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Accountable Care Organizations: Win-Win Collaboration between Health Plans and Providers

People matter, results count.

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1. Introduction

By design, an accountable care organization (ACO) requires a symbiotic and profitable collaboration between a health plan and the healthcare provider. An ACO is expected to perform, on the one hand, like a coordinated care provider that is committed to measurably raising the health care quality and, on the other hand, do so with the fiscal responsibility and accountability of a health plan and lower the population healthcare costs.

ACOs therefore require the unique and complementary strengths of health plans and provider organizations to implement qualitative shifts in the way healthcare services are produced, distributed, delivered, and paid. They are expected to pave inroads for a new quality-based healthcare model by:

- Implementing quality programs in healthcare service delivery systems
- Establishing new payment system innovations based on quality healthcare purchasing models

In order to provide an accelerated start to the adoption of ACOs, Health and Human Services has provided opportunities for gainful, risk free participation in ACO programs and quality driven initiatives. The new payment innovations are purposefully designed to reward participation in the new health care delivery models and quality reporting programs, and prevent non-participation with disincentives over time.

The true success of the ACOs rests on:

- Healthcare quality improvements afforded by the new quality-based purchasing model in the long run; and
- How effectively health plans and network providers can converge over such commercial opportunities

As expected the most important aspects in building and running an ACO include:

- Visualizing how health plans and network providers work together in an ACO model
- Sharing the healthcare quality transformation journey; and
- Building an effective population health care cost management practice

2. How HMOs and Network Providers Can Work Together

To better understand how health plans and the ACO network providers need to work together in the area of account, it is desirable to take a close look at the inner workings of an integrated delivery network (IDN) and how it operates like a health plan and provider organization simultaneously. The following exhibit provides one view on the roles that health plan and provider organizations can respectively play in an ACO.

Exhibit 1

Business Functions	Health Plans	ACO Provider
Patient Management Services		
ACO member/patient attribution and renewal	X	X
Care access services	X	X
Patient record services	X	X
Information services – program eligibility	X	X
Network Management Services		
Network policy	X	
Provider community enrollment services	X	
Contract management services	X	
Reporting services	X	
Provider credentialing	X	
Health Maintenance & Management Services		
Evidence-based medicine & management		X
• Evidence-based disease management		X
– Preventive care		X
– Medication intervention		X
– Alternative care – lifestyle conversions		X
• Population health analytics	X	X
– Healthcare costs & performance analysis	X	
– Service utilization patterns	X	X
– Health risk assessments	X	X
• Quality compliance & reporting		
– Care measure definition & compliance		X
– Care measure reporting		X
• Population care plan guides	X	X
– Medical management across continuum of care management	X	X
– Care delivery modeling		X
Care & Utilization Management Services	X	X
• Benefit eligibility verification	X	
• Level of care assessment		X
• Prior authorization	X	
• Health assessment & maintenance services		X
• Utilization review	X	
• Care co-ordination services		X

Business Functions	Health Plans	ACO Provider
Quality Management Services		
Medical management policy		X
Standards setting	X	
Performance assessment	X	
Regulatory & compliance services		X
Management of review process	X	
Provider advocacy, education & training	X	X
Research		X
Customer Services		X
Information services	X	
Plan member enrollment in ACO program	X	
Co-ordination of customer participation in managed care activities	X	
Customer complaints, grievances & appeals	X	
Community benefit	X	
Financial Management Services		
Financial operations	X	
Risk management services	X	
Claims management	X	
Cost management services	X	
Advanced revenue cycle management services		
Shared savings/ earnings	X	
Risk management	X	
Traditional revenue cycle services		X
Information System Services		
DC operations	X	
IT vendor management services	X	
Software and hardware maintenance services	X	
Market research	X	
Human resources	X	

It is easy visualize and identify the significant role a health plan can play in running the ACO effectively—especially in the areas of network management, health care analytics, financial and cost management, customer services, claims management, and IT.

Similarly, the oversight of health care delivery, care management, patient services, population health maintenance, health risk assessment, and quality management are understandably best led by partner provider organizations. Such operational collaboration places health plans and providers together at the starting blocks of a transformational journey.

3. Sharing the Healthcare Quality Transformation Journey

Healthcare quality and costs share a cause and effect relationship. It has been visible in the rising drifts in per capita healthcare costs coupled with declining healthcare quality standards over the years. The inverse effect is equally and favorably true: improvement in healthcare quality results in lower per capita healthcare expenditure and healthcare delivery costs.

So, the reform-led shifts in the industry necessitate quality transformations within healthcare providers and health plan enterprises.

Given this, the success of an ACO rides on how well healthcare providers and health plans adopt and implement quality transformations across their operations. Progressive ACOs give health plans and providers an opportunity to build a shared quality engineering practice, dedicated to creating a 360° quality excellence across business functions of an ACO, in all lines of health care businesses, and clinical settings.

Capgemini facilitates a natural progression within health plans and provider organizations to build a collaborative health care delivery model those shares:

- Shared quality vision: goals, objectives, and challenges
- Integrated quality improvement practice
- Participation in quality reporting programs led by industry and quality improvement organizations such as the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), the Joint Commission on Accreditation of Healthcare Organizations (JC), or Leapfrog

3.1. Building a shared quality vision: goals, objectives, & challenges

The quality-led transformational journey for HMOs and coordinated care providers requires a steadfast, long term commitment to common healthcare quality goals including advancing patient safety, improving access to timely care, and delivery of efficient, effective, equitable, patient centric healthcare services. It calls for a clear understanding of the quality objectives and challenges that are expected to drive the industry wide initiatives in the near and long run.

The road to quality engenders the need for a strategic map for organizational change, and supporting systems transformation. Capgemini uses the Accelerated Solution Environment to enable healthcare experts to plan the quality transformations with a strategic roadmap and detailed understanding of the system transformations and quality enablement solutions required in this journey.

Exhibit 2: Understanding the Healthcare Quality Framework

Quality Goals	Quality Objectives	Quality Challenges
Patient safety	Reduce medical errors	• Reduce the number of never events/ surgical and other procedures • Reduce ADRs/ DDR events • Reduce diagnostic inaccuracies • Reduce systemic failures in care delivery
Access & timeliness	Reduce time to right care	• Enable remote care in healthcare delivery system • Enable exchange of information and provider collaboration • Reduce wait times in critical care venues • Reduce wait times to primary care
Effectiveness	Improve outcomes	• Reduce hospital acquired conditions • Reduce mortality • Reduce morbidity • Reduce re-admissions • Improve quality measure compliance and reporting
Efficiency	Improve resource utilization	• Reduce direct cost of care • Improve the utilization of the care delivery and IT assets • Improve human resource utilization/ management • Improve care coordination between clinical venues
Equitable	Reduce care quality disparities across regions, states, and demographics	• Standardization of healthcare services and quality • No denial of care based on indigence • Create equal access and measures of quality care across population segments • Overcoming the language barriers in care delivery
Patient centricity	Honors patient choice/ access to care/ affordability	• Enabling transparency of outcomes for informed patient choice • Enabling access to specialized care (internal and external) • Enabling access to health plans

3.2. Creating a common quality improvement practice

The design and establishment of a quality improvement practice is understandably the most important exercise that ACOs undertake in its quality engineering and transformation journey. It relates directly to the level of excellence healthcare enterprise achieves and financial gains it will find under the quality programs and the new purchasing models.

Establishment of a quality practice calls for articulation of the healthcare quality principles, design and development of sustainable healthcare quality improvement models and methodologies, implementation of quality measurement framework, and organization of quality improvement initiatives through quality programs.

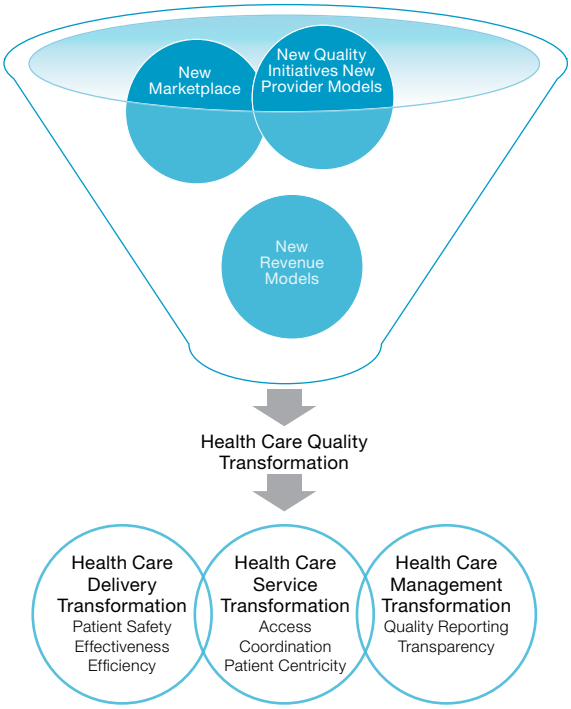
Capgemini can participate closely with ACOs to design and construct quality improvement practices aligned with industry shifts. For a start, Capgemini helps our customers understand the shortfalls in enterprise quality performance in comparison to the industry quality standards with a detailed assessment study of the current enterprise wide quality standards.

Accelerated Solution Environment: Enabling Collaborative Journeys

Our dynamic ASE seminars help you create solutions that increase profitability and maximize capacity, solving a targeted problem. This lets health payers and providers address the most urgent issues smoothly and effectively. An ASE allows you to:

- Accelerate the value creation of collaborative journeys and deliver what would otherwise take many months using traditional methods
- Mobilize participants around a commonly created solution
- Integrate the points of view of customers or suppliers
- Successfully manage complex integration issues
- Apply to a wide range of challenges using a patented process

Exhibit 3: Healthcare Quality Transformation



As a next step, we help our customers visualize and build a customized quality improvement framework, comprising a structured, best fit enterprise quality performance measurement set. This enables customers to discover opportunities for quality improvements—resource productivity, service and process improvement with greater standardization, outcomes and customer experience improvements.

In keeping with the goals of an ACO, the above quality improvement framework enables implementation of quality and performance KPI sets across clinical, administrative, revenue, and other business functions. These KPIs are carefully drawn to help ACOs realize greater cost, resource, and time savings and achieve greater operational effectiveness.

3.3. ACO alignment with healthcare quality reporting programs

The new ground realities in a quality based healthcare purchasing model indicate an obligatory and active participation by the coordinated care providers in the quality reporting programs launched by CMS and quality improvement organizations (QIOs). Successful participation in quality and reporting programs assures financial rewards and failures forebode long term financial setbacks.

Towards this end, ACOs need to share a fuller understanding of near and long term revenue earning opportunities available. Capgemini can further enable this understanding by using our unique Accelerated Solution Environment, framework to gain quick and full understanding of the quality measures that qualify for incentives and additional revenues and a roadmap to achieve compliance with the quality measures.

Exhibit 4: Quality Improvement Framework

Structured Performance Measurements Set	Quality Improvements
Efficiency Measures	• Improvement in high-value resource utilizations
Structure Measures	• Improvement in infrastructure; increased adoption of IT enabled solutions
Process Measures	• Improvements in of clinical and administrative process based improvements, adoption of best practices • Improvement in care planning, transition, and co-ordination
Outcome Measures	• Implementation of evidence based medicine; adoption of quality measures; for improvement in population management and disease management
Equity Measures	• Standardization of healthcare services
Patient Centered Measures	• Improvement in Patient experience, participation; choice, convenience

3.4. Overcoming the new quality management, compliance & reporting challenges

It goes without saying ACOs will need to continuously meet newer quality management, compliance and reporting requirements to successfully participate in a new healthcare service delivery model and quality programs.

The adoption of evidence-based medicine expected with the new quality programs will demand new patient management practices, care management and clinical transformations, including implementation of newer clinical pathways, adoption of new care co-ordination practices and clinical measures across the different care settings.

ACOs will need to gear up for stricter compliance standards and an ever-growing number of quality measures. New quality measures will expectedly create challenging requirements for availability and use of new clinical data and evidence in clinical decision making.

Some key challenges and requirements related to healthcare quality management, care co-ordination, and care management compliance and reporting include:

- **360 Data capture:** The application of quality measures and their reporting imposes the generation and capture of new clinical data as part of the patient and member record. It calls for ways to collect and present 360 view of the member data from the claims, care management and other ancillary systems. The introduction of new measures will call for frequent changes in quality systems and workflows to support timely capture of desired member data during episodes of care, and the entire continuum of care. Additional data challenges, including capture of structured vs. unstructured data may impair the ability to comply with quality measures and their reporting.
- **ACO member health surveillance to identify gaps in care :** Improving compliance of quality measures will require early patient health and risk assessments, with the help of data profiling and patient identification covered under specific measures. This in turn will demand continuous health surveillance by systems, and more importantly, to identify gaps in care and timely presentation of clinical evidence for effective clinical decision making, care management plans, and predictive burden of cost of care. The efficacy of health surveillance will depend on care systems that are enabled with alerts, notifications, and escalation to improve timely compliance by care providers.
- **Real-time quality measure generation:** Concurrent quality measure generation is an essential component to avoiding non compliance of quality measures. It requires system enabled automation of measure application, and calculation with live data during the episode of care and the continuum of care. Concurrent measure generation spins off other concurrency requirements such as real time generation of care delivery codes for compliance with quality measures. This ensures care delivery per the medical policy and the quality measures laid out in it.
- **Compliance reporting and analytics:** The common causes for compliance reporting failures include missing data, data invalidity, inconsistency, and non-reconciliation. The ability to generate reliable analytics is also impaired for the same reasons. The sharp rise in data volumes with the introduction of newer and growing numbers of quality measures will compound such problems even further. It is easy to guess quality reporting will create additional administrative and clinical work for healthcare enterprise.

4. Sharing a Rewarding Healthcare Cost Management Practice

Healthcare reform is now promoting a new payment system—incentivizing collaborative healthcare across the continuum of care, care delivery improvements that simultaneously produce shared savings for large population. It is easy to suppose quality care management and outcomes measurements applied to large population of members will begin to play a very significant role in the financial success of an ACO. Even more significantly, if it proves the improvements in care reduces the cost of health care. The ACOs and health plans can imaginably drive the cost reductions in empirical ways as outlined in the following sections.

4.1. Population cost management through care management

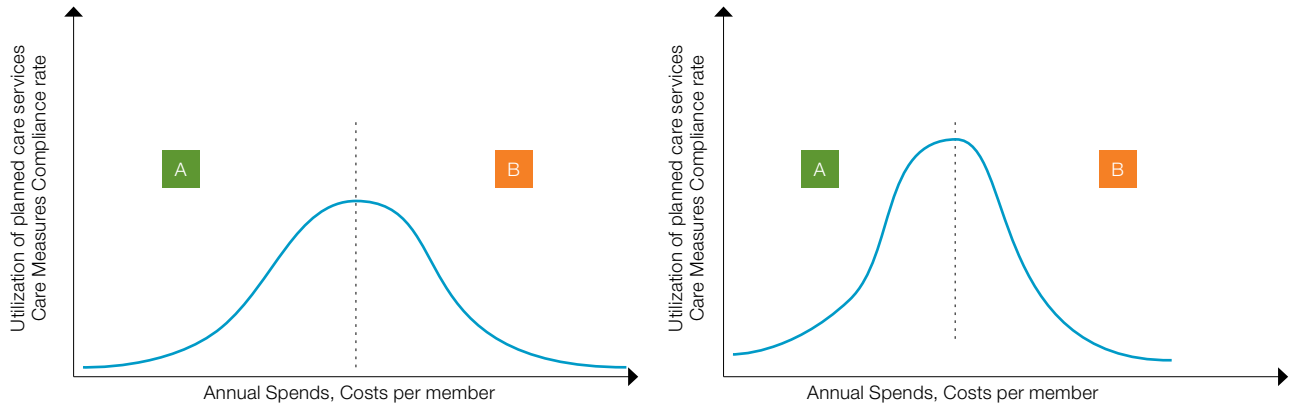
For a start, ACOs will need to delve deeper in population analytics, to study and identify viable populations—in terms of size, management capability, quality assessments, and provider network requirements—and assess clear opportunities to improve health outcomes and associated savings in cost of care.

This typically calls for a comprehensive study of populations, including the:

- Aggregate population heath care spends and costs;
- Annual costs of care per member;
- Population health risks and maintenance
- Variance in the health maintenance regimes and benefit plans;
- Utilization of preventive care benefits
- Compliance with utilization and quality care measures

It is important that an ACO identifies managed and unmanaged populations based on the consumption of preventive care, and wellness benefits. The financial insights into population health maintenance require an understanding of the effect that preventive, and wellness care utilization has on the planned health care costs and urgent care costs.

Exhibit 5: Cost per Member versus Care Management Compliance Rate



In general, unmanaged populations show:

- Higher overall annual healthcare costs
- Greater deviation and variance in:
  - Annual costs incurred per members
  - Utilization of planned services by members
  - Preventive healthcare quality measures compliance

Importantly there are three key insights:

- Outliers (members) in parts A and B represent higher risks of incurring unplanned and urgent episodic care costs
- Despite lower consumption of planned care services, unmanaged population are likely to incur higher healthcare costs
- Greater utilization of planned, preventive and maintenance services lead to fewer unplanned, urgent care episodes, and result in more effective management of healthcare costs

In addition to driving healthcare costs down with planned care, ACOs can improve the costs by effectively improving the episodic acute care outcomes, removing wasteful spends, and raising the operational efficiencies and throughput of the organization.

4.2. Building cost management practice

ACOs will need to progressively establish quality improvement and cost management best practices as overarching operating standard for provider organizations.

As expected, the efficacy of cost management services will depend heavily on:

- Improving the predictability of costs and savings
  - Planning and implementing planned, scheduled, evidence-based care;
  - Reducing the incidence of unplanned care and associated unplanned costs
  - Decreasing the non-emergency care episodes provided in the ERs
- Controlling and eliminating excess care costs resulting from:
  - Care services duplication including repeat diagnostics and ancillary services,
  - Untimely medical record services
  - Medical errors and diagnostic inaccuracies
  - Patient fraud and abuse
- Enabling cost effective alternative care delivery models
  - 24 X 7 outpatient and advice nurse services
  - Health coaching within home based care
  - Patient engagement and self managed care
- Optimizing operational costs and expenditures through enterprise performance improvements:
  - Improving patient flow volumes
  - Lowering the wait times for appointed primary care
  - Provisioning walk-in primary care for unplanned needs
  - Fully utilizing planned and scheduled care services
  - Complying with quality measures

4.3. Creating an advanced revenue model

Advanced revenue service involves the creation of a reimbursement model that facilitates the realization of shared savings in the per member, per month (PMPM) reimbursement model on one hand and enables a fair distribution of the savings amongst the participating providers on the other.

More importantly, ACOs need to carefully manage the risk of fixed PMPM reimbursement model with the risk reward relationships they form with participating provider network.

There are three models that ACO can use to manage their risk.

First, they can use a safety net with a near full-risk participation model. This model can be rendered with simple re structuring, and re-distribution of the negotiated PMPM re-imbursement package with the individual participating provider in it's as-is form. The risk exposure in this instance is limited to services provided by out-of-network providers, and in many cases transferred to the patient.

Second, ACOs can plan zero risk participation for participating providers, by assuming full risk of population and excess care overspends. ACO s can design this model with pay for service reimbursements to its provider network community, both in the form of: fixed reimbursement for a planned population care program and contracted rates for a menu of unplanned episodic care.

Third, ACOs can craft a shared risk model. In this model, ACO can baseline the costs for planned population care services/ health maintenance packages and share an agreeable portion of PMPM package as fixed reimbursement to providers. The remaining part of the population reimbursement package can be viewed as shared stop loss risk pool to cover unplanned and out of network care costs. The pool can then be maintained at a level to cover the risk exposure, savings in excess of the stop loss risk pool requirements can then be re-distributed amongst providers as:

- incentives for quality compliance
- relative share of savings in population care spends

5. How Capgemini can support ACOs

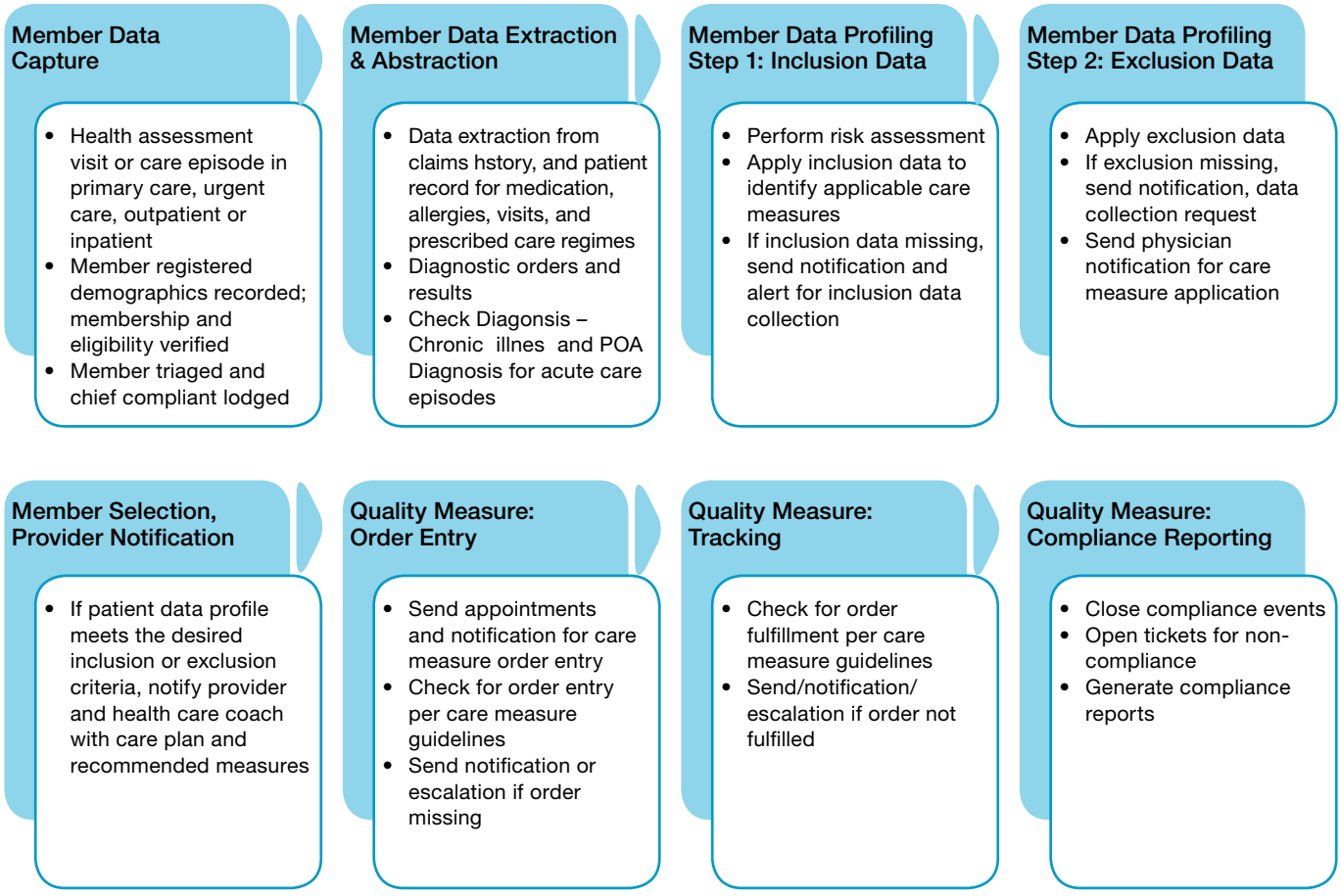
It goes without saying the ACOs require reinforced medical management policies and processes that provision continuous population and member health care surveillance, ensure consistency in patient assessment and application of coordinated care measures across, and support improved utilization of planned health care benefits across population, and put in force timely health risk assessment and interventions at the points of care across in coordinated care settings.

Given the revenue earning opportunities and financial rewards tied to savings, ACO will need to focus on:

- Early classification of high risk population and member identification using claims and medical record data profiling logic
- Identify the ACO care measures and care management regime that apply to the general and high risk pool
- Automate the tracking of ACO care measures intervention and fulfillment
- Escalation for non-compliance of planned care measures
- Non-compliance dashboards for timely focused improvement

The Capgemini ASE aims at helping ACOs visualize integrated Payer and Healthcare Provider medical management processes that enable health plans administrators and providers to quickly identify high risk pool of members in their opening care episodes and health assessment visits, and converge on care management plans for

Exhibit 6: Integrated Medical Management Process Model



effective member health management and cost controi as given below. The above model showcases how health plan administrators and care providers can:

- Converge on Point of care events,
- Build common sets of member medical data sets and rules for health risk profiling,
- Create real time and appointed care measure alerts for timely care measure and order entry using the care coordination platforms (HIEs)
- Monitor and track ACO care measure administration,
- Invoke timely alerts and escalations for non-compliance
- Identify inconsistencies in prescribed care in relation to managed care
- Improve care coordination
- Improves patient satisfaction

5.1. Capgemini ASE – Results and Value Summary

Achievable Results/ Outcomes
• Identify opportunity to build care management systems that provision 100% ACO care measure compliance requirements under the quality initiatives • Timely and up to date quality/ care measure reporting; • Zero quality reporting data shortfalls • Successful adoption by health administrators and care provider • Accurate care measure/health plan administration

Value
• 100% ACO quality care compliance , • 100% care measure compliance reporting incentive collection and PMPM cost savings • Achievement of highest quality standards and outcomes • Enables readiness/ means to achieve the desired care standards • Significant badge value and peer recognition

Appendix A: ACO Quality Metrics

Exhibit 7: Comparison of Final Rule's Quality Measures with Other Quality Reporting Programs

Domain	ACO Measure Title and Description	AHRQ	HEDIS	Meaningful Use Stage 1	PQRS	VBP
AIM: Better Care for Individuals						
Patient/Care Giver Experience	Clinician/Group CAHPS: Getting Timely Care, Appointments, and Information		X			
	Clinician/Group CAHPS: How Well Your Doctors Communicate		X			X
	Clinician/Group CAHPS: Patients' Rating of Doctor		X			
	CAHPS: Access to Specialists					
	Clinician/Group CAHPS: Health Promotion and Education		X			
	Clinician/Group CAHPS: Shared Decision Making		X			
	Medicare Advantage CAHPS: Health Status/Functional Status		X			
Care Coordination/ Patient Safety	Risk-Standardized, All Condition Readmission: The rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population.	X				
	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease [AHRQ Prevention Quality Indicator (PQI) #5]	X				
	Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure [AHRQ Prevention Quality Indicator (PQI) #8]					
	Percent of PCPs who successfully qualify for an EHR incentive program payment					
Care Coordination/ Transitions	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility		X			
	Falls: Screening for Fall Risk		X			
AIM: Better Population Health						
Preventive Health	Influenza Immunization		X		X	
	Pneumococcal Vaccination		X		X	
	Adult Weight Screening and Follow-up			X	X	
	Tobacco Use Assessment and Tobacco Cessation Intervention		X	X	X	
	Depression Screening				X	
	Colorectal Cancer Screening		X	X	X	
	Mammography Screening		X			
	Portion of Adults 18+ who have had their Blood Pressure measured within the preceding two years		X	X	X	
At Risk Population: Diabetes	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8%)		X			
	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (LDL) (<100)		X	X		
	Diabetes Composite (All or Nothing Scoring): Blood Pressure > 140/90 mmHg		X	X	X	
	Diabetes Composite (All or Nothing Scoring): Tobacco Non Use			X	X	
	Diabetes Composite (All or Nothing): Aspirin Use: Daily Aspirin use for patients with Diabetes and Cardiovascular Disease		X			
	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)		X		X	
At Risk Population: Hypertension	Hypertension (HTN): Blood Pressure Control: Percentage of patient visits for patients aged 18 years and older with a diagnosis of HTN with either systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care for hypertension.				X	
At Risk Population: Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100mg/dl		X			
	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic		X			
At Risk Population: Heart Failure	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)		X		X	
At Risk Population: Coronary Artery Disease	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol		X			
	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular stolic Dysfunction (LVSD). Percentage of patients aged 18 years and older with a diagnosis of CAD who also have Diabetes Mellitus and/or LVSD (LVEF <40%) who were prescribed ACE inhibitor or ARB therapy.					

About the Authors

Sanjeev Chanan is a member of the Capgemini's Health Insurance business leadership council, and leads the North America Health Insurance Solution Pillar team. He brings over 10 years health care advisory and consulting experience and is engaged in the delivery of health care projects at key accounts.

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