

# PERSPECTIVE

## Accountable Care Organizations and the Shared Savings Imperative



### Abstract

To realize their full potential, ACOs today would require reimbursement models other than the Fee for Service (FFS) model; while shared savings helps create incentives for efficiency and quality, other payment models create even stronger incentives. As the industry continues to move along this path, from a system that compensates volume and number of encounters to a system that rewards outcomes and cost savings, healthcare organizations face ongoing financial, operational, and structural challenges – thus demanding more coordinated and efficient processes.

## Accountable Care Organizations and the Shared Savings Imperative

One of the reforms initiated by the Affordable Care Act that has created a significant amount of interest and activity, is the establishment of Accountable Care Organizations (ACOs) and the Medicare Shared Savings Payment Model for Healthcare Providers that they may participate in. The Centers for Medicare and Medicaid (CMS) continue to evolve from the initial proposed rule three years ago, to recent updates to ACO implementations and the MSSP Shared Savings Program. An ACO is a group of providers who work together to provide and coordinate care for a specified patient population. Provider Members of the ACO collectively take accountability for providing and coordinating care for their patients across the care continuum and expect ACOs to deliver and be compensated for better-coordinated care (and therefore, higher-quality and more efficient care at a lower cost), fostered through concerted collaboration across providers.

To realize their full potential, it is expected that ACOs would require reimbursement models other than the Fee for Service (FFS) model used today; the private sector is exploring and piloting payment models to meet this need. While shared savings help create incentives for efficiency and quality, other payment models create even stronger incentives. These models involve shared risk whereby ACOs share in some of the losses when costs or spending exceed an established target. As the industry continues to move along

this path, from a system that compensates volume and number of encounters to a system that rewards outcomes and cost savings, healthcare organizations face an ongoing financial challenge – such as a decision to buy a piece of DME to drive an additional revenue stream – that may not be justified under an evolving shared risk model. How do we reposition to a more agile environment where FFS revenue “success” does not equate to a shared risk cost “failure”?

Providers face additional operational and structural challenges related to the ACO model of care, which demands more coordinated, and efficient processes. Some provider groups are more prepared for coordinated care delivery than others including in case management, disease management, and risk management, to name a few.

*A new initiative from the CMS Innovation Center — Next Generation Accountable Care Organization (ACO) Model — shifts 50 percent of all Medicare provider payments to an alternative payment model by 2018 and is intended for current ACOs demonstrating capability to manage Care Coordination more efficiently and effectively and offers financial arrangements with higher levels of risk and rewards than either the Pioneer or the MSSP model. This new model uses refined benchmarking methods that reward attainment and improvement in cost containment, reduces comparison to previous historical expenditures, and offers more payment mechanisms for transition*

*from FFS reimbursement to capitation. CMS expects 15+ ACOs to participate and this latest model consists of three initial performance years with two optional one-year extensions.*

*This Next Generation ACO Model assumes greater performance risk than the current ACO, but also has the potential to share in greater savings. The objective is to test whether the stronger financial incentives for ACOs, when coupled with better Patient Engagement and Care Management, and Coordination tools improve health outcomes and reduce expenditures. Additionally, the model includes several tools to help ACOs improve patient engagement including greater access to home visits, Telehealth services, and skilled nursing facilities to allow for greater collaboration between CMS and ACOs. This also improves the communications with patients about the characteristics and potential benefits of ACOs in relation to their care. CMS plans to publicly report the performance of these Next Generation ACOs for Quality, Patient Experience Ratings, etc.*

The need is great to leverage existing technology investments to effectively communicate with all stakeholders across the care continuum. Today, there remains a lot of focus and dependence on the EMR system to accommodate this; however, it is clear that additional technologies are required to ensure that communication reaches all Providers and Patient Populations across the community.

## Clinical Data Management across the ACO

Transforming a system that is based on episodic documentation and visit-based billing, to one that more effectively delivers population health management and care coordination workflow is daunting. Most EMR systems are not architected to effectively support population health management across ACOs or disparate EMRs for that matter. Inpatient EMR systems are designed to optimize patient data based on inpatient stay supporting multidisciplinary care plans, while ambulatory EMR systems are built to address the needs of a higher volume doctor office visits. Although EMR vendors are now integrating enhanced population health management and reporting capabilities, these platforms often still lack true interoperability or the capability to exchange clinical information. A more standardized Reference Architecture and evolution to true “plug and play” will further drive the impact and success these systems have on the healthcare communities they serve.

To avoid key cost drivers including unnecessary re-admissions and ER visits, the need exists to better understand the Care Continuum cost and value levers, as well as to solicit input from Caregivers for optimal insight. Given the sizable investment made over the past few years in EMRs and other platforms, it's not the technology that's the strategic value – the services and applications that drive quality care and operational efficiency are the true differentiators.

Still, today there exists physician confusion about the HIE marketplace and interconnectivity and a misperception that the HIE takes care of everything including Information aggregating and reporting. And there are exchanges with slightly different functionalities from transactional

(lab results, discharge summaries) to more sophisticated patient engagement and care analytics. Effective and efficient workflows – coupled with insight analytics data are foundational to changing the trajectory of the patient experience and outcome.

## Shared Savings Value

Health Systems exploring Shared Savings initiatives understand that the exchange of Patient-centered clinical, financial, and administrative information must be integrated into their associated workflow for maximum care coordination and management impact. This often yields a measurable 20% or more improvement in cost and care metrics, and reflects reducing redundant test procedures, better managing chronic illnesses, etc. Shared Savings value realization occurs when stakeholders move beyond patient-driven demands to a population management focus. Looking forward we can better optimize chronic disease care as well as decrease other costly care episodes.

## Broader Optics

Effectively managing ACO performance requires focus across the following areas:

- Simplifying the entire Patient Referral-through-Discharge Process to optimize the Revenue Cycle and reduce leakage, eliminate/shrink gaps in care, and reduce waste and potential for abuse
- Leverage Insight Analytics to analyze Care and Practice patterns and Patient-specific outcomes
- Take an Evidence-based Care approach to Population Health Management and identify Patients with greatest potential for avoidable expenses or re-admissions

- Implement a more streamlined method for capturing and reporting quality data (Stars, HEDIS) to include Claims, Informatics, Customer Service, Provider Networks, and Process Improvement
- More effective information exchange with external organizations and applications

## Patient Engagement

The Healthcare Industry is experiencing Consumers increasingly “owning” their care and treatment options – and the costs associated with them. Social media is allowing patients to network with others with similar health conditions and become more informed, not to mention the availability and adoption of remote monitoring devices and “wearables”. Technology to support patient engagement is critical both to the success of shared savings initiatives and to achievement of meaningful use.

## Value Transformation

Today, value in healthcare is sometimes difficult to see. Information regarding true cost of healthcare is difficult to comprehend and often anecdotal. Purchasers of healthcare – consumers, payers, and society have different opinions as to what constitutes good value. We are experiencing a “Consumerization” shift where we assume greater financial responsibility for our healthcare, which is driving demand for information value and accessibility. Payers are taking a more holistic view of value and how investments in Preventive Care with proactive health status management will improve quality and help minimize long-term costs. We now understand healthcare funds are not limitless and will demand that healthcare services quality be aligned to the value those services return.

## Consumer Transformation

Another key Transformation element is increased consumer responsibility for health management and maximizing the value received. Pressure has been mounting for consumers to change unhealthy behaviors and actively participate in their healthcare decisions and to better define value in healthcare. Rising rates for obesity and chronic disease are direct indicators of unhealthy choices. Organizations exist today to help patients identify the information required to make sound choices, more effectively interpret medical information including choosing between care alternatives, and more efficiently interact with their providers.

## Care Delivery Transformation

The final element is Care Delivery Transformation. Healthcare delivery has been focused on episodic acute care and has shifted to embrace prevention and chronic condition management to respond to societal changes. Preventive care is being delivered by mid-level providers – including PAs, NPs, and Minute Clinics with some coordination with doctors. As the incidence of chronic illness continues to expand, care management remains expensive, labor intensive, and subject to variations in the effectiveness of care. Chronic patients are becoming empowered to take control of their disease(s) through

IT-enabled Disease Management programs to improve outcomes and to lower costs. Treatment is increasingly centering on their location, thanks to connected home monitoring devices, which automatically evaluate data and generate alerts and action recommendations as needed. Health Infomediaries are replacing doctors and leading more chronic care management to further reduce costs. Looking forward, today's often large general-purpose hospital will evolve into a Center of Excellence focused on more complex conditions with post-treatment Recovery Centers, where patients are monitored and primed for Medical Home connectivity before discharge.

## ACO Transformation Accountability

The Healthcare Transformation Journey requires focus and mastery in execution – from an episodic care model, to embrace the longer, more coordinated management of preventive and proactive chronic care across ACOs. This requires establishing a more articulated accountability framework driven by aligned incentives with value realization defined by stakeholders. Successful transformation requires these same stakeholders to collaborate and be part of the ongoing change initiative.

### About the Author



#### Larry Howe

*Associate Partner, Healthcare Management Consulting practice, Infosys*

Larry Howe brings 25+ years of Healthcare Industry Strategy, Business Transformation, Process Optimization, and IT-enabled Consulting experience to Fortune 100 Clients (payer and provider). Larry is instrumental in defining, delivering, and managing E2E and B2C Solution Delivery across Operations/Admin/HR/Finance/IT Transformations, Regulatory Compliance (ACA and ICD10), Consumer Engagement/Digital Experience, ACOs/PCMHs, Population Health, Care Coordination and Management, BI Analytics and Big Data, BPO/ITO, and Risk Management.

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