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View Point

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Public Services

Embracing Accountable Care: 10 Key Steps

– Sivakumar Nandiwada and Vijay Sylvestine

Abstract

For quite some time now, the U.S. healthcare market has been grappling with issues of spiraling costs and disparities in the quality of care delivered. These issues can be attributed to the predominant fee-for-service reimbursement model that rewards quantity over quality, as well as a disjointed healthcare delivery system that has led to gaps and redundancies in care delivery. The recent Affordable Care Act (ACA) introduced the concept of an Accountable Care Organization (ACO) – a reformed payment and delivery system that addresses some of the issues above.

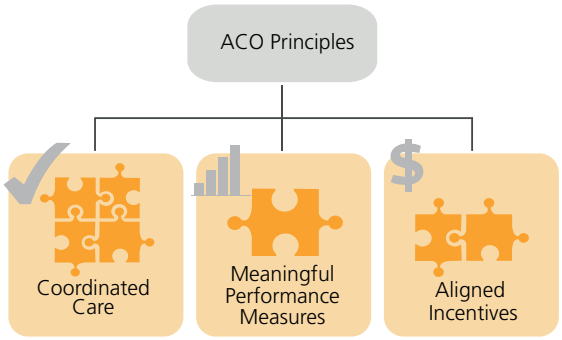
Though the proposal under ACA aims at establishing Medicare ACOs, the concept has seen an uptake especially among large commercial insurers – with several pilot projects up and running. However, 6 out of 10 payers polled in a recent Infosys Public Services survey were still in the initial planning stages of setting up ACOs. In a competitive landscape, it has become no less than an imperative for payers to seriously evaluate the need to embrace the ACO concept.

This Point of View examines key steps payers must take to establish and successfully manage ACOs — enhancing their ability to remain competitive through 2012 and beyond.

Background

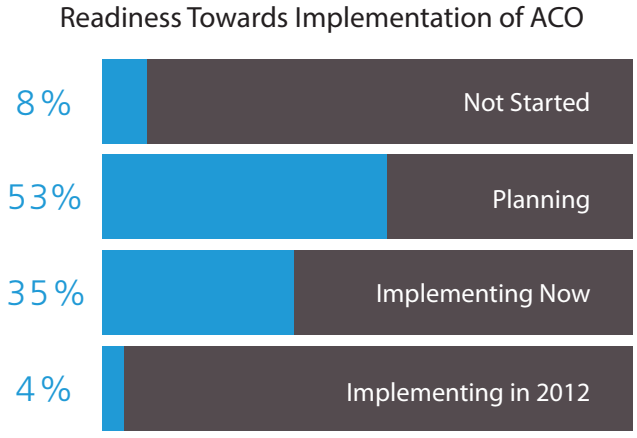
An ACO is a provider-led organization that will be responsible for managing the full continuum of care for a defined population, while also being accountable for the overall cost and quality of care that is delivered. The performance of ACOs will be measured across a set of parameters like efficiency, process and patient satisfaction. ACOs will be incentivized based on the treatment cost savings they are able to achieve while delivering quality care.

ACO as a concept is not new; an ACO resembles the historical model of a Physician Hospital Organization (PHO), which also created shared incentives and risks for providers. But these past models failed due to the unavailability of information required for managing the risk associated with patients, as well as an effective care management system. With coordinated care delivery and accountability, ACOs can help payers reduce medical costs through efficient resource utilization, reduced unit costs and improved outcomes.



Furthermore, this model will also allow payers to transfer some of the financial risks to the ACO when the treatment costs exceed the defined spending targets.

A survey conducted by Infosys Public Services at a recent America's Health Insurance Plan (AHIP) conference establishes that a majority of payers (more than 60%) are still in the initial planning stages of setting up ACOs. To remain competitive, it is imperative for payers to evaluate the need to embrace the ACO model and begin their ACO planning as soon as possible.



Source: Infosys Public Services survey at America's Health Insurance Plan (AHIP) Fall Forum 2011

Adopting an ACO model is a transformational change, and will require substantial planning and preparation from payers. A rapid transition to ACO could possibly overwhelm the organization and place considerable strain on the existing business process, people and systems. Given the uncertainties crowding the contracting model and reimbursement models (to be employed under the ACO concept), it will be beneficial for payers to commence pilot projects that can help assess what works and what doesn't – and plan their ACO investments appropriately. This in mind, payers need to put together a robust plan towards acquiring key capabilities in addition to following a phased approach to implementation.

10 Key Steps Payers Must Take

The key capabilities payers would need in order to commence pilot projects can be broadly classified into 3 phases:

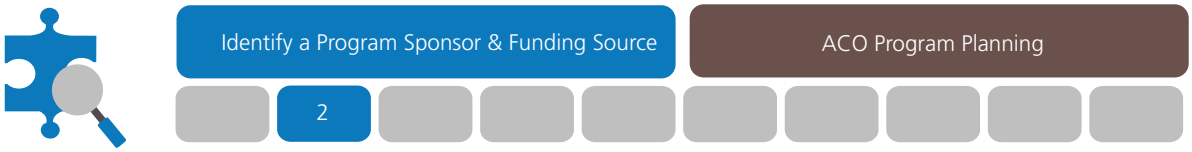
- ACO Program Planning
- ACO Program Administration
- ACO Program Evaluation and Optimization

ACO Program Planning

Payers must decide on the specific objectives that they wish to achieve by partnering with ACOs – like optimization of utilization rates; reduction of re-admission rates; improving primary care physician (PCP) engagement; improving patient access; or enhancing the effectiveness of care for certain populations.

To begin their ACO journey, payers must define a plan to achieve these objectives and quantify the goals that need to be achieved by the ACOs identified.

It is important to note that such objectives can only be established after careful analysis of member and provider data with regard to clinical and health outcomes.



Being strategic initiatives, ACOs will need buy-in and support from the executive management team. Executive sponsorship (from either the CEO or the CIO) will help market the concept to the various stakeholders – who will be impacted by the changes – and get their buy-in.

Executive sponsorship will also be beneficial in securing necessary funds. Given the magnitude of changes that will come along, the executive sponsor will need to be supported by a cross-functional team – comprising senior leadership from the Project Management Office, Provider Network Management, Medical Management, Product Development, Legal and Finance departments, among others.

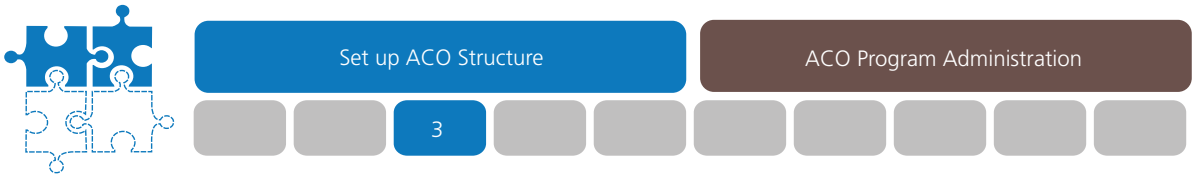
A key consideration here is that it will be absolutely necessary for the sponsor to ensure that the entire executive team is in agreement with the objectives of the ACO program and the shift to an ACO model.

ACOs will need significant capital for developing necessary IT infrastructure and staff recruitment, apart from other administrative tasks. There are multiple funding models from an ACO standpoint. Payers need to decide if they are willing to fund the cost of the initial infrastructure that ACOs need to set up, especially when it comes to smaller ACOs. This could help alleviate the initial financial barriers that ACOs face and promote ACO participation.

The Center for Medicare and Medicaid Services (CMS) has come out with a similar Advance Payment ACO model for its Medicare ACO program, in which ACOs will receive advances against future shared savings. Keeping in mind that this funding is an advance against future savings (that may or may not materialize), payers need to perform careful financial planning to set aside appropriate funds that can help integrate people, process and technology changes with an ACO.

ACO Program Administration

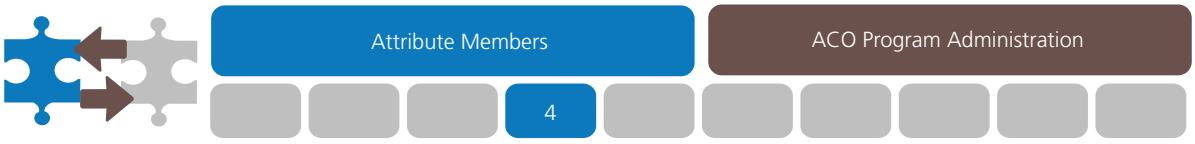
This can be done in multiple phases for different ACOs, so the learning from one cycle can be applied to other cycles.



The initial step for a payer participating with an ACO is to ascertain the geographic spread of the ACO and the kind of association that participating providers have with the ACO entity. Payers must also determine the mix of provider types within the ACO and define goals aligned to the provider mix.

An ACO comprising only primary care physicians (PCPs) can effectively coordinate care and promote preventive care, but this type of an ACO will not have the organizational alignment required to drive efficiencies and cost savings across the entire continuum of care delivery, especially in areas like in-patient care and ambulatory care. Ascertaining the provider mix will also help identify providers under the ACO who do not have existing contracts with the payer.

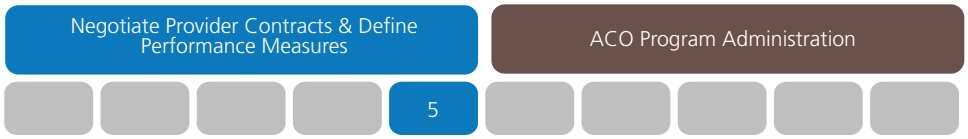
The nature of the relationship model that exists between providers and the ACO entity (integrated model / collective model / combination model) will define the subsequent steps in ACO program administration; hence, the model needs to be identified upfront. Payers must attune their systems and processes to support different ACO structures.



Once the ACO structure is finalized, payers must employ a patient attribution algorithm to attribute members to the ACO, and the ACO will be accountable for the quality and cost of treatment of these attributed members. Selection of such members can be based on the following parameters:

- Coverage type; e.g., medical vs. dental coverage
- Group type; e.g., large vs. small group
- Product type; e.g., preferred provider organization (PPO) vs. health maintenance organization (HMO)
- Line of business; e.g., Medicare vs. Medicaid vs. Senior
- Funding type; e.g., fully insured vs. administrative services only (ASO)

Payers can choose one of the many attribution methodologies available to complete the member attribution like Dartmouth model vs. Employer-Group-based model vs. PCP-based model. Constant churn is a possibility; to that end, payers must establish mechanisms to manage additions and terminations to the attributed population. The focus of this attribution process must be to capitalize on the existing member-provider relationships to achieve a personalized coordinated care for patients.



ACOs must be appropriately rewarded for delivering high-quality, appropriately-priced care to patients. Conversely, ACOs must be penalized for failing to achieve cost and outcome goals that are within their control. The contract between the payer and the ACO must clearly define the following performance measures:

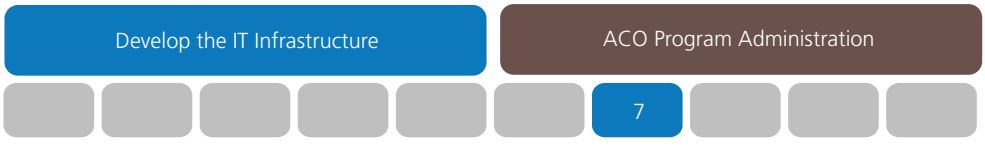
- Population that the ACO is going to be accountable for
- Quality, cost and efficiency (if needed) parameters that will be used to evaluate the performance of the ACO and the targets for each of these parameters
- Potential incentives that the ACO will receive for achieving the targets defined or the penalties that the ACO will be liable for if it fails to achieve the targets defined

Paramount to the success of the ACO model is the definition of performance measures and benchmarks that will help evaluate ACO performance effectively. The measures selected must be in line with the ACO program objectives that the payer is trying to achieve. Improved outcomes will lead to a focus on quality-related measures, and a focus on optimal utilization will lead to the setting up of efficiency-related measures. Payers must seek inputs from ACOs to define measures that will be relevant to the program and do not place undue administrative burdens on the ACOs. The measures selected must be quantifiable, evidence-based, and clinically valid, while being relevant to the program constituents.

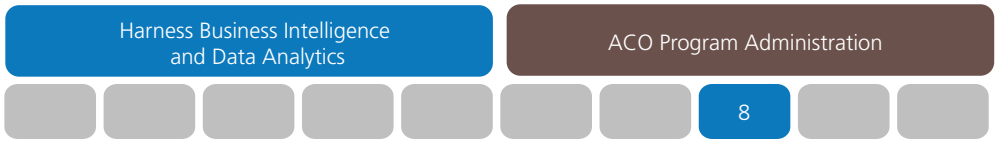
Actuarial projections of future expenses for the ACO-assigned population must be completed by the payer based on historical claim data or on a control group approach, and a mutually agreed upon spending target must be defined for the ACO. Prediction based on historical claim data has advantages over the other approach because it allows the payers to define prospective targets for the ACO at the beginning of the performance year itself. This allows the ACO to compare its actual performance and make necessary course corrections. The spending targets must be risk-adjusted for variations in the risk profile of the patients assigned with a view to incentivize:

- Providers who treat sicker patients to participate in ACOs
- ACOs to accept and treat sicker patients

The spending targets must also be adjusted for different geographic practice costs, including office rents and hospital operating costs.



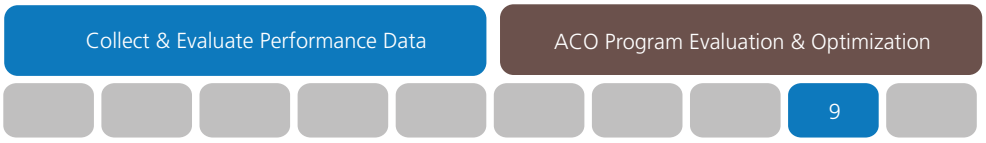
The adoption of the ACO model necessitates system changes at the payer-end to support newer capabilities like member attribution, and risk and reward modeling. Additionally, significant changes to existing payer systems will be needed primarily in provider contracting, claims adjudication and payment processing systems. Payers will also need to invest in performance evaluation and reporting systems. With no consistent model in sight for ACOs, payers must develop systems that are flexible enough to adapt to ACO variations without much effort.



Care management has been one of the top investment destinations for payers. Even so, due to their increasingly older and sicker membership, they have been challenged in determining the ROI and savings they realize from such programs. With the MLR mandate qualifying healthcare program costs as 'non-administrative' expenses and also limiting the profits that the payers can make, payers must carefully plan their investments and also track program savings. With the ACO model, it is imperative for the payers to forecast the program budget, define objective targets and measure ACO performance against the targets periodically to track program value.

Payers must develop analytical abilities around effective attribution of members, risk and reward modeling and performance assessment to support the new ACO model. Payers must shift their focus from traditional areas involving analytics to newer ones and also invest on predictive and forecasting capabilities.

ACO Program Evaluation and Optimization



The ability to collect, analyze and evaluate the performance of participating providers in an objective and transparent manner, which providers find easy to understand, is absolutely necessary for the success of the ACO model. Performance evaluation in an ACO model must extend beyond traditional clinical process measures and must include measures like outcomes, patient experience and treatment cost. In addition, the results of the performance evaluation exercise must be made available to the public or at least to the patients participating in the ACO program. If ACOs are able to demonstrate cost savings while delivering quality care, this public reporting of quality data will lead to more patients choosing high-performing ACOs over others, resulting in increased utilization rate for ACOs. It may also bring in additional revenue in the form of non-ACO population opting to take services from the ACO providers and will act to improve ACO participation.

To ensure success, payers and ACOs will need to develop a deeper and broader relationship than what has been traditionally practised. With the transition to ACO, providers will take up the responsibility for some of the key functions performed traditionally by the payer – including case management, network management and medical management. Since the payers already have significant experience in these areas, they must share their experience and enable the ACOs to dispatch these newer responsibilities in a better manner. Payers can also build on their existing disease management and wellness management capabilities and offer them as services to the ACOs, thereby creating a new revenue stream. A key area for collaboration can be around the monitoring and reporting of out-of-network services that a patient has incurred, helping the ACO gain a complete view of the patient's health.

The Way Forward

As can be seen from the previous section, payers must adopt substantial system, process and people changes to transition to the ACO model. There is no one consistent model for a successful ACO. Payers must have a clear business objective with clearly defined goals, start with small pilots, perform continuous assessments and apply the learning from pilots in order to be really successful. Payers who are quick at trying different pilots, strong in execution capabilities and excel in continuously improving on their learning will be successful in transitioning to the new ACO model.

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