In the new era of value-based payment contracts, health systems will require a business and clinical model designed to help them assume increased risk. If value-based payment contracts with a health system’s sponsored accountable care organization (ACO) or clinically integrated network (CIN) are to be more than simply the next incarnation of pay-for-performance, they must lay the groundwork for a comprehensive population health management strategy, with all the pieces in place to effectively manage the cost of care.

Balance the use of traditional and new metrics

The challenge for most health systems pursuing the value-based payment model is that they must do so while continuing to operate in a fee-for-service (FFS) world. That means they must continue using traditional FFS metrics focused mainly on volume while also developing new metrics and skill sets, such as:

- Analyzing measures such as episodes of care for chronic conditions, utilization rates and practice pattern variations, deviations from care pathways and errors in outcomes reporting
- Becoming proficient in benefit design, product pricing and curation of care networks
- Understanding how the benefit design and payment rate changes described in the contracts will affect utilization rates and financial performance

AT A GLANCE

To lay the groundwork for an effective population health management strategy, a health system should ensure five key elements are in place:

- Enhanced data analytics and revenue capture platforms
- High-performing clinical network
- Focus on patients presenting high or emerging risk
- Leadership, physician and patient buy-in
- Actionable plan for continuous performance improvement aimed at generating value

Assembling the essentials for successful population health management

Value-based payment can be a winning proposition, so long as an organization has all the right pieces in place.
Where to start?
One of a health system’s first tasks will be to develop an ACO or a CIN to assume risk of managing the health of a population. (See the sidebar on pages 3–4.)

Health systems then should turn their attention to developing a population health management strategy and organization. (See exhibit below.)

Key elements of an effective strategy
To ensure a value-based payment model can be a winning proposition, health systems should focus on the following five key elements, which are building blocks of an effective population health management strategy.

*Enhanced data analytics and revenue capture platforms.* Investment in systemwide population health management requires the creation of an infrastructure that allows for data exchange across multiple systems and EHRs. It also requires a closer working partnership among finance/revenue capture, administration and clinical leaders. In addition to accurately forecasting FFS collections, finance staffers must expand their focus to track value-based program measures on cost and quality, using actionable analytics dealing with clinical as well as financial indicators. Revenue capture should now be a strategic concern that is projected and tracked to prospectively manage performance.

With the shift to population health management, value-based payment modes from Medicare, Medicaid and commercial payers are putting a premium on the analysis of utilization data to identify key areas of practice variations. ACOs...
Timeline guide to developing an ACO/CIN

Given the complexity of the transition to managing risk, launching an ACO or a CIN requires an ongoing effort to achieve high-performing operational status. This effort unfolds in five overlapping stages lasting up to eight years. Health systems should use the following guide to ensure their strategies are on track and will achieve the intended results.

1 DEVELOPING THE VALUE-BASED STRATEGY (six to eight months)

Organizations too often underestimate the importance of this essential first stage, which is to develop a clearly defined, fully fleshed out strategy with appropriate benchmarks and a firm organizational consensus. Organizations should resist the urge to advance incrementally, thinking they can best move toward taking on risk by first gaining some experience and seeing how it relates to goals. Such an approach often results in the organization assuming risk before it is fully prepared to manage it. Instead, the focus should be on developing a plan that documents clear competency requirements, including agreement on clinical governance, network design, care model design, goals for consumer experience, technology and analytics, and the financial model.

2 FORMING THE ACO/CIN (10 to 12 months)

The costs of creating an ACO/CIN are likely to be minimal and incremental initially, relative to the organization’s top line. Much of the costs will involve reallocating staff, thus requiring no significant net new investment. In this stage, the organization should forge new connections among its clinical, financial and revenue cycle teams to identify issues around documentation or gaps in care.

In some cases, existing FFS infrastructure and revenue cycle management resources may provide the foundation for the value-based contracting and population health finances analytic team. The organization also may consider hiring an individual with health plan experience to start a team focused on analyzing and evaluating insurance impacts and value metrics. To keep health plan partners “honest,” the ACO/CIN will require actuarial capabilities to ensure targets for cost of care and administrative allocations are appropriate. Initially, the organization may want to engage a third party for this purpose, but the goal should be to bring this capability in-house.

Health systems have tended to sponsor ACOs led by primary care physicians, but as they have taken on bundled payments for specialty care, such as end-stage renal disease, they are increasingly developing specialty ACO models. As the clinical networks mature, providers will add high-value primary care and specialist practices and more efficient post-acute care sites. Optimizing and refining the clinical network will be an ongoing activity in an ACO’s development journey.

and CINs will need access to utilization data to set achievable and clinically appropriate clinical targets. As organizations pivot toward risk, ACO, CINs and insurers will increasingly need not only to understand utilization history, but also to incorporate social determinants of health (e.g., income, job opportunities, education and social support) into their databases to identify the resources and supportive activities needed to improve population health.

A high-performing clinical network. To develop a high-performing clinical network, physician recruiting should be focused on meeting emerging supply needs and building around culturally compatible physicians. The business model should include defensible methodologies for selecting participants who share the health system’s strategic objectives and for culling low performers. Infrastructure requirements include analytic capabilities for identifying practice variations based on detailed, condition-specific episode data. A key focus should be to understand physician variations in efficiency and cost effectiveness. The organizations should be able to measure overall effectiveness and efficiency at the provider or provider group level, while controlling for case mix and non-specific diagnosis codes.
At this stage, health systems begin implementing ACO/CIN programs for reducing costs. Such programs will require specific, measurable targets backed by performance reporting systems, with aligned incentives to ensure management is motivated to achieve results. To be able to meet the targets, organizations must move their revenue capture teams from the back office and train them with new skills in value-based forecasting that can help them both optimize financial performance and communicate more effectively with clinical leaders. At this stage, the health system’s investment in episode analytical capabilities plays a critical role in driving cost savings and quality improvements.

If a health system’s strategy includes participation in bundled payments (e.g., focused on hip and knee replacement, diabetes or maternity care), the organization also will require dedicated teams of specialists around the specialty procedures. Targeting and establishing clinical guidelines for high-risk patients is an early priority, with the addition of low-cost sites of care in the clinical network, and the development of patient portals for messaging and the transmitting electronic health record (EHR) data.

Most value-based contracts are based on a plan to reduce costs by eliminating inappropriate utilization, lower prices and increase market share by enhancing value to the consumer and reducing out-of-network referrals for care. Most ACOs and CINs, except for a handful of established, well-integrated medical groups in favorable markets such as South Florida, should expect to invest for several years before seeing sustained reduction in the cost of care.

This stage involves an ongoing focus on continuous performance improvement and geographic expansion to include additional populations. It will require the development of a new level of data sharing and collaboration among physicians and other clinicians to obtain optimum quality and financial results.

The Health Care Transformation Task Force (HCTTF), a Washington, D.C.,-based industry consortium of payers, providers and purchasers committed to accelerating the spread of value-based care, reports that ACOs successful in Medicare and commercial value-based payment contracting use a combination of centralized and embedded care management services to make the most efficient use of clinical resources. Allina Health in Minneapolis, for example, has launched a team-based approach to care management, with teams comprising primary care physicians.
advanced practice clinicians, special care workers, care guides and even pharmacists. Care managers (typically registered nurses, social workers and advanced practice clinicians) have become indispensable in caring for patients with chronic disease and complex conditions.

High-performing ACOs generally use claims and clinical data to test and refine their risk models. A major challenge they face is to make patient risk scores actionable, which requires being able to communicate the data effectively to discharge specialists and clinicians.

A focus on patients presenting high or emerging risk.

An effective disease management program has two pillars. The first is a strong focus on implementing evidence-based treatment protocols for patients with chronic conditions and identifying and closing gaps in the care continuum. The care model requires ongoing refinement in three areas, in particular:

- Integrating behavioral health with primary care
- Broadening patient focus to include moderate-risk as well as high-risk patients
- Expanded EHR use across the continuum of care

The HCTTF points to various approaches. Some ACOs have developed algorithms on the likely treatment plan for specific diseases. Others have delegated chronic disease management to condition-specific teams. Still others have used physician-led groups to establish consensus treatment protocols for priority conditions.

The second pillar of chronic disease management, of course, is patient self-management, which can take various forms, including online websites and personal coaching.

Leadership, physician and patient buy-in. Senior executives should lead the charge for the cultural and behavioral change required to move from FFS

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Characteristics of high-performing ACOs

A recent evaluation of high-performing ACOs conducted by the Health Care Transformation Task Force (HCTTF) sought differentiating characteristics in common among the ACOs. HCTTF reviewed a sample of 21 ACOs, each having at least one contract with the Medicare Shared Savings Program, one commercial contract and a diverse geographic service area. A recent HCTTF blog post notes shared saving rates among the most successful ACOs of greater than 2% and quality score above 90. The HCTTF found all 21 high-performing ACOs had five characteristics in common:

- Participated in the program at least two years and experienced improved performance over time
- Experienced prior risk-based contracting and were able to spread risk across several value-based payment arrangements, helping to finance necessary investments in innovative care delivery
- Built a high-value innovative culture with effective patient outreach and engagement
- Configured groups of effective population health programs, such as care management, post-acute care networks, behavioral health screening, substance abuse and e-screenings
- Invested in enough infrastructure to ensure continuous performance improvement over time, including investment in both total-cost-of-care and condition-specific-episode analytics

High-performing ACOs also all agreed “organizations need to spend to save” based on the realization that shared savings, even if achieved, would not be paid out for at least two years, the HCTTF found.

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Experience is showing that a value-based payer/provider partnership properly structured and having long enough investment and time horizons can reduce total cost of care while enhancing patient care and experience.

to a population health mindset. Ongoing education and communication are essential to build support. Tools for this purpose include:
- Senior leadership site visits
- Social media and patient engagement tools
- Social services and community outreach
- Board engagement and education
- Blogs from CEOs
- Webinars to educate the clinical networks and community

Bringing physicians on board for the transition to value may require investment in practice-improvement facilitators. The integration of analytic and performance improvement staff working with clinicians may be necessary to design improved workflows or pilot new delivery models. Partners Healthcare in Massachusetts, for example, has adopted the team approach to providing care, making a commitment to have all its primary care physicians certified as a National Committee for Quality Assurance Level 3 Patient Centered Medical Home and offering financial incentives to achieve the certification and maintain it.

Continuous performance improvement aimed at generating value. For the long term, a value-focused organization should have a multi-year payer strategy built from appropriate data, aligned with various organizational interests and broadly understood by the entire organization. The population health strategy should be aligned with the sponsoring system’s overall goals. And it should include an operational infrastructure that can provide the backbone for performance improvement. Financial metrics include contract performance, including opportunities to enhance revenue by reducing outmigration, improving care transitions, earning Merit-Based Incentive Payment System quality bonuses and capturing care management fees.

Generally, there are six ways an ACO or a CIN can deliver value:
- Preventing avoidable ambulatory and inpatient complications resulting in unnecessary hospital emergency department (ED) visits or readmissions or a lack of effective post-acute care planning
- Reducing duplicative and unnecessary diagnostic testing such as multiple magnetic resonance imaging and unnecessary lab diagnostics
- Promoting use of appropriate lower-cost treatment alternatives, such as drugs, surgical alternatives, psychotherapy or medical devices
- Improving continuum-of-care processes to ensure patients are directed to the most cost-effective and appropriate sites for care (e.g., freestanding ambulatory facilities versus hospital surgery sites, urgent care centers versus EDs and skilled nursing facilities [SNF] versus post-acute home care
- Managing referrals to ensure patients stay in the network and receive care from the most appropriate sources
- Promoting use of the highest-value SNFs and home health agencies

Experience is showing that a value-based payer/provider partnership properly structured and having long enough investment and time horizons can reduce total cost of care while enhancing patient care and experience.
Summary checklist for assessing readiness for value-based care

- Do we have a broadly understood multi-year payer strategy to guide specific contacting work?
- Have we realistically assessed our organization’s clinical and financial risk readiness capabilities?
- Will we have sufficient scale and volume of business to motivate a change in physician practice patterns from relative-value units to value-based practice?
- Do we have a well-articulated road map for developing our clinical risk-management capability?
- Do our decision-making processes and organizational structure align with our payer strategy?
- Are our internal and external data being leveraged effectively in all key decision-making?
- Does our organizational culture encourage individuals to set stretch goals and provide the sustained support needed to achieve our goals?
- Do we have the appropriate contract terms in place to protect our organization as we transition to greater levels of downside risk?

Final considerations
Health systems with experience in value-based payment are more optimistic about the future of the new business models in which they have heavily invested. A major academic health system in the Northeast, for example, having gone “all in” on population health, has tracked performance since 2014 and is just beginning to see its savings surpass its infrastructure investment. Experience is showing that a value-based payer/provider partnership properly structured and having long enough investment and time horizons can reduce total cost of care while enhancing patient care and experience.

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With its ongoing focus on improving value, the organization also can benefit from tapping into its population health management team’s skill sets regarding benefit design, product pricing and network adequacy to effectively design insurance products. And beyond the usual contractual arrangements with directly employed clinicians, the population health strategy should include a plan for offering physicians incentives for continuous performance improvement.

It’s also important to recognize different types of population health interventions require different amounts of time to show results. For example:

- Efforts to reduce readmissions by improving care management transitions or to reduce ED visits by using case management for high-risk patients with targeted conditions may require as little as six to 12 months.
- Efforts to improve use of specialists or reduce testing can show results in 12 to 18 months.
- Interventions for low-risk chronic disease patients, preventive care screening and promotion of lifestyle changes can take several years to show results.