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Acountable Care Organizations in California.pdf

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Lesson Five: ACOs are not a panacea for health care spending control.

Some of California's provider organizations have been able to use their market clout to extract high payments from health plans, as the plans' ability to exclude providers from their networks is limited by consumer demand and regulatory network adequacy requirements. Higher-cost and inefficient providers have not faced enrollment penalties because the current California market does not incentivize purchasers or consumers to choose lower-cost or more cost-efficient providers. As ACOs are rolled out across the country, health insurance benefit designs should reward patients for choosing higher-value ACOs, which will necessitate that cost and quality data are available and that consumer cost sharing is higher for less efficient providers.

Lesson Six: ACOs must be agnostic to insurance type; most provider organizations in California have focused on commercial, Medicare, and Medicaid HMO plans for their patients, but for ACOs to be viable across the country, mechanisms must be found to encourage PPO and traditional Medicare and Medicaid patients to use their services.

In California, provider organizations have developed hand-in-hand with HMO products, and have been largely unsuccessful in their attempts to diversify into serving PPO patients. This has been driven in part by regulatory restrictions at both the State and Federal level surrounding providers accepting capitation and FFS payments. Downward trends in HMO enrollment in California have meant that this failure to

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How do you compare a low quality hip replacement that has 1-5 year better performance but poorer 10-20 year performance - no quality measures for that
if patients like provider better but outcomes poorer should provider be paid more or less?