



12 Things You Need to Know About Value-Based Reimbursement

Building an Infrastructure for Financial Risk

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Introduction

Public and private payers, including Medicare and some of the nation's biggest health insurers, plan to hasten the migration of the healthcare reimbursement system from pay-for-volume to pay-for-value. The acceleration in the pace of change from fee for service to risk-based reimbursement is likely to reshape the healthcare business over the next three to five years.

While all healthcare stakeholders will be affected, the pioneers of this approach to healthcare financing will be large, integrated delivery systems (IDNs) and accountable care organizations (ACOs). Some of these organizations already take varying amounts of financial risk, but the percentage of their revenues coming from shared savings, bundled payments, and global or partial capitation is certain to rise in the next few years.

To prepare for these imminent changes, these organizations must rethink their near-term financial and clinical strategies. They must consider not only how to make the transition to new payment models, but also how to maximize their reimbursement in the new world of population health management. A key part of their strategies will be health IT, which will continue to evolve in tandem with the changing reimbursement landscape.

This paper will describe the strategies of some large healthcare systems and ACOs in preparing for the impending acceleration of the shift to value-based reimbursement. The focus will be on such topics as care management, patient engagement, and information exchange with an emphasis on health IT requirements. In addition, the paper will discuss how these IDNs and ACOs plan to use data aggregation, analysis, and predictive modeling to identify and manage high-risk patients who generate the majority of costs.



Background

The Department of Health and Human Services (HHS) recently announced that 30% of Medicare payments will involve alternative payment models (APMs) by the end of 2016. By the end of 2018, HHS said, half of Medicare payments will go to APMs such as ACOs, patient-centered medical homes (PCMHs), and healthcare organizations that accept bundled payments.¹

Meanwhile, a group of 20 leading insurers and provider organizations has announced their commitment to putting “75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020.”² Other major insurers previously announced their intention to move to value-based payment models.

The setting of target dates for the transition from pay-for-volume to pay-for-value means that provider organizations must ramp up their own preparations for adopting an approach that emphasizes population health management. But the infrastructure to do that is largely nonexistent in most current ACOs, says David Wennberg, MD, CEO of the Northern New England Accountable Care Collaborative (NNEACC), which provides data and analytic support to four New England ACOs.

As a result, relatively few organizations are prepared to take financial risk for the care they deliver, he notes.

This factor has already had consequences for the Medicare Shared Savings Program (MSSP) of the Centers for Medicare and Medicaid Services (CMS). When the program was launched, CMS intended to require all ACOs to take downside risk if they renewed their three-year contracts with MSSP. But it recently decided to allow ACOs to continue taking only upside risk when they renew their contracts.³ Wennberg says CMS did this to avoid large-scale dropouts from the program.

Nevertheless, CMS is determined to move ACOs into risk contracting. CMS' recent proposal to improve the MSSP lowers the shared savings for ACOs that take upside-only risk from 50% to 40%. ACOs willing to bear downside risk can still receive 60% of the savings and assume 10% of any losses. Under a new third track in the MSSP, they can net 75% of the savings and take 15% of the losses.⁴⁻⁵

Commercial payers are also offering ACO contracts that involve increasing amounts of risk. According to a study in the American Journal of Managed Care, 56% of health plan contracts with ACOs feature downside risk. They delegate this risk through capitation, global budgets, or shared savings contracts that include shared losses. In contrast, just 7% of MSSP agreements entail downside risk.⁶

Despite this aversion to risk among many ACOs, the ACO leaders who participated in IHT's research project agree that risk is coming and that they have to prepare for it.



56% of health plan contracts with ACOs feature downside risk.

Background

“The potential upside of getting into a financial risk arrangement far outweighs the upside of any gain sharing or shared savings,” explains Marcia Guida James, MS, MBA, vice president of accountable care for Mercy Health System.

A four-hospital, Philadelphia-based healthcare system that is part of Trinity Health, Mercy has an ACO that participates in the MSSP and holds a couple of private managed care contracts. Under its commercial contracts, Mercy is eligible for upside-only shared savings, but James knows that more risk is on the way.

“We’re not ready to move to risk yet, although we’re going to get there very quickly,” she says. “We have to get the infrastructure in place before we accept any downside.”

Robert Fortini, RN, MSN, chief clinical officer of the Bon Secours Virginia Medical Group (BSVMG), also sees the writing on the wall. The Richmond, Va.-based multispecialty group, part of the Bon Secours Health System’s Virginia branch, has an ACO that participates in the MSSP and contracts with several private plans. BSVMG is now negotiating its next three-year contract with Cigna, and Fortini says the group will be assuming risk in that agreement. In addition, a United Healthcare Medicare Advantage plan just offered the group a three-year pact that includes risk in the third year. “We anticipate that every single one of our payers will have that transition to risk,” he notes.

Patient-centered medical homes

Before delving further into the strategies of our participants, it would be helpful to explain the background and the current state of the three major alternative payment models: patient-centered medical homes, bundled payments, and ACOs.

Patient-centered medical homes (PCMHs) have been a focal point of healthcare reform for some time. Endorsed by several medical societies in 2007 as a vehicle for rebuilding primary care, the PCMH movement began to grow rapidly after payers started incentivizing practices that had achieved recognition as medical homes from the National Committee on Quality Assurance (NCQA) or other certifying bodies. As of September 2014, NCQA had recognized 8,112 practices encompassing 40,841 clinicians as PCMHs.⁷

The key elements of the PCMH--which some observers regard as essential building blocks of ACOs--include a personal physician who provides continuous and comprehensive care to his or her patients; a physician-led care team; a “whole person” orientation; care coordination across all care settings, facilitated by information technology; an emphasis on delivering high quality, safe care; and enhanced access to care through such methods as open access scheduling, expanded hours, and secure email.⁸



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Background

Bundled payments

Bundled payments have a long history within hospitals. Medicare DRGs are essentially bundled payments for diagnosis-related services, and some private payers offer bundled payments for procedures such as hip replacements and coronary artery bypass grafts (CABGs). However, CMS' Bundled Payment for Care Improvement (BPCI) initiative has greatly expanded the scope and reach of bundled payments.

BPCI offers four models for bundled payments that cover different combinations of hospital, physician and post-acute services, including retrospective acute care hospital stay only; retrospective acute care hospital stay plus post acute care; retrospective post-acute care only; and acute care hospital stay only with a single, prospectively determined payment. In the retrospective models, the actual charges are reconciled against a target and participants can keep any money they save.⁹

Nearly 7,000 hospitals, physician groups and post-acute-care organizations have signed up for the three-year demonstration project,¹⁰ but most of them are not yet taking bundled payments.¹¹ The rest of the organizations enrolled only for the non-risk-bearing initial phase, in which they were able to see Medicare claims data and information on historical spending. Moreover, a study of hospitals participating in the retrospective hospital stay plus post-acute care track found they are accepting bundled payments for only a few conditions.¹²

Many ACOs are interested in bundled payments. Wennberg says that all four of the ACOs his organization supports are talking to private payers about such deals; one of them, anchored by the Maine Medical Center, is participating in the Medicare pilots of angioplasty and CABG bundled payments. Wennberg doesn't view bundled payments as an alternative to shared savings contracts, but as a way to augment them, especially if an ACO includes a tertiary care hospital.

Mercy Health is also involved in some bundled payment arrangements, including the BPCI demonstration, James notes. Many other hospital systems signed up for the first phase of BPCI, thinking that it might be a better way to go than shared savings programs, she notes. After looking at the data, she says, some of them shied away, either because they didn't have the necessary infrastructure or because they were afraid that participation might induce some referring physicians to go elsewhere. But after other hospitals and ACOs recognize how much savings can be had in the post-acute-care space, she predicts, they might return to the program next year.



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Background

Accountable care organizations

The ACO concept goes back only to 2006. But the Affordable Care Act of 2010 gave ACOs an enormous boost by authorizing CMS to launch a shared-savings program with ACOs in 2012. Under this approach, an ACO that meets specified quality goals can split with CMS any savings that surpass a minimum level.¹³

The MSSP requires that an ACO have at least 5,000 fee-for-service Medicare beneficiaries assigned to it. In addition, the ACO has to include enough primary care physicians to care for those patients. Among the MSSP's other requirements, the ACO has to report on quality measures in the first year; after that, it has to meet quality goals to get shared savings.¹⁴

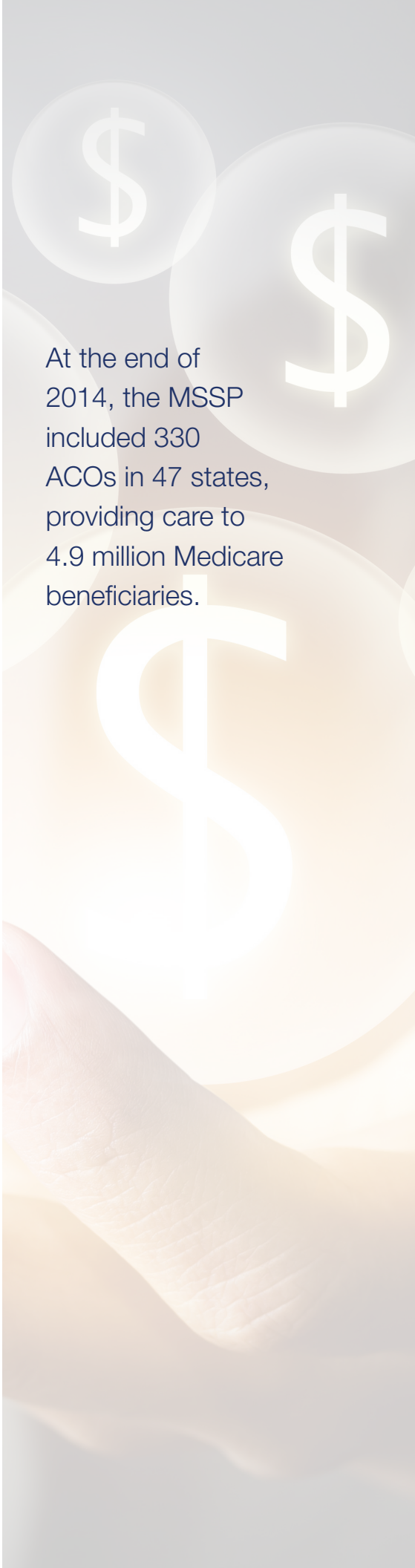
Besides the MSSP, CMS offered the Pioneer program for advanced ACOs. These organizations share financial risk with CMS from the outset—a stiff challenge for some of them. Of the 32 original Pioneer ACOs, only 19 remain in the program today. Some of the dropouts switched to the MSSP.¹⁵

Only about a quarter of the ACOs in the shared-savings program have made money from it. In the MSSP's first year, 58 of the participating ACOs saved Medicare \$705 million and qualified for bonuses adding up to over \$315 million. Another 60 ACOs held expenditures below their benchmarks for historical costs, but not by enough to qualify for shared savings. The rest of the ACOs spent more on care than their benchmarks.¹⁶

Nevertheless, interest in the MSSP has remained high. At the end of 2014, the MSSP included 330 ACOs in 47 states, providing care to 4.9 million Medicare beneficiaries.¹⁷ This year, another 89 ACOs joined the program.¹⁸

Many commercial payers have jumped on the bandwagon. Based on a May 2013 survey, Leavitt Partners estimated that there were 626 ACOs, of which 329 had government contracts, 210 had commercial contracts, and 74 had both. Leavitt couldn't determine what the other 13 ACOs had.

By the first quarter of 2014, Leavitt found, about two-thirds of these ACOs served 20.5 million people. Commercial contracts accounted for 12.4 million of these consumers. MSSP, Pioneer, or state Medicaid contracts covered the rest.¹⁹



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Background

MSSP shortcomings

While Medicare is still the leading ACO payer, observers and participants have criticized the MSSP on a number of grounds. Among the program's current drawbacks, one critic says, is that it does nothing to engage or reward beneficiaries, gives providers only modest incentives, and restricts mechanisms to lower costs and improve quality.²⁰

In a recent report, the Bipartisan Policy Center (BPC) pointed out that the retrospective attribution of Medicare patients to ACOs has meant that the organizations don't know whom they're responsible for until the end of an accounting period. They also have very limited ability to engage patients, who are given neither a choice nor an incentive to participate in ACOs. Because the patients can seek care wherever they want, two thirds of specialty office visits for attributed Medicare beneficiaries occur outside ACOs, the BPC noted.²¹ That could be a big problem when ACOs take downside risk.

In addition, the potential rewards for participating in the MSSP often don't justify the expense and risk of building the infrastructure, the BPC pointed out. The upfront cost to start an ACO is typically \$2 million;²² for a hospital-led ACO, it can be \$5.3 million to \$12 million.²³

The BPC also noted that ACO benchmarks are reset after each three-year contract period, so ACOs must continually improve to generate shared savings. This feature of the MSSP is especially challenging for more efficient providers.

CMS' MSSP improvement proposal includes some changes welcome to ACOs: Beneficiaries can be assigned to midlevel practitioners; CMS will streamline data sharing; and, as mentioned earlier, it will not require ACOs to take downside risk in their second three-year term. In addition, CMS pledges to use regional cost data in benchmarks to make them independent of ACOs' past performance.²⁴

But the proposal does not address attribution or patient engagement—two of the biggest drawbacks to the MSSP. CMS recently proposed another program for “next generation” ACOs that would allow Medicare beneficiaries to sign up with these risk-taking organizations and would reward them for receiving care within their networks. The first next generation ACOs will start operations on Jan. 1, 2016.²⁵



\$2 million

The typical upfront cost to start an ACO.

Strategies

To prepare for financial risk, ACO and IDN leaders know, their organizations must be able to manage population health and intervene with patients before they generate high costs for the system. But how they define population health management (PHM) differs considerably from one organization to another. Some organizations place most of their emphasis on managing high-risk patients, since the sickest 10% of patients account for about 70% of health spending. Others see a need to reach out to and monitor their entire population. They reason that the sooner they detect developing health problems, the better they can deal with those in low-cost settings, preventing hospitalizations and ER visits.

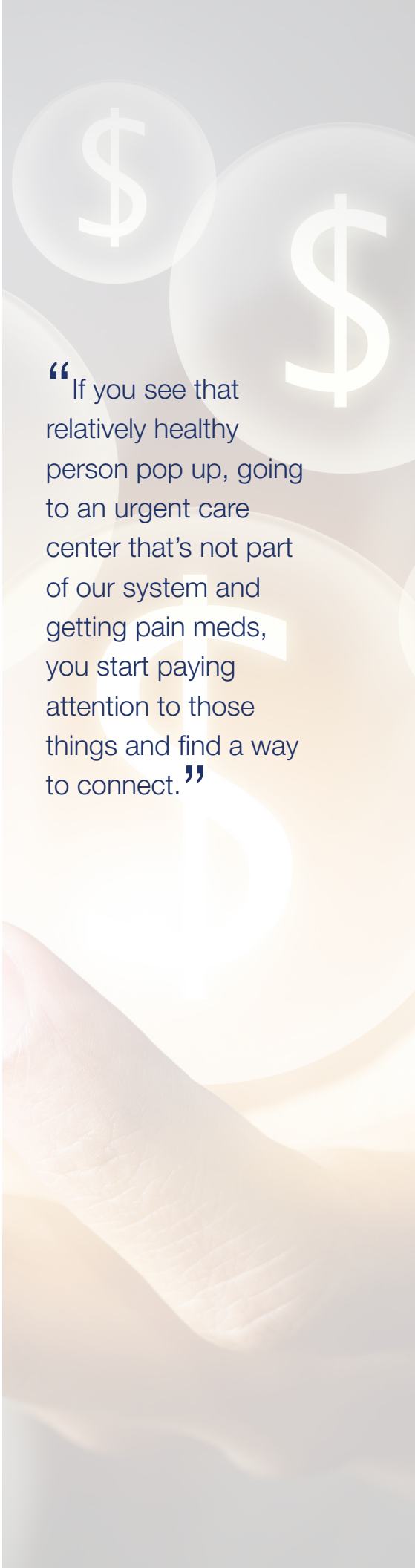
In a recent report, the ACO implementation collaborative of the Premier Health Alliance stressed that high-risk care management is not sufficient to move the needle on costs. Instead, Premier urged ACOs to target care management at “broad segments of the population.”²⁶

Even ACO leaders who embrace this concept, however, concede that resource availability helps shape their PHM strategy. BSVMG, for example, has PHM software that uses a registry and clinical protocols to trigger automated phone messages that alert patients when they need to visit their provider for preventive or chronic care. However, Fortini says he understands why some ACOs might take a narrower approach.

“The 20 preventive care protocols that we use now are casting the net as wide as possible and include well patients. But right now, my best bang for the buck is to interrupt those who are visiting the ER 12 times a year or who are newly diagnosed with a comorbidity that’s going to result in that [ER visit]. It’s just a matter of time and resources.”

The Heritage Provider Network (HPN), a southern California IPA that includes an ACO and has long experience in managed care, focuses less on population-wide outreach than on managing the top 10%-20% of health service utilizers. “You want to get to them, because they’re the ones who could head downhill quickly,” says Mark Wagar, BA, MHA, president of Heritage Medical Systems, an affiliate of Heritage Provider Network (HPN).

HPN does, however, keep a close eye on the all of its patients’ contacts with the healthcare system. “If you see that relatively healthy person pop up, going to an urgent care center that’s not part of our system and getting pain meds, you start paying attention to those things and find a way to connect,” Wagar says.



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Strategies

Care management approach

ACOs also differ in how they approach care management. Some believe care managers should contact all patients manually. For example, Mercy Health is implementing PHM software, but James doesn't believe it should be used to automate outreach. Instead, she says, the application should help care managers prioritize their management of high-risk patients. "If someone has a high risk score and they haven't been in, that person is going to be prioritized."


An ACO that has risk contracts, she adds, should hire the appropriate number of care managers rather than rely on automation. "If you are short of care managers, the money you spend using a vendor to provide some of those services could be better spent hiring more care managers."

In contrast, Fortini holds that automation at all levels—including patient outreach—can help care managers be more efficient and serve more patients who need their help. He notes that about 30% of the 75,000 automated calls that BSVMG makes annually to patients have gotten results. "By saving all those hours on nurses' outreach calls, we can focus on other things that are much more important and a better use of their training," he says. "So I find a lot of efficiency in it."

Care management can be centralized, dispersed to provider sites, or both. BSVMG, for instance, has 52 care managers who are embedded in practices and another dozen in a central location. Fortini explains that the group has co-located most care managers with providers because patients respond better to people they know and trust than to strangers who call them on the telephone. Also, he notes, care managers can perform billable work that helps cover their salaries if they're imbedded in offices. An RN care manager, for example, can perform Medicare wellness exams that bring in \$145 each.

Some other ACOs, Wennberg notes, coordinate all care from a central location. For example, the Maine Health physician-hospital organization, the contracting entity for the health system's ACO, has nurses and other health professionals do telephonic care coordination in a central office.

In the long run, he predicts, the hybrid approach to care management will win out. The right hybrid model, he says, "allows you to take advantage of the efficiencies associated with centralization, along with the face-to-face impact of the distributed model."



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Strategies

Primary care and PCMHs

To be effective, ACOs need plenty of primary care, our participants agree. Primary care is central to the strategies of all four of the ACOs that Wennberg's company supports, he says. BSVMG has gone even further: Among its 624 providers, including 150 midlevel practitioners, the ratio of primary care to specialty care providers is now 60% to 40%, vs. 30% to 70% several years ago.

"We did that by design, strategically," Fortini says. "We knew what value-based payments were going to look like, and we saw the growing gap in the primary care delivery system and the increasing needs of the population."

The main reason why primary care physicians are needed to manage population health, he notes, is that "a generalist is capable of taking care of a wider range of problems. Putting that person in place who can deal with more of those issues in a single shot is going to be much more effective."

Fortini also regards the patient-centered medical home (PCMH) as crucial to ACO success. All of his group's primary care sites have received PCMH recognition from the NCQA, he says.

"Building the medical home is foundational to an effective ACO. We have had dramatic success in the last five years in getting this foundation in place and achieving the outcomes that an ACO wants to achieve."

James, who is also enthusiastic about the PCMH, points out that most of Mercy's primary care practices are recognized medical homes. "The medical home provides a different way of looking at your patient population," she says. Instead of treating each patient episodically for a particular problem, she notes, "the PCMH pulls together the view of that whole person." In addition, she says, the PCMH can "help keep patients close to you," making it less likely they'll seek care outside the ACO.

Physician attitudes

With its concentration on primary care, BSVMG was able to create an ACO for the MSSP from its own physicians, Fortini notes. The majority of ACOs, however, include independent physicians. Some healthcare systems don't employ enough primary care doctors to create ACOs without recruiting providers from the community. And, of course, ACOs formed by physicians—which account for slightly more than half of all ACOs²⁷—necessarily consist of nonhospital-owned practices. As we'll see in the next section, this has important implications for data aggregation.



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Strategies

In terms of ACO strategies, employed physicians are not always easier to influence than independent doctors, notes James. Moreover, Wagar observes, independent practitioners can manage care as well as employed doctors, if they're "supplied with information and with the right infrastructure." In southern California, where HPN takes global risk for about 800,000 patients, he says, it provides the same managed care infrastructure to both small and large practices in its IPA. (HPN also has operations in Arizona and New York.)

Regardless of how much risk an ACO takes, physicians can be paid fee for service, capitated or salaried, with various quality incentives. How their compensation is structured is the key to changing their attitudes from a fee-for-service to a value-based mindset, James and Wennberg say.

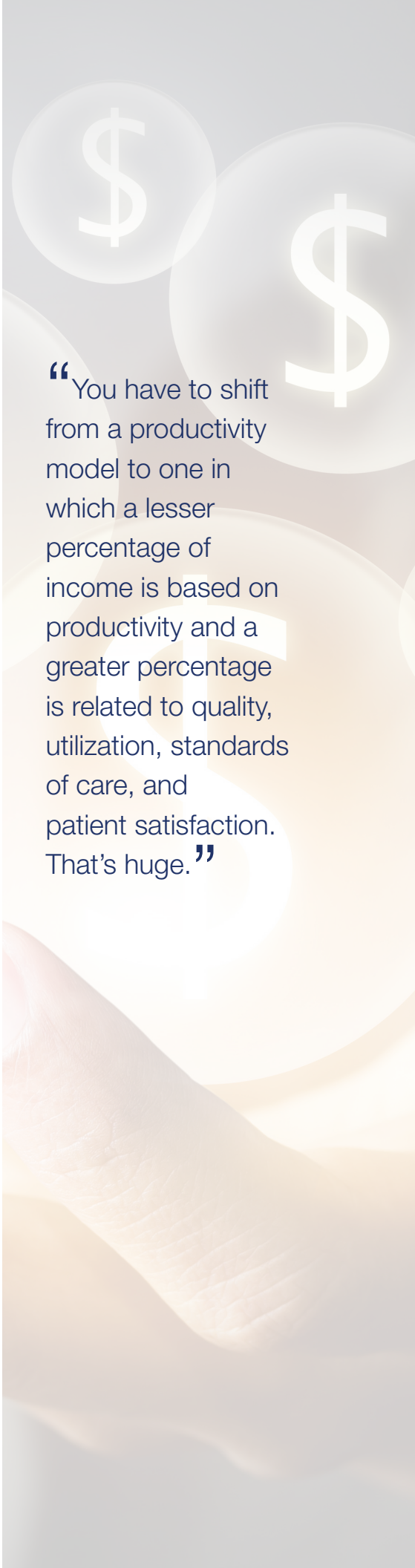
"If doctors are employed, that movement of reimbursement model will require a concomitant change in compensation," James emphasizes. "You have to shift from a productivity model to one in which a lesser percentage of income is based on productivity and a greater percentage is related to quality, utilization, standards of care, and patient satisfaction. That's huge."

Independent physicians, she says, represent an even greater challenge. "Those physicians are strictly on a productivity model. Eventually, you've got to have a large enough percentage of that practice's payers who have value-based contracts available for them to change their mindset."

Tipping point

James guesses that the tipping point for physicians will probably come when the percentage of their reimbursement that is value-based reaches 60%-75%. Wennberg believes it's closer to 50%. In either case, most ACOs have a long way to go before their risk contracts generate that much of their reimbursement.

But when physicians do reach that point, as many have in California, it makes all the difference in the world, Wagar says. The physicians employed by HPN groups get most of their revenue from global capitation contracts, and risk contracts supply well over half of the income of the independent doctors in the HPN network. Regardless of how individual physicians are paid, therefore, they have "similar incentives for quality and efficiency and effectiveness," he says.



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Infrastructure

Most ACOs recognize they need an infrastructure to handle risk and manage population health. But they may not know how to create one. In that case, they may hire an outside vendor to provide an infrastructure or bring in outside consultants to advise them on how to build one. Alternatively, they may come together in a mutually supportive arrangement.

The four ACOs that formed the Northern New England Accountable Care Collaborative (NNEACC) “realized that they needed an infrastructure, and we are their strategy to get there,” says Wennberg. “A lot of other people are looking for simple vendor solutions that they can apply across their enterprises.”

Wennberg’s organization supplies its ACO customers with a “hosted data model.” NNEACC aggregates clinical data from its constituent health systems with claims data and data from health information exchanges. In the near future, Wennberg says, the data warehouses that NNEACC hosts for its ACOs will also include patient-generated data.

After integrating all of this data, NNEACC applies predictive modeling, which uses algorithms to forecast the health risks of individual patients. It also offers a suite of web-based applications for physicians, care coordinators, and financial administrators. Most of its solutions are proprietary. In developing these applications, Wennberg’s team used the expertise they acquired when they worked for Health Dialog, a care management firm that contracts with payers, he says.

NNEACC is not trying to boil the ocean in its approach to value-based care, Wennberg notes. “Our role is in population segmentation, benchmarking, and contract performance assessment. When we get data from the clinical systems, we’re not getting all EHR data. We’re getting data that’s relevant to population segmentation and predictive tools or for the quality measures. You can’t do everything, so that’s our focus.”

Data aggregation

EHRs are not designed for population health management. While some of the larger EHR vendors have added PHM tools, including registries, those applications are not viewed as very robust. Moreover, most of the clinical data in an EHR is generated by the organization that uses that EHR; it doesn’t include data on healthcare services that were provided outside of that enterprise.

“My view is that EHRs are a necessary component of the delivery of care,” says Brian Drozdowicz, Senior Vice President and General Manager for Caradigm, a developer of PHM software. “I don’t believe they’re sufficient for population health. They were built and designed to facilitate single provider to single patient care, and they do a good job of that. But when you look across a population, and you’re managing the population, it’s more than just multiplying those single relationships.”



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Infrastructure

To supplement the information contained in a single EHR, an ACO needs claims data, and it must also be able to aggregate information from the EHRs used by other ACO participants. Both of these tasks present big challenges, say our experts.

ACOs can usually get claims data from their payers, but the information is out of date and is therefore less actionable than clinical data. While claims data can be useful for certain things, such as identifying preventive care gaps, it may be less valuable in other cases.

“We get a CMS data dump every month, and depending on how well CMS is functioning that month, that claim could be for care that was delivered from 30 to 90 days earlier,” says Fortini. By the time BSVMG receives the claims of its high-risk Medicare patients, “10-15% of those patients have expired,” he notes. “So it’s worthless data. It’s too late to do anything about it.”


Overall, however, claims data is improving, James argues. “When MSSP first started, there was a six month lag. Now folks are getting payers down to quarterly and we’re getting some plans down to monthly [releases of claims data], and it will go down from there. So we’re trending in the right direction.”

Drozdowicz views both claims and clinical data as essential to PHM. “Claims data fills up the bulk of what we do in terms of risk stratification and predictive analytics for identifying patients who are at low or medium risk who are likely to move to higher risk. But for identifying gaps in care or alerts for care planning or managing the care plan, we’re using real time clinical data, including lab and pharmacy data.”

ACOs face a big problem in getting clinical data from disparate EHRs—the “interoperability” issue that has been so widely discussed in the industry and beyond. Where effective health information exchange (HIEs) exist, ACOs may be able to obtain the data they need. But HIEs are either not present or not effective in many areas of the country.

This can be a challenge for ACOs that include many independent practices that use different EHRs. If they hire an outside PHM vendor like Caradigm, says Drozdowicz, that vendor may have a library of interfaces that it can use to stitch together data from multiple EHRs. Some ACOs have sidestepped the problem by requiring that members use one of just a few EHRs, he adds.

HPN’s ACO takes a different tack. While it collects clinical data from only some of its participating practices, it combines that with very recent claims data that covers the other groups. “As a result of having all this globally capitated business, we have the claims data right away. We don’t have to wait a few weeks or months or half a year to get information for the ACO,” says Wagar.



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Infrastructure

Getting tips from hospitals

HPN also uses another system to gain intelligence on what's happening with patients on a timely basis. When a hospital queries its system about a patient's coverage, its staff knows immediately that the person has been admitted or is going to have a procedure or receive some other service.

"When you get that query, you can find out whether primary care physicians are aware of this, and can also ask specialists if they're aware of it," Wagar says. "If an invasive cardiologist sends a query for a service that nobody knows about, that can be as important as somebody popping up in an emergency department."

Similarly, some payers are giving BSVMG "real-time data" on hospital admissions, ED visits, and referrals to case management, Fortini notes. In the latter case, he adds, the group's own care managers can confer with the health plan's case managers.


HPN's ACO and some other ACOs are also starting to link their systems with hospitals' admission/discharge/transfer (ADT) systems. This is another way to get information that can be valuable in care coordination.

Analytic applications

Once the data has been aggregated and "normalized" in a data warehouse, the ACO can apply a variety of analytics to that information so that it can be used in population health management. These clinical intelligence tools are designed to aid high-level decision making, to automate care management, to monitor patient health status, to engage patients in their own care, and to provide feedback to both the organization and to individual providers and sites on their performance.

The first task of analytics is to stratify the patient population by their health risks. This risk stratification is used to sort patients into different categories so that appropriate interventions can be applied to each person. In addition, the population can be categorized by condition, which is essential for tailoring care and education to each patient. Patients' diagnoses are just the starting point for this approach; other data such as lab results can help pinpoint the patients who need help urgently, notes Fortini. This is one reason why clinical data is needed to supplement claims.

Predictive modeling, which was mentioned earlier, is another key facet of PHM. IT vendors developed most of the applications used for this function for health plans, so they usually depend on claims data, Drozdowicz points out. In addition, James notes, some insurers will give ACOs their own analyses of patients' health risks, which she finds to be fairly accurate.



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Infrastructure

Use of registries

To monitor patient health status, identify care gaps, and provide actionable data to providers and care managers, some ACOs use registries fed by clinical and claims information. These registries list patients' diagnoses and lab results, what was done for each patient and when, and when they are due for particular kinds of care, among other data points. If the information in a registry is timely and comprehensive, it can be a powerful PHM tool, says Fortini.

Drozdowicz agrees. Registries cannot only help ACOs identify care gaps, but can also show which patients' health risks are rising, he says. "High-risk patients are often easy to identify, but rising risk gives you opportunity to intervene and make a difference." Nevertheless, he adds, ACOs and IDNs have just begun to recognize the importance of registries.

The PHM software that Mercy Health is rolling out includes a registry, says James. While there hasn't been much discussion about the registry, she thinks it might be used for disease management.

HPN's ACO uses registries mainly for research on which interventions work best in chronic care, plus "some special healthcare circumstances," Wagar says. But the ACO also uses analytics to supply actionable, up-to-date information to providers and care managers on "what's happening, what the treatment plan is, and where the care gaps are," he adds.

Care management

The PHM approach to care management depends on care teams that are structured to optimize preventive and chronic care, both in the office and between visits. The non-visit care can benefit from care management software that identifies care gaps and that helps care managers prioritize their interventions. This not only makes the care managers more efficient but also ensures that they work with the patients who most need their help, such as those with out-of-control hypertension or diabetes.

The latest care management programs are "pretty good in a lot of circumstances," Drozdowicz says. Among other things, he says, they:

- Use evidence-based guidelines to develop personalized care plans;
- Are better integrated with registries and risk management applications than older programs were;
- Can generate self-care action plans for patients.



“High-risk patients are often easy to identify, but rising risk gives you opportunity to intervene and make a difference.”

Infrastructure

“In care management, you’ll want to use that software on high-risk or highest-risk patients,” he says. “Then you look at people with moderate chronic illness. Some condition management programs send reminders not only for appointments but also on self-care to these patients. They can also be used to tailor ongoing education programs to fairly healthy patients to help them stay healthy.”

Fortini also sees a role for telehealth in care management. BSVMG is having discussions with American Well about using its telehealth service, he says. “There’s no doubt about the effectiveness, the speed and the cost of that healthcare delivery mechanism. We have to explore that.”


As organizations start assuming risk, he predicts, many of them will embrace telehealth because a virtual visit costs a small fraction of an ER visit. “The ramifications of telehealth for a value-based payment system are extraordinary, and physician resistance to it is a manifestation of the fact that they’re not compensated for engagement at this point,” he says.

Financial analytics

Analytics that can predict which patients are likely to generate the highest costs in the next year are essential to any organization that takes financial risk. Similarly, ACOs need budgeting tools that can help them forecast their costs so they can negotiate realistic contracts.

Risk-taking organizations use historical costs, based on claims data, in figuring out how much they’re likely to spend, given the health risks of their population. What most healthcare organizations lack, however, is the ability to calculate the costs of care delivery at a granular level. Some experts maintain that to succeed under risk contracts, ACOs and IDNs need to understand how much it costs to provide each unit of care.²⁸

Drozdowicz agrees, but notes that software designed for “activity-based cost accounting” has not gained widespread acceptance. Wagar admits that it’s hard to predict future costs on the basis of historical costs, because the environment is always changing; but in his view, the key to managing an ACO’s budget is to focus on limiting utilization and to negotiate good prices with hospitals and specialists.



“The ramifications of telehealth for a value-based payment system are extraordinary, and physician resistance to it is a manifestation of the fact that they’re not compensated for engagement at this point.”

Infrastructure

James is also skeptical about software that purports to help ACOs figure out how much care delivery costs. For one thing, she says, payers can provide valuable information that shows how much it should cost to care for a patient population. She agrees that hospitals don't know how to figure out their margin on a particular hospital stay, with the costs of that stay broken out from their overall costs. But she doesn't think that ACOs need activity-based costing software.

ACOs know their own cost of doing business, she says, as they can negotiate subcontracts with outside providers, such as skilled nursing facilities or home health agencies for specific pricing. If they do that, they don't need to know how much it costs to care for patients in those settings.



Conclusion


The conversion of the healthcare industry from pay-for-volume to pay-for-value isn't going to be easy or pretty, and it won't happen until providers decide they have to assume risk, Wennberg says. "That's the chicken-or-egg issue people will have to figure out from a policy standpoint. It's just a lot easier to do what you've always done and make money at it than to take risk if you don't have to."

The second major takeaway from our conversations with ACO leaders is that a certain amount of scale is required for success. Whether an ACO is hospital-led or physician-led, it needs deep pockets to build the necessary infrastructure and hire sufficient care managers. For that reason, James appreciates the fact that the Mercy Health ACO is associated with Trinity Health, which has substantial resources. And, while HPN's ACO is physician-owned and operated, it has grown into a behemoth that delivers care to around 1 million people nationwide.

Third, providers will have to become accustomed to the idea of delivering high-quality care within a budget. To Wagar, that's a "clinical obligation" that providers must accept so that resources are available to care adequately for a population.

Hospitals will have a harder time than physicians in making this adjustment, notes Wagar. Although many healthcare executives talk a good game about moving to value-based care, he says, many of them find it daunting when he tells them that "40% of the patients in your hospital don't need to be there if we're able to get the information and do things differently."

Despite all of the doubts and the resistance, however, Wagar believes that an increasing number of providers are ready for accountable care. "We've seen more physicians and hospitals step up and say, 'We want to help drive this change. We're afraid it won't be done right if we're not involved.' So let's step up and do it, and maybe this time we'll take two steps forward instead of one."



“40% of the patients in your hospital don't need to be there if we're able to get the information and do things differently.”

Recommendations

1. Make sure you have enough primary care physicians and other clinicians to provide comprehensive preventive and chronic care.
2. Restructure physician comp to align provider incentives with value-based care.
3. Create patient centered medical homes or use existing PCMHs as building blocks for your ACO.
4. Focus on care management for high-risk patients as well as other segments of the population that could become high risk in the future.
5. Automate as much of population health management as you can while emphasizing human contact for high-risk patients.
6. Embed care managers in practices wherever possible to create close relationships with patients.
7. Don't try to manage population health with your EHR alone, but use applications built for population health to help accomplish your goals.
8. Integrate claims data with clinical data to provide breadth, timeliness, and adequate detail for analytic purposes.
9. Find ways to obtain timely information from hospitals and health plans about admissions, discharges, and procedures
10. Use predictive modeling to intervene with patients who are likely to get sick in the coming year.
11. Use registries to track patients' health status and make sure they get the services they need.
12. Apply financial analytics to budgeting, using historical data on costs and, if possible, activity-based cost accounting.



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