ACCOUNTABLE CARE: ROADMAP TO VALUE

Perspective

The adoption of Accountable Care and value-based reimbursement has dramatically increased these past several years. New organizations are being established as well as existing provider organizations adopting the concepts of Accountable Care through agreements with payors. With a focus on value, rather than volume, provider roles and relationships with the patient are changing. Enhanced technology and processes must be implemented to manage population, support provider collaboration and achieve desired outcomes.

AGREEING TO BE ACCOUNTABLE

There are typical components of an agreement between an organization and payor when providing Accountable Care or participating in an accountable care based network. Each of the components will likely be slightly different for each payor or agreement, which adds to the complexity.

Management of High-Risk Patients:

As part of achieving cost and quality goals, a segment of high-risk patients or other groups of patients may be managed by the ACO. Identifying members of this population may be based on a risk score, using prior encounters, or by a patient’s chronic condition. Outreach is usually expected for these high-risk patients or other groups to provide care management with measured outcomes. This then helps to lower cost while improving the patient’s experience and care.

Quality Objectives:

As part of Accountable Care, measures related to the quality of care are usually tracked and reported on a regular basis, e.g. quarterly. Examples include reporting an outcome or the occurrence of a procedure or test. In addition, a patient’s access to care and satisfaction may be measured. Goals are set for each measure, potentially with some financial benefit or penalty to the organization.
Provider Assignment:
Each agreement will define a method to associate patients to the ACO. This may be achieved with the patient selecting a provider as their primary care provider or by a payor-driven process that depends upon the analysis of prior visits by the patient. This association, called Attribution, is to ensure that a patient’s care and cost, in particular if they are high-risk, is managed along with maintaining a relationship with the ACO. Attention should be made to this process to ensure that it is understood and accurate.

Care Transformation:
An ACO works toward the transformation of the delivery of care through various practices, such as reducing readmissions, minimizing ED visits, discharge transition improvements, patient-centric Medical Home and managing high-risk patients. Some of these practices will be required as part of the ACO’s agreement with a payor. And, the payor may track progress and impact of these transformation practices on cost and quality of care.

Cost Objectives:
Accountable Care agreements have cost targets. Even if reimbursement is fee-for-service, per member per month (PMPM) cost objectives will be set. These targets, which may change over time, may differ based on how the patient is associated with the care organization and the risk-level of the patient.

PRACTICING AS AN ACCOUNTABLE CARE ORGANIZATION
There are challenges as an organization works to or continues practicing as an Accountable Care Organization. Following are guidelines and best practices to help an organization successfully meet the requirements of Accountable Care.

Create a Program:
To add structure and visibility to the scope and requirements of an ACO, it is suggested that a formal program be established. The ACO program should include a governance structure, e.g. steering committee, and serve as an umbrella for ACO related implementation projects and on-going operations. Having a program manager or leader that can both work internally to coordinate efforts and represent the organization externally to operationalize the requirements of the ACO agreement is important.

TRANSFORMING INTO A SUCCESSFUL ACO INVOLVES MORE THAN JUST COMMITMENT TO CHANGE; PROVIDERS AND PAYORS MUST IMPLEMENT STRUCTURES AND PROGRAMS THAT SUPPORT A NEW WAY OF DELIVERING CARE.
Create a Plan:
It is important to recognize that there is complexity to operating as an ACO as it works to meet business and clinical objectives. As an organization implements new processes and technology to support accountable care, new requirements will likely arise with each payer agreement with the ACO. The use of workstreams is recommended to organize activities while lessening complexity. The workstreams will assist in communicating with stakeholders. Within the workstreams, the plan should identify one-time implementation projects and the start of on-going operational activities. Often, a payor agreement will include required start-up activities with expected timelines. This should be considered in the plan.

Use Workgroups:
Workgroups may be used to support decision making, problem analysis, operational improvements and other work required for implementation and on-going support of the program. A workgroup may be established to serve a single, one-time purpose or may be created long-term to provide continuity as the program develops over time. To be responsive, the workgroup should stay small and agile.

Workgroups may be long term or ad-hoc, depending upon the need of the program, projects or operations. They may also piggy-back on existing operational organizations. For example, a workgroup may be defined as a way to collect data requirements across departments. This workgroup example would need both technical and operational members.

Create a Communication Strategy and Use It:
As an organization works to establish Accountable Care, there is a need to communicate and recommunicate. This may be from a more general perspective, educating people on ACOs, or in a very specific way to ensure processes are followed by the organization. The strategy may also include publishing metrics related to the population, new processes and quality of care. Examples of communication tools include orientation sessions, a SharePoint site, regular bulletins, process guides, and pop-up information booths.

PROGRAM WORKSTREAMS

| OPERATIONS | Clinical and operational activities to provide care to the ACO’s patient population. Examples are processes to manage care and patient access to the ACO. |
| MANAGEMENT | Oversight of ACO-related activities. This includes program management, financial performance management and contract management. Includes both internal and external activities. |
| COMPLIANCE | Operational work required by the payor. For example, tracking and reporting quality measures and activities related to care transformation. |
| TECHNOLOGY | Activities to implement new and update existing technology to support the ACO requirements. Includes technology required to support compliance reporting and other workstreams. |
Remain Flexible:
Accountable Care is in growth mode. New concepts regarding the transformation of care are being introduced with this growth. Also, an individual payor may have care delivery or other requirements that are new to an organization. It is important that the ACO understand the need to be agile with resources that can quickly move to support new or updated operational, clinical and compliance requirements.

Understand the Cost:
In addition to working toward lowering the cost of healthcare, an organization may contract with a payor to gain or maintain market-share. The financial benefits may be unknown or don’t happen until two to three years into the agreement with the payor. That said, it is possible to model the cost of care, with a comparison between practices of the ACO and traditional care delivery. While a provider organization may already be working toward the transformation of care, an ACO will likely need additional resources. This includes clinical, technical and administrative resources.

Relationships are Important:
Most organizations do not have staff or networked care providers to meet the complete care requirements of an ACO. Therefore, there is often a need to affiliate with other provider organizations. And, it is important to provide an understood incentive to these providers. In addition, the need to manage care and provide quality measures may add an extra burden to the affiliated provider. Where possible, the larger contracted organization should provide support or shared services to ensure success of the entire ACO.

Mind the Gaps:
Each accountable care based agreement will have differing quality, compliance and cost requirements. As each agreement is negotiated or established, it is helpful to do a gap analysis. This should identify needed updates to operations and technology while providing an understanding of compliance reporting needs. Where possible the organization should set operational policies that abstract from all agreements to simplify operations, better ensuring success.
Check the Numbers:
Accountable Care reimbursement and incentive arrangements with payors are varied and usually complex. As value based reimbursement is new to some payors, their systems may not support accurate calculation of savings or quality driven bonuses and penalties. Also, typical contract management solutions available to provider organizations don’t have the rigor required to monitor all financial elements of the payor agreement. It is important that an organization put a system in place to regularly audit payor payments.

Be Prepared for Data (lots and lots of data):
An ACO runs on data. Data is needed to understand the patient population, the status of transformation items (e.g. risk management), quality of care and cost. These are needed in comparison to monthly, quarterly and annual goals that are either set by the payor or needed to assess the ACO program’s status. Data will be received from payors that should be considered in addition to each agreement requiring regular reporting of quality and other measures.

It is important to have sufficient resources to support ACO data related activities. This includes both those that are technical and those that understand clinical operations. Activities include providing on-going data analysis and reporting, the processing of incoming data as well as meeting reporting requirements for contract compliance.

It Takes Technology:
To meet patient access and other care transformation requirements, an organization’s EHR will likely need to be updated. This includes giving users access to guidelines and ACO-specific patient information. Provider organizations without an EHR will have difficulty tracking quality measures and meeting compliance reporting requirements. Provider organizations that have an EHR and reporting tools, will need to meet requirements that are not often met by these solutions. This includes required management of populations, support of care management activities, and analysis of claims and cost. It is important to take a complete view of requirements and develop a technology vision that optimally meets user and patient needs.
IN SUMMARY

ACOs are an important part of the move to value based care. Operating as an ACO is complex and requires updates to operations, management and technology. By formalizing these activities into a program, with supporting resources and activity planning, increases the ability for an organization to manage this complexity. North Highland develops ACO strategy, performs baseline assessments, and evaluates the operational capabilities of an organization considering scalability of clinical programs and operational support. In addition, we work to secure physician and health system alignment, develop metrics to demonstrate high quality with low cost, measure clinical transformation, and manage overall population health and readmissions reductions.

ABOUT NORTH HIGHLAND

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