healthcare for all. The Campaign for Better Care has developed principles for developing a patient-centered practice that should be included in any new models of care developed under the ACA. Called the “Yardstick” for Better Care, these principles include:

- Understanding patients’ and caregivers’ needs and preferences
- Care coordination and management
- Clinical outcomes and continuous quality improvement
- Patient/caregiver engagement and experience of care
- Accountability

A copy of the Yardstick for Better Care is attached at the end of this paper. Many of the principles articulated by the Campaign for Better Care in its Yardstick apply to the creation of Accountable Care Organizations. They include:

- Any new delivery system pilot program or payment model should include ongoing assessment of clinical quality, appropriate public reporting, and implementation of continuous quality improvement programs;
- Robust clinical performance measures should be used to evaluate care delivery across the care continuum, and such evaluation should move quickly from today's generation of measures to encompass patient-centered outcome and experience measures;
- Any new delivery system pilot program or payment model that creates new provider financial incentives should calculate rewards by weighing both quality measures and cost-savings;
- Race, ethnicity, primary language and gender data are collected and used to identify and eliminate disparities;
- Provider performance on patient and, where practicable, caregiver experience of care surveys is used in calculating any provider financial rewards under new pilot programs or payment models;
- Patients are notified of providers' and facilities' participation in any delivery reform pilot program or new payment model, including disclosure of any provider or facility financial incentives or shared savings opportunities;
- Patients are clearly informed of the opportunity to opt-out of any pilot program or new payment model;
- The methodology for determining provider/facility payment under any delivery reform pilot program or new payment model should include risk adjustment to reflect differences in health status among Medicare beneficiaries; and
- Decisions about expanding pilot programs, and the evidence to support the decision, are transparent and there should be opportunity for public comment to inform this decision-making.

The Campaign for Better Care has also developed resources to address the needs of family caregivers who are taking care of elderly family members with chronic health conditions.^{xxv}

IV. OPPORTUNITIES FOR IMPLEMENTATION IN NEW MEXICO

The Affordable Care Act is intensifying interest in Accountable Care Organizations and will likely result – over the course of many years – in significant changes in healthcare delivery and payment systems. The purpose of ACOs is to improve health care quality and outcomes while at the same time containing costs. But other models for promoting better coordinated care, reducing duplicative and unnecessary services, and improving health care quality and outcomes are also being developed and could serve the needs of families and communities better than ACOs. To the extent Blueprint for Health New Mexico seeks to improve health care quality and health outcomes in New Mexico communities, it should consider developing the resources to better understand and participate in the development of new models of health care payment that are emerging nationally and in New Mexico. These payment structures are complicated but it is important for communities, patients, families, and caregivers to participate in key decisions regarding development of these new models.

Because these systems will be developed and change over many years, the goals and objectives relating to ACOs and other payment models will likely evolve and develop as well. As a preliminary matter, Blueprint for Health New Mexico could consider the following possible areas of activity:

1. Develop greater knowledge and expertise among participants in the Blueprint for Health New Mexico regarding ACOs and other payment reform initiatives in New Mexico.
2. Identify key partners in quality health improvement in specific communities, including the Albuquerque Coalition for Healthcare Quality in Bernalillo County.
3. Identify which healthcare providers in New Mexico (and particularly within the four targeted counties) have or are considering creating an Accountable Care Organization that will participate in the Medicare Shared Savings Program or another ACO initiative.
4. Collaborate with leaders of those ACOs and participating providers to work with them to develop patient-centered, coordinated systems of care that will increase quality and be transparent to the community and meet the needs of the most vulnerable community members.
5. Identify diverse community members who can serve on the governing bodies of ACOs or their advisory committees and urge the ACOs to seek strong community partners.

6. Monitor announcements from CMS regarding the Pediatric Accountable Care Organization Demonstration Project, evaluate any guidelines issued by CMS regarding that Project, and collaborate with pediatric care providers, Medicaid and CHIP beneficiaries and their families, and HSD to determine whether a Pediatric ACO could benefit children in the Medicaid and CHIP programs and, if so, how it could best be structured to meet the needs of children and their families.
7. Collaborate with officials at the New Mexico Human Services Department to ascertain whether HSD is considering the use of Accountable Care Organizations or other payment reform initiatives in its Medicaid Modernization effort and seek ways to involve communities to work with HSD to develop the structure and policies relating to any such program that will meet patients' needs and work effectively for patients and their families in diverse communities.
8. Consider joining the Campaign for Better Care and/or adopting and implementing its principles with respect to delivery and coordination of patient care and the development of new payment models, including ACOs.

V. ENDNOTES

ⁱ The Patient Protection and Affordable Care Act (Public Law 111-148) was enacted on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act (Public Law 111-152), which was enacted on March 30, 2010. This paper uses the acronym ACA or the term "Affordable Care Act" to refer collectively to both of those laws.

ⁱⁱ See World Health Statistics 2011, pages 127-37 published by the World Health Organization. In 2008, 15.2% of the United States' GDP was spent on health compared to 8.5% spent throughout the European region. The international median that year was 6.1%. The report can be found online at <http://www.who.int/whosis/whostat/2011/en/index.html> (last accessed August 24, 2011).

ⁱⁱⁱ Kaiser Family Foundation has extensive data on an array of healthcare issues, including the insured and uninsured. It also maintains data on individual states. Its most recent "State Health Facts" on Health Coverage and Uninsured Persons in New Mexico can be found online at <http://www.statehealthfacts.org/comparecat.jsp?cat=3&rgn=33&rgn=1> (last accessed August 23, 2011).

^{iv} The report summary and links to the PDF can be found at <http://www.rwjf.org/pr/product.jsp?id=35368> (last accessed August 24, 2011).

^v A good overview of ACOs and the significance of promoting clinical integration as a means to reduce costs and improve health care quality and outcomes is Sara Rosenbaum's article, "An Overview of the Administration's ACO Policy: Opportunities and Challenges," *Health Care Policy Report*, Vol. 19, No. 20 (May 16, 2011) (reproduced with permission from BNA's *Health Care Policy Report*, 19 HCPR 783 (May 16, 2011)). The article also identifies numerous challenges for providers to set up ACOs and notes that the regulations favor large "mature" entities that are less likely to provide care to underserved and low-income communities. *See id.* at 7-8.

^{vi} *See* Debra Ness, "Women, Caregivers, Families and the Affordable Care Act's Bright Promise of Better Care," *Journal of the American Society on Aging*, Vol. 35, No. 1 (Spring 2011). A link to the article is available at http://www.nationalpartnership.org/site/PageServer?pagename=cbc_index (last accessed August 24, 2011).

^{vii} Elliott S. Fisher, Douglas O. Staiger, Julie P.S. Bynum and Daniel J. Gottlieb, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs*, 26 no. 1 (2007):w44-w57 (Published online December 5, 2006; 10.1377/hlthaff.26.1.w44)(last accessed August 22, 2011 at <http://content.healthaffairs.org/content/26/1/w44.full.html>).

^{viii} The Physician Group Practice Demonstration Project was described in an article republished by the Commonwealth Fund in August 2011. *See* Jane Norman, CQ HealthBeat Associate Editor, "Washington Health Policy Week in Review: Medicare Touts Success of Demonstrations that Paved the Way for ACOs." <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2011/Aug/August-15-2011/Medicare-Touts-Success-of-Demonstrations.aspx>(last accessed August 15, 2011). For more information about the Demonstration, go to <https://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS023618&intNumPerPage=10> (last accessed August 22, 2011).

^{ix} Michael Hely, Staff Attorney for the New Mexico Legislative Council Service, gave an overview on Accountable Care Organizations to the New Mexico Legislative Health and Human Services Committee in August, 2011. A copy of his PowerPoint presentation is available on the website of the New Mexico Legislature at <http://www.nmlegis.gov/lcs/handouts/aco%20presentation%20Hely.pdf>.

^x A link to the proposed Medicare Shared Savings Program regulations may be found at <http://www.kaiserhealthnews.org/~media/Files/2011/ACO%20Proposed%20Rule.pdf>. The regulations were published in the Federal Register on April 7, 2011. *See* 76 Fed. Reg. 19528. Citations in this paper are to the double-spaced version of the proposed regulations released by CMS on March 31, 2011 and most readily available on public websites such as the one cited here.

^{xi} Proposed Regulations at 24 (emphasis added).

^{xii} *Id.*

^{xiii} A table containing all 65 proposed quality measures can be found beginning at page 174 of the proposed regulations.

^{xiv} See Proposed Regulations at 225.

^{xv} Sara Rosenbaum, JD and Peter Shin, PhD, MPH, “Medicare’s Accountable Care Organization Regulations: How Will Medicare Beneficiaries who Reside in Medically Underserved Communities Fare?,” at 3, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief # 23, The George Washington University School of Public Health and Health Services Department of Health Policy (April 20, 2011).
<http://www.rchnfoundation.org/main.cfm?actionId=globalShowStaticContent&screenKey=cmpProjects§ion=research&htmlId=18433&s=rchn> (last accessed August 24, 2011).

^{xvi} Information about the Pioneer ACO can be found at <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/> (last accessed August 28, 2011).

^{xvii} A Google search of “Accountable Care Organizations” produced a list of nearly 1.5 million hits. Numerous organizations have created fact sheets and definitions of ACOs.

^{xviii} Suzanne F. Delbanco, PhD., Kristine Martin Anderson, M.B.A., Catherine Eikel Major, M.B.A., Mary Beth Kiser, M.P.H., and Brynna Wammack Toner, M.P.H., “Promising Payment Reform: Risk-Sharing with Accountable Care Organizations” The Commonwealth Fund (July 2011) (available at <http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Jul/Promising-Payment-Reform.aspx>) (last accessed July 27, 2011). Suzanne Delbanco is with the Catalyst for Payment Reform; the other authors are with the firm Booz Allen Hamilton.

^{xix} *Id.*, Executive Summary at vi.

^{xx} *Id.*, Executive Summary at vii.

^{xxi} The specific page for health care quality is at <http://www.countyhealthrankings.org/health-factors/quality-care>.

^{xxii} Robert Wood Johnson Foundation’s Aligning Forces for Quality website is at <http://www.forces4quality.org/welcome>. The Albuquerque Coalition for Health Care Quality’s website is at <http://www.abqhealthcarequality.org/>.

^{xxiii} CMS’ announcement of the Bundled Payment Initiative and links to more information about the Initiative can be found at <http://www.hhs.gov/news/press/2011pres/08/20110823a.html> (last accessed August 24, 2011).

^{xxiv} The Campaign for Better Care has numerous resources that address the needs of chronically ill elderly patients and their families, including its Yardstick for Better Care and its comments on the ACO

proposed regulations for the Medicare Shared Savings Program. These materials can be accessed at the Campaign's website: http://www.nationalpartnership.org/site/PageServer?pagename=cbc_index

^{xxv} See Debra Ness, "Women, Caregivers, Families and the Affordable Care Act's Bright Promise of Better Care," *Journal of the American Society on Aging*, Vol. 35, No. 1 (Spring 2011). A link to the article is available at http://www.nationalpartnership.org/site/PageServer?pagename=cbc_index (last accessed August 24, 2011).



A “Yardstick” for Better Care

Elements of Patient-Centered Practice for Inclusion in New Models of Care

Understanding patients’ and caregivers’ needs and preferences

- ~ Individualized care plans that reflect the patient’s personal goals are developed in collaboration with the patient and authorized caregiver;
- ~ Where appropriate, comprehensive geriatric assessments, including use of risk assessment tools and the evaluation of physical, emotional, social and functional capacity, are conducted;
- ~ Where appropriate, assessments of caregivers’ needs are conducted;
- ~ Care team conducts ongoing clinical monitoring, patients and caregivers are contacted periodically, and beneficiary advance directives are kept up-to-date; and
- ~ Patient decision tools are used to guide “shared decision-making” by patients/caregivers and practitioners.

Care coordination and management

- ~ An interdisciplinary care team is established and meets regularly;
- ~ Patient information and medical history are current and available to the care team and patient and family caregiver, as appropriate;
- ~ Processes are in place to effectively monitor and manage all tests, referrals, and procedures;
- ~ Medications are actively managed and reconciled to avoid adverse interactions;
- ~ Patient care transitions are planned, managed, and tracked, using appropriate tools, such as transition checklists, medication reconciliation, and care plans;
- ~ The needs of patients with physical or cognitive limitations, language or cultural differences, and other issues that could impede access to care are identified and accommodated;
- ~ Care team connects the patient and caregiver with community-based support services, as needed;
- ~ Care team is available by phone, email, or in-person during evenings and weekends, and in-office appointments are scheduled promptly; and
- ~ Ongoing assessments of care coordination strategies are conducted and plans for improvement are implemented, as needed.

Clinical outcomes and continuous quality improvement

- ~ Any new delivery system pilot program or payment model should include ongoing assessment of clinical quality, appropriate public reporting, and implementation of continuous quality improvement programs;
- ~ Robust clinical performance measures should be used to evaluate care delivery across the care continuum, and such evaluation should move quickly from today’s generation of measures to encompass patient-centered outcome and experience measures;
- ~ Performance assessment should include: measures of clinical quality patient outcomes, care coordination, avoidable hospitalizations, readmissions and ER use, adverse drug interactions, and resource use;
- ~ Any new delivery system pilot program or payment model that creates new provider financial incentives should calculate rewards by weighing both quality measures and cost-savings;
- ~ Race, ethnicity, primary language and gender data are collected and used to identify and eliminate disparities.

Patient/caregiver engagement and experience of care

- ~ Patient and caregiver experience is evaluated frequently through patient surveys and the results are used both to improve quality and to inform patients and caregivers;
- ~ Aid is provided to help and support patients and caregivers in managing their conditions;
- ~ Provider performance on patient and, where practicable, caregiver experience of care surveys is used in calculating any provider financial rewards under new pilot programs or payment models.

Accountability

- ~ Patients are notified of providers' and facilities' participation in any delivery reform pilot program or new payment model, including disclosure of any provider or facility financial incentives or shared savings opportunities;
- ~ Patients are clearly informed of the opportunity to opt-out of any pilot program or new payment model;
- ~ An external appeals process is available to patients whose providers or care facilities are participating in a pilot program or new payment model that offers providers/facilities the opportunity to profit from the savings generated for the Medicare program;
- ~ The methodology for determining provider/facility payment under any delivery reform pilot program or new payment model should include risk adjustment to reflect differences in health status among Medicare beneficiaries;
- ~ Before any pilot program is expanded to a broader population, a comprehensive, independent evaluation of quality and cost outcomes should be conducted, and its design should include comparison groups with similar demographic make-up located in areas with similar Medicare spending growth rates; and
- ~ Decisions about expanding pilot programs, and the evidence to support the decision, are transparent and there should be opportunity for public comment to inform this decision-making.