On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS) released regulations governing the establishment of accountable care organizations (ACOs) to mixed reactions from the provider community. Much of this reaction is driven by the governance, risk management, and operational complexities of establishing a Medicare ACO.

As proposed by the regulation, provider groups would have limited quantifiable performance feedback before they assume the associated financial risk. CMS would not begin performance analysis until the third quarter of the second year. There would be significant start-up costs for an ACO, with estimates ranging from $1.7 million, according to the U.S. Government Accountability Office, to $26.1 million, as estimated by the American Health Association.

The ACO must continually submit proof of compliance with CMS’s regulations to receive payments, with the prospect of 25% of the payments withheld, to be adjusted against losses in the third year. Some examples of proof of compliance are:

- Proof of development, implementation, monitoring, and enforcement of evidence-based clinical guidelines
- Proof of adequate use of information technology to support the program
- Proof that at least half of the primary care physicians are “meaningful users” of electronic medical records (EMRs) by the end of the first year of participation in an ACO
- Demonstration of financial ability to repay amounts owed to CMS when shared losses are involved
- Demonstration of prior and periodic review by CMS of all marketing and advertisement material used for shared savings
- Ability to notify CMS 30 days before a material change of its ACO participants, and the ACO must submit a recalculation of its primary service area.

Additional considerations to traditional provider groups include the network nonexclusivity provisions, the impact of retrospective member attribution, and presubmission of member communications to CMS. These challenges have dampened the enthusiasm for establishing Medicare ACOs. For example, the Mayo Clinic, Geisinger Health System, the Cleveland Clinic, and Intermountain Health have indicated hesitation toward setting up an ACO as proposed by the recent regulations.

An emerging alternative to provider groups independently establishing ACOs is partnerships between private payers and provider groups in establishing ACO-like entities. These partnerships are being designed to combine the payer’s expertise in administration along with the provider’s expertise in care delivery. One recent example of such a partnership is the Pittsburgh-based Highmark’s acquisition of West Penn Allegheny Health System, as was reported in the Wall Street Journal, “With spending on health care spiraling, insurers and health-care providers are looking for ways to cut costs, creating a range of different relationships in an effort to become more efficient. Some health plans are buying clinics, and hospitals are exploring payment models that increasingly resemble insurance.”

Such strategies provide a valuable template for establishing ACOs. Regardless of the approach, establishing accountable care will require 5 core competencies, as described below.

**Core Competencies for Establishing Accountable Care**

Accountable care represents a systemic and program-based approach to unifying several innovations in payment, care delivery, and outcomes coordination. The interdependency among care teams, member outcomes, and provider payments calls for the coordinated development of the following 5 core competencies:

- Population risk modeling
- Care network design and rollout
- Care coordination enablement
- Value-based reimbursement
- Productization of accountable care.
Population Risk Modeling

Characterizing the risk represented by an ACO’s member population is a key first step. This involves understanding the potential utilization patterns of the diverse risk groups and projecting the financial costs incurred by such utilization.

Effective modeling of the population risk—based on utilization patterns, along with access requirements and other performance criteria—is the basis for determining optimal care networks that are best suited to deliver care. Traditionally, health plans have had the tools to characterize population risk and have accumulated significant experience in understanding whether the revenues can sustain these risks.

Care Network Design and Rollout

Effective population risk modeling provides a rational basis for designing provider networks. Risk modeling provides the number and type of providers required to service the population. This, along with provider performance goals, can be used as the network design criteria. The resulting network design criteria will govern the participation of providers in the ACO network. The new ACO regulations’ nonexclusivity clauses for network participation are an example of how such network composition may be further affected by regulatory requirements.

Provider groups by themselves are ill-equipped to undertake such analysis. However, this is an area where health plans can offer significant help. Leading health plans have already been on a path to implement such criteria-based network designs. They can bring significant capabilities to enable a prospective ACO in designing and maintaining these care networks.

Care Coordination Enablement

The ACO regulations place significant emphasis on patient-centeredness in care delivery.1 The 8-part definition of patient-centeredness guidelines in the regulations draw significant attention to enabling care coordination. It calls for beneficiary “experience of care” surveys, care coordinators, and care coordination technologies to electronically exchange clinical summary information during care transitions, medical records access, and communication of clinical and evidence-based knowledge to beneficiaries.1

Care coordination enablement requires clinical data integration, secure messaging with all stakeholders, and a longitudinal view of the patient across all care encounters. In addition, coordination also needs access to clinical workflow automation tools, such as EMRs, e-prescriptions, and e-laboratories. Development of care coordination platforms requires the cooperation of health plans and providers to avoid fragmentation.

In the payer–provider partnerships, provider groups can leverage their existing clinical information technology infrastructure (eg, EMRs) while health plans enable the integration of patient data across all stakeholders. Plans can also facilitate communication across all care delivery teams to ensure continuity of care and timely interventions. Such coordination is particularly important to populations with chronic conditions.

Value-Based Reimbursement

Accountable care incorporates a shift from volume-based reimbursement to outcomes-based (ie, value-based) provider reimbursement. It also incorporates risk sharing to incentivize the achievement of high-quality outcomes. The performance of providers is measured against specific financial and quality goals. The right mix of payment strategies is leveraged to incentivize the desired performance. Bundled payments and shared savings are a typical part of this approach. However, they introduce complexity in payment partitioning among the different providers in a care network. Effective decision support needs the description of the details of reimbursement partitioning in a single source of truth.

Although ACOs are likely to be reimbursed through shared-savings models, they may have to reimburse their providers through fee-for-service, episodic care, or other payment arrangements. Efficient reconciliation of this paradox will be key to the financial success of each ACO and the approach to accountable care.

Once again, a health plan’s experience with such complex reimbursement scenarios is increasingly seen as an argument favoring a partnership between health plans and provider groups. However, existing health plan claims pricing competencies will need to be augmented to deal with value-based reimbursement. A key component of payments in accountable care is the continual demonstration of compliance with performance guidelines. Provider groups will need to facilitate access to performance data to enable the application of appropriate payment.

Productization of Accountable Care

Productization of accountable care—namely, the incorporation of accountable care into existing products—will be crucial to the commercial success of accountable care. Accountable care offers the prospect of designing products with lower premiums and improved outcomes. ACO products will need to include benefit designs that steer members to the ACO as the preferred provider.

Employers are increasingly demanding such customized benefit designs that better serve their employee populations. Employers see this as the basis for contain-
ing premium growth. Although health plans have addressed these needs for select employers, expansion across the customer base introduces significant administrative costs.

Productization of accountable care is an area where a health plan can demonstrate significant leadership. A partnership with provider groups will foster the adoption of accountable care products with employers. Critical Success Factors for Accountable Care Alignment of Network, Product, Care Model, and Reimbursement Design

The alignment of network, product, care model, and reimbursement design is critical to balancing the value of care to insured members (eg, reduced premiums and high quality of care) against the value to the ACO (eg, revenue, expenses, and provider satisfaction). The proper design of care networks is critical to this alignment. Network designs perform several functions. They create effective steerage targets for product benefits. Network designs ensure high quality of care through care team design. Network reimbursement policies drive provider reimbursement to incent the desired outcomes.

Administrative Simplification through Integrated Systems

The complexity of payer–provider ACO partnerships brings the prospect of significant administrative costs. Some of these costs stem from the existing disconnect ed nature of administrative processes and systems. Mitigating this issue and simplifying the administrative challenges requires the integration of key systems. Currently, health plans’ provider management and claims systems are poorly connected to several key business functions, such as utilization management, contracting, and financial planning.

Such disconnectedness renders basic decision support ineffective. As an example, many organizations routinely struggle to answer 2 critical questions: “Which providers are covered by a particular contract?” and “What are the diverse arrangements that cover a particular provider?”

A patchwork of ad hoc solutions often serves these tactical needs. This is inadequate in the face of increasingly complex, overlapping payment arrangements implicit in the ACO regulations. Support of tailored ACO products will increase the burden on these disconnected and inflexible systems. The complex demands of provider network performance-related payments will increase the risk of information leakage, payment errors, and performance misreporting.

These daunting challenges call for an integrated approach to provider management. This approach will integrate network, reimbursement, and clinical systems and would establish a connected platform that not only reduces administrative complexity, but offers a platform for informed decision-making and transparency. Buy-In through Provider and Member Transparency

Measuring and reporting provider performance are key components of the ACO initiative. Participating providers will legitimately demand to know what payment rules and performance measures influenced their individual payments. Members will demand the quality outcomes of their care teams and the details of their medical expenses. This demands a dynamic and flexible reporting capability. The reporting capabilities need to enable transparency across all stakeholders, by presenting a consistent rationale for the different constituents: members, participating providers, the government, and the employers.

Conclusion

Although the Medicare ACO regulations are being contested, the spirit behind ACOs to promote value-based designs and payments is being embraced. Many aspects of the incentives and challenges are still undergoing serious reexamination. Ultimately, the promise of accountable care depends on the intelligent alignment of products, networks, care models, and reimbursement designs. A look at the history of healthcare evolution ensures us that although the acronyms may change, our pursuit of accountable, affordable, and high-quality care will continue. The investment in the areas described here are critical in this iteration of our healthcare journey and the next one that is sure to follow.

Author Disclosure Statement

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References


