Accountable Care NEWS

ACOs: Five 'Needs' for Successful Move From Volume to Value

by Wren Keber, MBA

With 480 accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP), as of Jan. 1, 2017, and another cohort set to begin in January of 2018[1]—not to mention other kinds of Medicare and Medicaid ACOs in several states—ACOs are now well established as vehicles to move healthcare providers from volume to value across the continuum of care. Despite the high number of MSSP ACOs, only 31% of those networks generated enough savings to receive a payment for performance year 2016.[2]

There are five things that ACOs could undertake to successfully move from volume to value:

1. **Treat an ACO as a strategic initiative.** Unsuccessful endeavors are often ones that aren't given time and attention. Many health systems with an ACO might have multiple contracting vehicles. They could range from disconnected, multiple managed care contracting departments to independent practice associations that bring together independent physicians in a contract for services. Using an ACO as a key tool in implementing a mature strategy away from fee-for-service reimbursement toward accountable, value-based payment mechanisms (including risk-bearing arrangements) allows an ACO to attract the attention of senior leadership and to receive resources to be successful in achieving the triple aim.

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   Through demonstrated experience, an ACO should define and prove its value proposition to an ACO's participants and patients, but also to a payer community. Ultimately, treating ACOs as "special projects" could become a disadvantage.

2. **Size care management appropriately.** ACO clinical leadership should spend time evaluating and optimizing its care management service offering on an ongoing basis. There are many care management models (centralized, federated/embedded, telephonic), each with their own strengths and weaknesses, to consider. Regardless of the chosen model, it is important to create an offering that is right-sized for the patients it will serve.

   Creating care management programs of the appropriate size is an exercise that most commonly starts with risk stratifying an attributed population, along with simple estimates of expected members who will have increasing risk over time. In the absence of scientific risk stratification, ACOs also could use basic demographic data sourced from claims or from electronic medical record (EMR) systems to identify members who might be appropriate for care management services and who then are enrolled through a screened referral process. Depending on the care management model chosen, there are well-established methods for calculating a correct number of care managers—often based on a ratio of patients to care managers. When a care management model is not adopted wholesale, or is a hybrid model, organizations could use market research to set staffing ratios.

   Often organizations "borrow" ACO care management resources from existing programs, such as inpatient case management at an in-network hospital. These programs tend to be undersized for an ACO population and therefore, they are likely to be ineffective. Not only do these joint programs have an insufficient number of care managers, but these managers also might not have enough time to dedicate to an ACO panel. Instead, they might be splitting their responsibilities among these patients and other patients under their management.

3. **Take advantage of useful data analytics.** Despite barriers, ACOs need to adopt and optimize tools that enable clinical leadership to identify opportunities for managing quality metrics, stem migration to high cost/low value providers and close clinical care gaps for members that could drive costs if left unmanaged.

   If a newly minted ACO lacks data analytics tools, it could focus on establishing care guidelines for certain disease states that positively impact quality and develop pilot programs to test whether certain assumptions about a population are true. For example, a pilot could examine referral guidelines from primary care to specialty providers to enhance patient experience and reduce unnecessary testing and specialty utilization or study members that seek care outside an ACO. Clinical leadership could be confident that these kinds of programs would manage quality and total cost of care—even in the absence of data analytics tools.

4. **Empower clinical leadership and governance.** ACOs are challenged by their payer partners to provide value to patients, improving population health and resulting in lower utilization and decreased total cost of care. Successful ACOs should designate dedicated leadership to oversee clinical programs, support providers and provide leadership with adequate administrative tools and staff.

   Clinicians should play a dominant role in governance of an ACO, accepting accountability for providers in its network, promoting best practices and ensuring that clinical care guidelines are updated periodically and evolve as an ACO matures. These clinicians should determine what is working well in an organization and help clinical leadership make important decisions about how its network's overall clinical care model functions.

   In addition, clinical governance should facilitate quality improvement programs for network partners that lag in performance of clinical metrics, promote consistency in and compliance with care delivery and ensure participants are using programs and resources to their fullest potential.

5. **Create a transparent funds flow methodology with incentives.** ACOs should provide easy-to-understand and transparent incentives to clinicians to encourage a change in behavior. A simple funds flow and distribution methodology could help build trust within a network.

   Network participants who understand how an ACO calculates "its piece of the pie" might be more likely to push for quality improvement and follow established ACO clinical care guidelines because they have an opportunity to earn an equitable portion of an ACO's revenue.

[1] "Program Data." Centers for Medicare & Medicaid Services. 2017. Accessed Dec. 8, 2017.
[2] "Side-by-Side Comparison: Medicare Accountable Care Organization (ACO) Models." Kaiser Family Foundation. Accessed Dec. 8, 2017.

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