How-To Guide:

Standardized Plan ACO Reporting for Customers (SPARC)

HOW TO USE THIS GUIDE

This guide is for employers and other health care purchasers who 1) are interested in the accountable care organization (ACO) model for their population and are looking for a prime health plan partner, or 2) have a population that is affected by their health plan's ACO arrangements and want to know how effective they are. This guide outlines tools purchasers can use to find the right health plan partner and/or to hold their health plan partner accountable for reporting the results and impact of their ACO arrangements on the purchaser and their population.

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Disclaimer: Engaging with health plans about their contracted accountable care organizations may result in individual negotiations on various provisions. Catalyst for Payment Reform is not providing legal advice or direction on how to address these specific negotiations. The tools provided in this guide are for information purposes only. Before any decisions are made as to whether to use these tools in whole or in part and to understand the legal implications of doing so, employer-purchasers should consult with a qualified legal professional for specific advice.

Overview – SPARC Purpose and Goals

Catalyst for Payment Reform and The Urban Institute define Accountable Care Organizations (ACOs) as "groups of physicians and hospitals that share financial and medical responsibility for providing coordinated care, with financial incentives to provide high-quality care and to limit avoidable, unnecessary spending."[1] With the drive toward population-based care, health plans are increasingly offering ACOs to their purchaser-customers. Some health plans automatically attribute purchasers' populations to these programs. Others offer ACOs as insurance products. In either case, purchasers have found a lack of transparency about how these programs are designed and the results they achieve. The reporting that purchasers receive from health plans varies significantly; metrics often seem cherry picked to focus on positive results and some display information that is not relevant or meaningful to the purchaser.

In 2016, CPR convened a group of seven purchasers and a subject matter expert to develop a set of tools to hold health plans accountable for greater transparency into their ACO arrangements. Their months long collaboration resulted in the creation of the Standardized ACO Report for Customers – a toolkit of resources that Purchasers can use to evaluate health plan strategies, ensure they are delivering on their promise, and assess their impact. Larger purchasers with greater purchasing power and leverage may be more likely to succeed at using these resources with their health plan(s), particularly the Standard Plan ACO Report. However, as use of these resources becomes more common, and therefore standardized, smaller purchasers may also succeed at getting their contracted health plans to report to them in the same way.

SPARC Core Design Elements and Terminology

Created through a brain-trust of subject matter experts

CPR did not create the SPARC in a vacuum. This toolkit is the product of the combined expertise of health care purchasers and payment reform experts. It also incorporates the work of the Integrated Healthcare Association (IHA), the Pacific Business Group on Health (PBGH) and CPR to develop a common set of performance measures for ACOs know as "Align. Measure. Perform. (AMP) Commercial ACO" measure set. Source information for the structural and evaluative elements of SPARC are cited below:

[1] https://www.urban.org/sites/default/files/03_accountable_care_organizations.pdf

Quality Measurement

The quality measure set for the ACO evaluation tool is sourced from the AMP Commercial ACO Measure Set, which includes key cost and utilization metrics, in addition to quality. We chose this measure set because it represents the most comprehensive effort to date and it also considers the priorities of purchasers.

While some measures need further development (e.g. patient reported outcomes), purchasers should ask health plans to track and report the performance of their ACOs using this list of measures, **even if it may take a year or two before the health plan is able to report on all of them**. These requests will help drive toward measurement that is more meaningful and tracks critical areas for care improvement.

Defining and Qualifying an ACO

Health plans offer two types of ACO programs—attribution-based plans and product model ACOs. We highlight this distinction in the resources as some metrics are more applicable to one model than the other.

What is an attribution model ACO?

In an attribution model ACO, the health plan assigns employees and their dependents to an ACO based on the number of encounters they have had with a provider in the ACO during a certain time period. Once a member has been attributed to the ACO, the ACO is financially accountable for the cost and quality of the patient's care. In such an arrangement, members are likely unaware that they are attributed to the ACO and may not have financial incentives, such as lower co-payments, to seek care specifically from ACO providers. The upside of this model is that patients can seek care from whomever they choose in the broader PPO network. The downside is that the ACO has little ability to control where its attributed population seeks care, making it difficult to manage and oversee their care. This attribution model is currently more common, affecting more covered lives, than product model ACOs.

What is a product model ACO?

A product model ACO adds a network component to the ACO model, which employees and their dependents actively select during open enrollment. Selecting an ACO product means that the plan member chooses to seek all care (with some exceptions) from the ACO provider network, typically in exchange for lower premiums and lower cost-sharing. In this model, ACO providers have a greater ability to manage and oversee these patients' care because it is easier to manage network leakage -- the patients are less likely to seek care outside of the ACO, given the significant out-of-pocket costs they could face out-of-network. Given the "opt in" nature of the product model ACO, uptake has been lower than the passive attribution model, which automatically affiliates members with ACO providers without any benefit or penalty.

What does this distinction mean for SPARC?

SPARC resources can be used for both attribution and product model ACOs. However, in certain cases, some resources are more applicable to one arrangement than the other. In addition, health plans have suggested that they have different abilities to use these resources for one model versus the other.

Standardized Plan ACO Reporting for Customers (SPARC) Contents and Instructions

CPR, along with the ACO collaborative participants and subject matter expert, developed a set of resources that purchasers can use to hold their health plan accountable for its ACO strategy. The SPARC consists of the following:

- Request for Information (RFI)
- Model Contract Language
- Performance Guarantees
- Provider Checklist
- Standard Plan ACO Report

Below, we describe the purpose of each of these tools and what a purchaser needs to know to use them effectively.

Request for Information (RFI)

Purchasers can use the RFI to assess health plan ACO strategies as part of the process of selecting an Administrator. Purchasers can field this RFI to prospective health plans to learn about their ACO strategy, along the following topics:

- Portfolio of programs the health plan offers by geography
- Health plan's ACO definition and selection process
- Support the health plan offers the ACO with respect to coordinating care
- Quality measures the health plan uses to measure provider performance – such as the measures listed in the AMP Commercial ACO Measure Set
- Payment arrangements the health plan uses to reward providers for cost and quality outcomes

Purchasers can also ask questions about the health plan's ACO strategy in specific markets to learn what opportunities are available to them.

Purchasers can also use the RFI to assess their currently contracted health plan's ACO strategy. By fielding all or some portion of the RFI, the purchaser will discover more about the design of

their current partner's arrangements, the utilization of the health plan's models within the purchaser's population, and the health plan's future plans for expansion and evolution.

The RFI also inquires after the health plans' willingness to use the Standard Plan ACO Report to share the results of their ACO arrangements with the purchaser. This willingness is critical as current health plan reports do not meet many purchasers' needs.

Model Contract Language

Purchasers can use the Model Contract Language when contracting with a health plan that has an ACO strategy in place, whether the ACO operates as a product, as an attribution model, or both. This resource outlines purchaser expectations for the health plan's ACO arrangements, as well as the reporting on ACO performance.

In particular, purchasers should require that the contracted health plan offer an adequate high-value network of providers, ensure adequate care coordination services, measure the ACO's performance on a defined set of measures, pay providers in a way that promotes value, make information available on the price and quality of ACO providers, maintain market competition in the face of consolidation, and support benefit and network strategies that encourage members to seek high-value care.

Purchasers should also require the health plan agree to use the Standard Plan ACO Report to provide bi-annual or annual results on the impact of the ACO program, including on the purchaser's population, as feasible. Coming to agreement on these terms will help to advance the reporting practices of health plans and create greater transparency and insight into the impact of their ACO arrangements.

Performance Guarantees

The Performance Guarantees can be used by purchasers alongside the Model Contract Language to ensure that their health plan partner meets mutually-agreed upon performance standards. CPR recommends that purchasers review the Performance Guarantees to identify which metrics are top priorities. Ultimately, the selection of Performance Guarantees and the percent of fees at risk for not meeting them will be a result of negotiations between the purchaser and the health plan. The CAHPS ACO-9 Survey is not yet widely used; therefore, purchasers may receive pushback from health plans to put fees at risk for meeting this metric.

The purchaser should also explore strategies and methods to help the health plan meet its goals. For example, if the purchaser expects a certain percentage of plan members to be assigned or attributed to ACOs in shared risk arrangements, then the purchaser may need to offer incentives to members to select these ACOs.

Provider Checklist

Purchasers can use The Provider Checklist when there is an opportunity to meet directly with providers in the ACO. These questions can help purchasers learn more about the arrangement and how the ACO operates. The questions in the Checklist are organized into six categories, which can help the purchaser prioritize questions of interest. These categories include the provider makeup of the ACO, the electronic health record system, ACO management, patient engagement, the ACO's experience with payment reform and quality measurement, and how it receives and acts on the quality and cost reports the health plan provides.

Another resource purchasers can use in direct interaction with ACO providers or representatives is the Purchaser Value Network (PVN) ACO Assessment Toolkit. The PVN conducted research to identify better and best ACO practices in the areas identified in CPR's Checklist. Purchasers can compare ACO responses to the questions in the CPR Checklist to the best practices listed in section 1 of the PVN Toolkit.

Standard Plan ACO Report

The Standard Plan ACO Report is inspired by the Nutrition Label, which was developed to provide a quick, standardized way for consumers to identify the nutritional qualities of their food, particularly as the number of processed foods increased. As the number of ACOs have increased, employers and other purchasers need a quick, standardized way to evaluate their results. Even though health care is more complex than a box of crackers, the template report helps to set a standard for meaningful and accurate reporting on ACO performance, in a way that is easy, transparent and intuitive for the purchaser to use and interpret.

The metrics identified in the report are those that are most meaningful to purchasers. While standardized benchmarks or performance indicators are not yet available, the hope is that collecting this data in a standard way over time, will enable a comparison of results and enhance understanding how these programs are faring.

How is it organized?

The Standard Plan ACO Report has six tabs; three are informational, three are designed for data reporting:

A. Informational Tabs

Introduction: provides an overview of the SPAR, with operational instructions on how to complete each of the three reporting sections.

Definitions: defines industry terminology, operational metrics, calculations and quality measure specifications in the ACO Facts tabs for Purchasers and Health Plan Book of Business.

Quality Measure Specs: provides the source, type, and definitions for the measures in the AMP Commercial ACO Measure Set. Note that some of the measures are currently in use and others are under development with the expectation that they will be in use within the next year or two.

B. Data Reporting Tabs

Outcomes This tab asks for the detailed cost, quality and utilization performance on each of the ACOs, for which the purchaser has more than 500 covered lives, for the current period only. This tab includes the metrics that are reported on the ***ACO Facts*** tabs, but asks for each ACO's performance on additional cost and utilization metrics, as well as the entire AMP Commercial ACO Measure Set.

ACO Facts: Purchaser This report provides purchasers with an ACO "nutrition-label" through a quick-to-digest, standard layout describing ACO outcomes for the purchaser's population. This tab should draw from data reported on the ***Outcomes*** tab about individual ACOs where the purchaser's population receives care. This tab displays critical cost, quality and utilization metrics, including a subset of 10 measures from the AMP Commercial ACO Measure Set, selected by CPR members and quality measurement experts, as the best indicators of how well ACOs are managing care.

ACO Facts: Book of Business This tab details the results of the health plan's ACOs across its commercial book of business. This tab acts as a source of comparison to the health plan's commercial book of business, as it measures the same metrics as the ***ACO Facts: Purchaser*** tab.

If you plan to compare the statistics in SPARC with other data points, note that factors such as the population risk status or geography may influence your conclusions.

Health plans should complete and share this report with purchasers on either a bi-annual or annual basis per the purchaser-health plan agreement. To require completion of the Standard Plan ACO Report, purchasers should incorporate expectations for its use into the contract with the health plan and ensure it is delivered in a timely manner by using the Performance Guarantees. Purchasers may also want to incorporate coordination of this report into their consulting agreements where a consulting partner manages the health plan on the purchaser's behalf.

Conclusion

To ensure greater transparency into health plan ACO arrangements, purchasers need SPARC. A collective voice with a consistent "ask" can make the business case for health plans to become

more accountable and comprehensive in their reporting to customers. If purchasers begin to use SPARC, they will glean insight into how a health plan's ACOs are designated and designed, and ensure that health plans represent the entire picture when reporting on the results of these arrangements. Given that these models are prevalent, and many purchasers and their populations are affected by them whether they choose to participate in them or not, we need to ensure that these programs are providing meaningfully better value in health care.

Appendix - Participants & Funding

CPR would like to thank our participants, our subject matter expert* and the Peterson Center on Healthcare for participating in and supporting this process and contributing to the development of these resources. A list of the contributors is below.

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