A Closer Look at ACOs

A series of briefs designed to help advocates understand the basics of Accountable Care Organizations (ACOs) and their potential for improving patient care.

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Designing Consumer-Friendly Beneficiary Assignment and Notification Processes for Accountable Care Organizations

Introduction: What Is Beneficiary Assignment?

An Accountable Care Organization is an entity that is made up of health care providers from across the continuum of care (acute care, post-acute care, long-term care, and behavioral and mental health care) that agrees to be held accountable for improving the health of their patients while also lowering the cost of care. ACOs are intended to better coordinate patient care and to engage patients so that they are active participants in their own health care.[1]

To determine whether ACOs are improving quality and lowering costs, both the ACO and its payers (whether Medicare, Medicaid, or private insurers) must know which patients the ACO is accountable for. The process that is used to determine which patients an ACO is accountable for is often referred to as "assignment" or "attribution."

Designing an assignment process that is transparent and easy for beneficiaries to understand is one of the major challenges in developing ACOs. ACOs can succeed only if beneficiaries see them as improving their health care experience. Using a transparent assignment process and providing beneficiaries with adequate notice that they have been assigned to an ACO are important to ensuring patient buy-in and engagement with ACOs and ACO providers.

Advocates have an important role to play in ensuring that ACOs are designed in ways that meet the needs of patients and the community. This brief discusses the challenges advocates will face when developing beneficiary-friendly assignment processes, and it recommends including certain notice requirements and beneficiary protections.

Challenge 1: How Will Beneficiaries Be Assigned to an ACO?

There are two common approaches that will be used to assign patients to ACOs: Beneficiaries can be automatically assigned to an ACO, or they can actively select an ACO. However, ACOs and insurers can design alternative approaches as well.

Automatic Assignment

Under this approach, beneficiaries do not select an ACO. Instead, the payer assigns the beneficiary to an ACO. Ideally, the insurer would make the assignment based on where the beneficiary already receives his or her care as determined by claims data. But it is possible that insurers could make assignments based on other criteria, such as which ACO has providers that are accepting patients.

Under the Medicare Shared Savings Program Accountable Care Organization (MSSP ACO), beneficiaries will be automatically assigned based on where they receive their primary care.[2] For example, if Ms. Smith receives most of her primary care from Dr. Jones, who is part of a MSSP ACO, then the Centers for Medicare and Medicaid Services (CMS) will assign Ms. Smith to that ACO. (CMS would use claims data to determine where Ms. Smith receives her primary care.)

For ACOs that decide to use automatic assignment, it will be necessary to determine which providers will be used to make assignment decisions. ACOs should be built on a foundation of primary care, because primary care providers usually deliver the most care to patients; have ongoing, long-term relationships with patients; and are central to care coordination. As a result, it makes sense to assign patients to ACOs based on who their primary care providers are. In some cases it may be appropriate to limit assignment to primary care physicians only; for example, if the ACO does not include any non-physician providers. In other cases, it may be appropriate to define primary care providers more broadly to include providers other than physicians. For example, in some areas, nurse practitioners and physician assistants provide most of the primary care to patients. This may be especially true in rural areas or at safety net facilities, like federally qualified health centers. But some patients may get their primary care from specialists. Therefore, depending on the patient population and the makeup of ACO providers, it may be appropriate to also make assignment based on certain specialties, such as oncologists and cardiologists, who also have ongoing, long-term relationships with patients and who provide primary care to their patients

Originally, CMS proposed to use only services that are provided by primary care physicians to make assignment determinations. However, in its final MSSP ACO rule, CMS acknowledged that some patients get most of their primary care from specialists or non-physician providers such as physician assistants. As a result, it decided to use a step-wise approach to assignment. Under this approach, CMS will first look at claims data to determine whether the beneficiary

received primary care services from a primary care physician. If so, the beneficiary will be assigned to the ACO that the primary care physician belongs to. If the beneficiary did not receive primary care services from a primary care physician, CMS will determine whether a specialist or a non-physician provider delivered primary care to the beneficiary. If so, the beneficiary will be assigned to the ACO that that provider belongs to.

The MSSP ACO model is an open system: Beneficiaries can still see any provider who accepts Medicare, even those outside the ACO. Under other ACO models, however, insurers could require patients to see only ACO providers, similar to a closed network in an HMO. This restriction could interfere with existing relationships with non-ACO providers and could interrupt ongoing treatment. It could also cause problems with getting patient buy-in if the patient feels that his or her access to providers or medical care is being restricted.

If ACOs use this approach, it is important to build in beneficiary protections to try to eliminate these potential problems. One important protection in a closed model is an easy-to-use opt-out option. For example, beneficiaries should be able to call the insurer's customer service department and request to opt out. Requiring beneficiaries to complete specific forms and then mail the forms to the payer or ACO creates an unnecessary level of complexity that may prevent some beneficiaries from using the opt-out process.

If the insurer does not provide an opt-out process, it is important to have strong care transition protections in place. For example, if a beneficiary is undergoing a course of treatment with a provider who is not part of the ACO, it will be necessary to ensure that this course of treatment is not interrupted. Ideally, the patient should be permitted to continue seeing that provider. At a minimum, the beneficiary should be permitted to finish the course of treatment with his or her current provider.

Beneficiary Selection

Some ACOs may allow beneficiaries to enroll in the ACOs that the beneficiaries themselves choose rather than using an assignment process. In this case, the enrollment process would likely be similar to the process used when a beneficiary selects a health insurance plan or a primary care provider in an HMO. If such an approach is used, beneficiaries will need to have adequate information to make informed decisions. Insurers should provide beneficiaries with information about which providers are part of the ACO, the ACO's quality ratings, the number and types of complaints or grievances filed against the ACO (if any), the cost-sharing enrollees would pay for services from ACO providers, whether beneficiaries would be required to see only ACO providers, and any other information that will help beneficiaries make the best decisions based on their circumstances and health care needs. This information should be presented in a standardized format that is easy to understand.

Issues for Advocates

- Does the ACO meet the provider and care needs of the patient population?
- Will assignment be automatic, or will beneficiaries have to enroll in an ACO?
- If the insurer assigns beneficiaries to the ACO, will the insurer use claims data to make the assignment?
- Will beneficiaries be locked into a specific ACO, or will beneficiaries maintain freedom of choice of provider?
- Will beneficiaries have access to an opt-out process? Is the opt-out process easy to use?
- If necessary, will there be adequate care transition protections?
- Which providers will be used to make assignment decisions?
- If beneficiaries must enroll in an ACO, what information will be provided to help them make an informed decision? How will that information be made available to beneficiaries?

Challenge 2: Will Assignment Be Retrospective or Prospective?

Assignment to an ACO can be either prospective or retrospective. Under prospective assignment, the patient population is assigned to the ACO at the beginning of the performance period. With retrospective assignment, patients are assigned at the end of the performance period. The performance period is usually the length of time, most likely one year, over which an ACO will be evaluated for quality and costs.

Each approach has advantages and disadvantages. Using retrospective assignment will help ensure that the ACO provides all of its patients with patient-centered, coordinated care, instead of just the assigned population. This is because the ACO will not know which patients are assigned to the ACO until the end of the performance period. Therefore, the ACO will need to manage costs and quality for all of its patients. However, delivering patient-centered, coordinated care will likely require a significant investment both in technology and personnel, and the more patients receive health care services, the greater the investment. Some providers object to retrospective assignment because they will not be able to target services to a select group of patients; for example, the highest-cost patients with the greatest needs, who will likely generate the biggest return on investment.

Prospective assignment, on the other hand, will allow the ACO to know its patient population in advance, which will enable it to design care models that are in the best interest of that specific population. This approach would give the ACO and its providers the ability to target limited resources in the most effective way.

A retrospective approach would provide certainty as to the ACO's expenditures and savings or losses because it would hold the ACO accountable only for the patients seen during the performance period. A prospective approach would likely result in at least some patients being assigned to an ACO who never receive any care from an ACO provider during the performance period. To address this problem, the payer may need to use a reconciliation process at the end of the performance period to determine the exact patient population, which will add an extra layer of administrative complexity and expense.

Prospective assignment makes giving beneficiaries notice of how they've been assigned easier for the ACO and the insurer, since notice can be directed to the patients who the ACO knows are assigned to the ACO. Giving advance notice to beneficiaries is still possible under retrospective assignment, but some beneficiaries who are not ultimately assigned to the ACO may receive this notice, which could be confusing.

CMS originally proposed using retrospective assignment for beneficiaries in the MSSP ACO.[3] But in response to the strong concerns expressed by providers, CMS adopted prospective assignment with a reconciliation process in its final MSSP ACO rule. Under this procedure, CMS will preliminarily assign beneficiaries to an ACO prospectively. The ACO will be notified about who these patients are at the beginning of the performance year. This list will let the ACO know which patients are likely to ultimately be assigned to it. CMS will update this list quarterly. At the end of the year, CMS will perform reconciliation, determine which patients meet the criteria for assignment, and officially assign that population to the ACO. This means that the ACO will have a pretty good idea at the beginning of the performance year of which patients it will be held accountable for. However, the final assignment—the actual patients for whom the ACO will be held accountable—will be determined at the end of the performance year.

Advocates should work to ensure that the decisions ACOs make regarding whether to use prospective or retrospective assignment are based on assessing which approach will provide the greatest benefit to enrollees. Retrospective assignment will benefit the most patients, since the ACO will likely provide patient-centered, coordinated care to all of its patients. It is also likely to be easier to administer, since they won't need to perform reconciliation at the end of the performance period when determining the ACO's expenditures.

It is important to note that this decision must also take into account the existing health care system, its capacities, and its limitations. For example, if retrospective assignment would prevent providers from forming ACOs because the up-front investment is too much, it may be best to pursue prospective assignment, as is being done with the MSSP ACO. This will help move the health care system toward better-coordinated, lower-cost care, which will improve care for the assigned beneficiaries (at minimum). However, if a particular health care system is already highly integrated and uses sophisticated health information technology, retrospective assignment may be the better approach, because it will require the ACO to deliver the same high-quality care to all of its patients, not just the assigned population.

Issues for Advocates

- Which approach would provide the greatest benefit to enrollees?
- Which approach would work best given the existing health care system in the area?

Challenge 3: How Will Beneficiaries Be Notified that They Have Been Assigned to an ACO?

ACOs are a model of health care delivery that is designed to put the patient at the center of all its activities and to ensure coordination of care. To meet this goal, patient trust and engagement will be vital. An open and transparent process that includes providing meaningful notice to beneficiaries from the outset is among the best ways to build that trust and begin the process of engaging patients in their care.

In the MSSP ACO, CMS will require providers to use a standardized written notice at the point of care (for example, in the doctor's office) to inform beneficiaries that they are participating in an ACO and to post signs notifying beneficiaries that they are part of an ACO. ACOs also have the option of (but are not required to) notifying beneficiaries in advance that their provider is part of an ACO. CMS will develop educational materials for beneficiaries but will not send a separate notice telling them that they have been assigned to an ACO.

Unfortunately, the process that CMS adopted is not as transparent as it could have been. A better approach would be to provide beneficiaries with two notices: The first would come from their provider explaining that the provider is part of an ACO. The second would come from the insurer explaining that the beneficiary has been assigned to an ACO. The notice from the provider would be made in writing prior to the beneficiary's first appointment with the ACO provider. This advance notice will provide a meaningful first step in the process of patient engagement. Providing notice prior to the point of service will give the patient time to read it carefully and contact the provider with any questions. Waiting to provide notice until the patient is at the point of service will not allow the patient adequate time to read and understand the notice, nor will he or she likely have the time to ask any questions. Providing advance notice can also give the patient information about how to prepare for his or her next appointment, including preparing a list of all medications and health care providers.

Any assignment notice should explain that the beneficiary's provider is a member of an ACO and should clearly explain what this means for the beneficiary. It should include an explanation of beneficiary rights and responsibilities (including the right to see providers outside of the ACO and where to file complaints or grievances), what changes to expect in their care, how they will benefit, the provider's responsibilities and financial incentives, and where they can call to ask questions and get more information. To help build the relationship between the patient and the provider and begin the process of patient engagement, this notice should be made by the provider rather than the insurer.

In addition, at the time that the insurer assigns a beneficiary to an ACO, the insurer should notify the beneficiary in writing of the assignment. The notice should include many of the same elements described above, but it should also include, if appropriate, whether he or she can opt out, and, if so, how and where to do so.

All notices should be written at an appropriate literacy level for the patient population and should be in the beneficiary's primary language. If it is not possible to provide notice in the beneficiary's primary language, the ACO and insurer should provide oral translation using appropriately trained staff or language access services.

Issues for Advocates

- When will beneficiaries receive notice that their health care provider is a member of an ACO?
- When will beneficiaries receive notice that they have been assigned to an ACO?
- What information will be included in the notice?
- Are the notices written in a way that beneficiaries will understand (in terms of literacy level and language)?

Conclusion

Creating transparency in ACO assignment and notification processes is key to beneficiary buy-in and engagement. Beneficiaries are often wary of change, and if they feel they have been placed into a system not of their choosing and without their permission, they may reject the new system outright.

To avoid these potential problems, policy makers and advocates must work to ensure that beneficiaries and their needs are the focus as ACOs are designed. Designing an open and transparent assignment process with meaningful notice requirements is necessary if ACOs are going to meet their goal of improving care and lowering costs by delivering patient-centered, coordinated care. Advocates have an essential role to play in making sure that the assignment and notification processes meet the needs of patients.

Endnotes

[1] For more information, see Michealle Gady and Marc Steinberg, *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know* (Washington: Families USA, September 2011), available online at http://familiesusa2.org/assets/pdfs/health-reform/ACO-Basics.pdf.

[2] Centers for Medicare and Medicaid Services, "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, CMS–1345–F," *Federal Register* 76, no. 212 (November 2, 2011), available online at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf.

[3] Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program Proposed Rule* (Washington: CMS, April 2011), available online at http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf.

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