So, you want to form a healthcare network - now what?

Received (in revised form): 12th August, 2021

Melody Danko-Holsomback
Vice President of Education, National Association of ACOs, USA

Melody Danko-Holsomback, CRNP, MSN, has over 27 years of nursing experience, 21 of which have been within Geisinger Health. She has performed nursing roles in community practice, inpatient and post-acute care settings. Additionally, she has worked in various analyst and consulting roles in information technology (IT) and population health consulting before entering her role as Chief Administrative Officer and Director of Operations and IT for Keystone Accountable Care Organization (KACO). In addition to her KACO role, she also worked per diem as a skilled nursing facility provider (SNFist) for Geisinger Clinic. Keystone ACO, LLC is a Medicare Shared Savings Program, Basic Level E Track Accountable Care Organization (ACO), serving over 75,000 Medicare beneficiaries. In August of 2021, Melody started the role of VP of Education for the National Association of ACOs (NAACOS) to lead the organisation's continued value-based care, educational and support needs. She has served as a member of the National Association of ACOs (NAACOS) Quality Committee, The National Quality Forum (NQF) Measure-Loop-Feedback Committee, Health Care Transformation Task Force (HCTTF) committees, and board, and is a Days-at-Home Technical Expert Panelist. Melody attended Ohio University for her BSN and Wilkes University for her MSN as an Adult-Gerontology Primary Care Nurse Practitioner.

National Association of ACOs (NAACOS), 601 13th Street, NW, Suite 900 South, Washington, DC 20005, USA
Tel: +1 202 640 1985; E-mail: mdholsomback@naacos.com

Abstract Healthcare networks are rapidly developing owing to the rising costs of maintaining independent practice while complying with changing rules and regulations. As groups are looking to create a network, a thorough evaluation completed in preparation for participation will assure their new venture greater success. The experiences of current networks, including those associated with accountable care organisations (ACOs), provide a road map for others. Keystone ACO, LLC has more than eight years of network experience in value-based contracting within the Medicare Shared Savings Program. (Keystone Accountable Care Organization, LLC is a Medicare Shared Savings ACO currently participating in the Basic Track E risk track. Information on Keystone ACO can be found at Keystoneaco.org.) This paper presents experiences of management consideration and staffing structures within Keystone ACO. Observations that are both positive and negative, coupled with policy and regulatory statutes, can assist new networks in selecting participants, evaluating opportunities and providing the staffing resources to create a successful healthcare network. The content of this paper provides examples and thought processes behind building a successful network.

KEYWORDS: network development, network staffing, network road map, data needs evaluation, value-based care, accountable care organisation

INTRODUCTION

The concept of 'value-based care' was historically initiated in the 1970s as insurers started to develop health maintenance organisations (HMOs) like networks to manage the cost of their members.[1] Fast forward 30 years and The Centers for Medicare and Medicaid Services (CMS) began to realise they needed to do something similar to curb rapid spending

increases within their programmes. Official CMS programmes started to be developed around 2008, beginning with the Medicare Improvements for Patients and Providers Act (MIPPA).[2]

- As healthcare takes a deeper dive into the value-based care movement, including payment risk arrangements at the local, state and national level, what is required to achieve and sustain success?

The continued push towards risk contracting is noted in a CMS press release dated 15 September 2020,[3] as CMS issued new guidelines to state Medicaid directors to enhance value-based initiatives in their Medicaid programmes and better align incentives across payers. Understanding the complexities of how provider groups or integrated healthcare systems can partner contractually to support the needs of providers and patients is one of the first steps in the development of a successful healthcare network. The most significant portion of this work includes developing a plan to share and strategise resources to maximise output. Once this aspect is understood, strategies can be created, implemented and evaluated. Accomplishing the previous steps with confidence requires data to be collected, structured and analysed, which can become an additional multifaceted project.

Depending on the experience of the network participants, some steps may move faster than others. Some participants may require foundational groundwork planning, including workflow and analysis of their electronic medical record (EMR) functionality, assuming they even have one. This paper will provide an overview of how to perform programme evaluations, create a staffing plan and develop an infrastructural budget plan. It will include descriptions and use case examples for operationalising resources to support providers and build IT infrastructure, including data reporting options. The options discussed to start, participate in and evaluate network programme opportunities will lead to better patient and provider engagement and outcomes. These actions will eventually reduce overall cost and increase the quality of the care provided.

ROAD MAP TO DEVELOPING A HIGH-PERFORMANCE NETWORK: WHERE TO START?

The first step of operationalisation is the evaluation of the programme's needs from a compliance and performance perspective. From a compliance perspective, one must become familiar with the legislative rules at both the state and federal levels to develop contracts and partnerships that do not cross any legal lines, such as noncompete laws. Accomplishing this may be easier said than done. ACOs are often set up as limited liability companies (LLCs) or clinically integrated networks (CINs) to allow multiple organisations, provider groups or independent providers to legally work together and combine financial investments in value-based risk contracts. The governance structure will also be constructed according to the programme's regulatory or statutory requirements. From a performance perspective, the choice of participants with like objectives, including a willingness to work together to meet set goals, is imperative for positive outcomes.

Networks formed rapidly to participate in new payment models such as those sponsored by CMS or The Center for Medicare and Medicaid Innovation (CMMI)[4] often do so without thorough planning. Understanding how the network will meet the required benchmarks and quality gates while staying within compliance and achievement timelines is imperative. Even in programmes that can be relatively simple to implement, such as Medicare Shared Savings Plan (MSSP)

ACOs,[5] understanding population health needs and whether resources are available within the network can be complicated. The network's size and partnership make-up may help operations, or it may add a layer of complexity. The triple aim of the MSSP includes promoting accountability for a patient population, coordinating items and services for Medicare fee-for-service (FFS) beneficiaries and encouraging investment in high-quality and efficient services.[6] Decisions of outsourcing support services should be considered very early on as contracting and implementing said services may take several months or more to be completed.

Programme needs, cost and outcome potential are imperative to understand and are not always readily obtainable. This is especially true when participating in a new or piloting model. Outlining an essential infrastructure for accomplishing goals and having an action plan in place at the start of a value-based contract prevents participants from operating with blinders on and just hoping for the best.

Regardless of the programme's participation contractor, it is imperative to understand relative legislation such as Stark Laws[7] that may complicate care design or use of contracted resources. The associated laws may dictate the type of services that can be offered and define deployment efforts. For example, ACOs are often comprised of otherwise competing provider groups. Suppose an ACO network participating in only one programme wants to provide paramedic or pharmacy consultant services to support patients and providers in care improvement efforts. In that case, the positions are limited to servicing only programme attributed patients unless the resources are fully funded at the participant level and not the network level. Network decisions require an understanding of implementation and provider engagement limitations that may come with population segmentation for services.

- The discerning questions to ask are, will each participant pay for additional resources at the organisation level, which will allow them to utilise the services for any patient in need?
- Or will resources be financed at the network level and only be used for programme-defined attributed patients?

If affordable, participant-paid resources are a better choice for ease of new workflow and process development. Comprehensive processes are less complicated for providers and staff to manage versus a special procedure for a select population.

An essential understanding going into this type of venture is that success is not always immediate, as reflected by the results of Keystone Accountable Care Organization, LLC (Keystone ACO or KACO). Keystone ACO started with a modest positive savings rate of 2.3 per cent in 2013, which quickly turned negative in the following three years (2014–2016) before moving again to positive savings (Figure 1). Several years of work went into setting up infrastructure, developing the right partnerships and changing the way care was delivered to produce increasingly positive results. It is prudent to note that for Keystone ACO the volume of patients in the contract, which reduced benchmark volatility, and the change from retrospective to prospective beneficiary assignment methodology,[8] which reduced beneficiary inclusion fluctuation, both helped stabilise the effects of the financial bottom line.

BUDGETING CONSIDERATIONS

General network structure

Network budget preparation is more accurately defined after infrastructure design and deployment drafting is completed. Administrative services, care management services, information technology (IT) personnel and platform needs and marketing for patient engagement services are all part

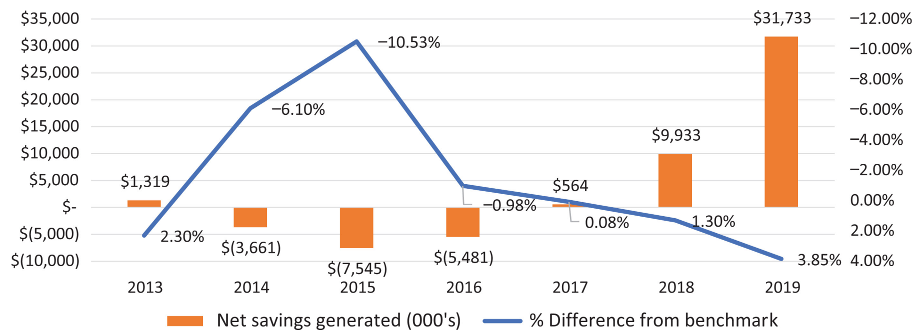

Figure 1: Keystone ACO financial performance results from 2013 to 2019.

of the foundation of a robust healthcare network budget. Staffing a network may mean creating new roles or splitting full-time equivalent (FTE) hours to fit the management needs. Having a dedicated team is the best option for more extensive networks to ensure that the programme's objectives and outcomes do not get reprioritised along the way.

Programme requirements and expanded services

New programme benefits will require dedicated management. Understanding the intricate details of the value-based contract specifications is an excellent place to start to construct plans. Quality metrics are always part of value-based care contracts and often require dedicated staff for reporting capabilities. Some programmes include payment for services not covered under traditional payment methods such as home health visits for patients without a home-bound status, skilled nursing facility (SNF) 3-day waivers, or beneficiary incentives like cost-sharing for preventative services. Initial questions to ask include the following:

- Will the network need to pay for staff to manage and support the programmes, or will they be budgeted at the participant level?
- Are workflows in place or do they need to be created?
- If new workflows are not in place for all patients, can the targeted population be easily identified for all participants, or does each participant need a different process to accomplish the task?

For example, the MSSP SNF 3-day waiver[9] can be utilised for beneficiaries attributed to an ACO that may otherwise not qualify for SNF services but do not have a qualifying 3-day hospital stay. Appropriate implementation and tracking of the SNF 3-day waiver services include creating a detailed implementation plan for CMS and developing and executing contracts with facilities with a three-star or better overall rating with Medicare and are willing to work together to create a sound process for validating and admitting patients to their facilities.

The process needs to involve the ACO physicians required to approve the admission to the SNF and the discharge case managers or discharge planners to assist with placement criteria, fill out forms and complete the search for services. The SNF facility staff will require education on the process, and a patient acceptor, usually the admission coordinator, will need to understand the signing requirements and communication process. The SNF billing staff require education on 3-day waiver service billing practices, including specific payment codes or modifiers necessary for bill submission. Detailed plan documents

will need to be drafted for each service enhancement that is not part of the current daily work of involved staff. Additional considerations include staff to complete post-acute placement review and care plan management of this patient cohort, quality outcomes management and contract negotiation. An additional question for the network leadership is

- Will the post-acute contract include shared savings distribution or promotion of increased network referrals for positive performance?

Provider needs

The healthcare industry is aware that it is increasingly challenging for healthcare providers to maintain independent practice. Many factors have affected this, including the requirements for EMRs, which can be very expensive to buy and maintain. Additionally, payment models are changing, with many payers now moving to value-based contracts in some markets or within defined demographics. If patients are not well managed, provider revenue profits decrease, or penalties are sustained under value-based contracts. Without proper financial and infrastructure supports in place, the factors mentioned make continued success harder for independent providers. Provider networks would allow for value-based purchasing of services that would otherwise not be affordable. They also provide additional resources for independent providers such as quality reporting and care management, which reduce these burdens. Structuring a network to include independently practising providers will likely add additional FTE requirements to the administrative team. Still, if done strategically, the cost will be minimal and, from experience, have been an important ingredient in good provider engagement and outcomes.

Integrated health systems, large provider groups or insurance payers with greater cash and credit resources are often the conveners of value-based contract ventures. Joining together with smaller practices and independent providers can help sustain these practices while improving care outcomes that can have a positive effect on larger institutions' star ratings or quality scores.

Staffing a network

When considering staffing models for network administration needs, the first need includes choosing a strong leader with experience and strategy skills to lead the team. Additional network services that drive success include practice transformation coordinators (PTCs), patient care coordination and service management support staff, marketing and engagement support, quality data tracking and management and claims and EMR data analytics support. While all these services will increase how rapidly favourable outcomes are achieved, care management, data analytics and quality management support are most imperative for network management start-up and strategy development. Descriptions and examples of these roles are provided in this section.

PTCs are one option for network support. The role of the PTC is to be the point person with the knowledge, time and ability to assist providers and practices in completing the external needs of a value-based programme. For example, a PTC can evaluate each healthcare provider or group for their readiness to participate in a value-based programme. PTCs should be fluent in project management workflow creation to effectively capture and report care gaps and develop and execute education programmes for staff and providers in needed areas. As discussed, most providers have a hard time just keeping up, and requiring their staff to add any extra workload without assistance and guidance is often a failure waiting to happen. A positive difference can be seen in staff attitudes and programme

acceptance when they know someone with expertise is only a phone call away to help them.

Care management (CM) services are a must for successful outcomes that do not overburden providers. The services may be embedded as part of the provider office team or work in a more centralised manner performing telephonic outreach to patients. Regardless, documentation of the CM services needs to be accessible to the providers within their daily workflow for consistency and reduced workload for the care team. The effectiveness of the CM services is diluted if patient outreach documentation concerning care coordination or gaps is not available to providers or the documentation is not accounted for in the programme's quality outcomes. The structure of CM services can be hired directly by the providers or groups, as part of the network infrastructure team, or by contracting with a CM vendor. CM services may encompass many aspects of care. Creating teams such as outpatient primary and speciality care teams, inpatient discharge navigators and post-acute placement and follow-up CM teams allows for specialisation and increased impact. The utilisation of predictive analytics to assist in prioritising services for the implied intensity level of support is an ever-growing field of innovation.[10]

Beneficiary or patient engagement in their care should also be an area of focus. As more emphasis is placed on social determinants of health (SDOH) and patient choice, helping patients understand how to navigate through available services, providing information on wellness and chronic condition resources and updating them on community events to partake in are essential.

- How can patients help themselves if they are unaware of services or are unengaged in their care?

Providing information on events and services such as health fairs, support groups or basic needs, including food, or medication assistance, is a great way to help build patient rapport and reduce the impact of negative SDOH that can perpetuate increased care cost. Roles supporting this work may include a patient engagement liaison and a community healthcare associate (CHA).

The patient engagement role works on marketing campaigns or newsletters, required mailings to meet programme compliance, wellness information development and distribution, and working with patients at health events. The CHA can work alongside all staff but is most effective as an extension of the CM. The CHA's role includes going to patients' homes to assist with social need evaluations, help non-mobile patients with telehealth, and complete forms for indigent programmes such as the medication, transport or meal assistance.[11] While these resources may not be immediately set up within a network, they are roles that can positively impact patient engagement and outcomes. They can complete tasks not requiring a licence or certification at a much lower cost than a registered nurse (RN) care manager.

Quality metric management is an additional area of need that may require an extra layer of support depending again on the size and composition of your network. To that point, the network may need a quality manager to provide oversight of the programme's care gap closure, data capture and transmission to CMS, contracted payer or other regulatory body. If the network has limited complexity, this oversight could become part of another administrative position within the network. Regardless, identifying the data needs for quality reporting, determining whether the capabilities are available in-house or whether a vendor is required, and working with the teams on quality improvement projects and tracking mechanisms are tasks that require thoughtful oversight.

Data analysis is essential to understanding the need for and driving the work of the

previously outlined staff resources. It may sometimes feel as though regardless of the data sources, there always seem to be holes in it that can obscure the total data picture sought to be obtained. For example, EMR data reports can be produced near real time but only show the picture of what is happening within the constraints of that health system or specific EMR. Adding data from local health information exchanges (HIEs) can provide further information from other healthcare systems and post-acute facilities. Registry data can also expand on the view of a patient, provider or office regarding practice habits and outcomes, but this occurs only if the healthcare facilities or practices are transmitting data to those HIEs or registries the network also utilises. State and federal grants have been made available in the past to assist with costs associated with connecting to HIEs and building a data infrastructure[12] that meets a quality payment programme's (QPP) promoting interoperability (PI) guidelines.[13] PI was previously known as 'meaningful use' and focuses on the ability of the provider to collect and transmit electronic or digitally captured healthcare information.

Payer data can provide a more comprehensive picture of patient activity, but claims lag creates a gap of a minimum of two to three months in information. For these reasons, the 'Data Considerations' section will provide examples of how to use the various data resources alone or together to find opportunities for improvement and how staff can create and implement new programmes and workflows to close care gaps and optimise care.

Provider engagement is most often data driven. The ability to provide clinicians with data that is robust, validated, intuitive, easy to access, actionable and that can be trended against others is essential to capturing and sustaining their engagement. Although data is often not perfect, understanding imperfections and the reason they cannot be 'fixed' should be noted early on, or many providers will discredit the data and disengage. The providers may feel as though they will never win or that they are doing well and therefore have no need to understand the cost and quality drivers. One example of this is patient attribution logic. In most ACO models, patients are attributed at the ACO level, not the provider level. Claims are older than EMR data, and some patients may have recently changed to a new primary care provider who is not within or who was newly hired into the network, and therefore the attribution logic has not yet reflected the change. The providers need to understand this type of limitation, as does leadership. Even with such limitations, breaking data down to the patient and disease levels allows providers insight into best practice medicine opportunities and referral options for chronic condition management or exposes the need for additional documentation tools or workflows to better manage patient outcomes. Once resources are provided, patient satisfaction and open quality care gaps are more readily pursued and satisfied.

Analytic team staffing may include many job descriptions, such as business analyst, data architect, EMR or application developer, information security, software engineer, bioinformatics analysts, database administrator, and digital solution analyst. The number, type and structure of each network's IT teams will depend on the maturity of the participants, capital available for use and current or potential vendor contracting provided support. Regardless of whether this process sounds manageable or daunting, be assured it is possible. It is possible to start with high-level data and limited resources by working to conquer the so-called 'low-hanging' opportunities or those easy to recognise and fix. Then project by project, grow your programme to impact more patients and take on more risk in the move to win at value-based care contracting.

DATA CONSIDERATIONS

Turning data into action

Data management services are imperative to a well-functioning network. The first evaluation that should occur is the breakdown of what data the network will be receiving and what must be reported to meet programme requirements.

Will claims information be received for analysis from payer contracts, or do the contract expectations include only transmitting EMR and billing data to meet quality metric and programme parameters?

A complete picture of required, available and desired but not currently accessible data should be documented in an actionable data plan. Consider support to provide clinical data needs such as patient demographics and health information, diagnosis codes, EMR orders, test results, procedural information, etc. Claims-based data also includes facility demographic information from within and outside of the network, diagnoses, cost and utilisation information, durable medical equipment (DME), part B and or part D medications, service types including office visits, surgeries, emergency department (ED) and hospital admissions. All this information can equate to thousands of data points. Claims line feeds can provide a more comprehensive picture of total care but are not promptly available for real-time action plan development. Immunisation and pharmacy registries can also provide data that help define patient care needs. While creating the analytics structure for each network and/or programme, the ultimate goal is to create symmetry within existing systems to ease data exchange, aggregation and reporting. The utilisation of automation tools to assist with previously defined manual processes are also an aspect of design that may require more up-front cost to implement but can reduce overall staff workload for repetitive well-defined IT service needs.[14]

EMR data is most accessible and abundant for healthcare network participants at a local level. Depending on the EMR, discrete data capture and reporting capabilities may be a straightforward function, or the process may require additional FTEs or vendor resources. Financial considerations may help with decisions to utilise vendors to create interfaces for access, format data from one or multiple platforms and convert it into reports or dashboards. If the network operates one EMR, collecting, storing, organising and maintaining the data is much less complicated. If network participants use multiple EMRs, mapping for aggregation of the information for management and reporting purposes becomes a massive project to complete. HIEs can help the data transfer and mapping process if all network participants connect and transmit the necessary information. HIEs are most often utilised to transmit continuity of care documents (CCDs) or other types of data files to meet the QPP's PI measures.[15]

The additional challenge comes when CCDs do not contain the data required to evaluate or report quality metrics or when the data exists but has not been correctly mapped to meet the programme reporting or registry needs. Some vendors create interfaces to assist with data transfer directly into registries. If the data is not currently conveyed, flat files can be developed and scheduled for transfer to HIEs, registries or population health platforms. Once the data is mapped and aggregated, dashboards, reports and bidirectional data ingestion can be accomplished by the assigned analysts. This work will provide the information in a format better able to effectively assist providers and support staff in closing care gaps.

With all these factors in mind, where should one start to decide how to resource these data needs?

From experience, it is best to start with the evaluation of IT support services and capabilities currently within the network

participants. Next, evaluate the data processing requirements for network payer contracts. This evaluation should include data transfer, formatting and ingestion into the population health data platform. Additionally, the FTE requirements to code and design reports, develop risk analysis, track performance and design EMR tools or dashboards creation require evaluation and funding for a robust data support team.

Comparison of staffing from within existing teams that already have the needed skills should occur before looking at vendors and signing contracts for services. The aim is to create as much synergy between the current resources and additional staff or vendors utilised to fill the holes in the 'Big Data' picture. For example, if any of the participants have experience in claims analysis, EMR data manipulation, dashboard development, sophisticated care gap closure workflows or tools, or diagnosis coding education or if they have existing vendor contracts, etc., leverage that experience.

While the previous details explain how to examine network structure for specific data needs, the following questions can serve as a high-level guide during the evaluation process.

- Are additional staff, tools or platforms needed to support the network?
- Can those resources be added within the current network infrastructure, or do they need to be outsourced?
- Do additional tools or platforms need to be purchased?
- If vendors are required to fill your data needs and they advertise that their tools and workflows will positively impact the network outcomes, can a deal be made with them in which they also take on a percentage of the risk?

Just one or all these options may be used, but be very careful to ensure that all the services work together and do not create silos that inhibit data mapping and aggregation, and slow care initiatives.

As CMS looks to have all quality metrics reported digitally by 2025,[16] the regulations and required technology to complete reporting may be expensive and challenging to implement. The current requirements to change the MSSP ACO quality reporting from the web interface reporting system to electronic clinical quality measures (ECQMs) has become a logistical and financial nightmare for some networks that have participants on multiple EMR platforms. The 2022 ECQM requirement is an example of how attempting to change a process to reduce provider reporting burden could negatively affect provider performance and participate in value-based programmes.

When considering the new application programming interface (API) Fast Healthcare Interoperability Resources (FHIR)[17] technology that is being promoted as 'the solution' for ease of reporting and data capture, the tools and staffing to convert and support the necessary changes can be very costly. Most popular EMR vendors currently utilise FHIR technology, which can help with data extraction and interoperability but does not solve all the problems associated with combining data sources to produce an all-encompassing population health platform. It is always good advice to talk with other users about their positive and negative views of vendor platforms before purchasing.

Formatting data to drive network performance

Now that the resources needed to support a network have been reviewed, the following questions can be pondered.

- What works best for data presentation and implementation practices?
- How should one begin to look for low-hanging opportunities, and after identifying them, what are the next steps?
- What type of data leads to these opportunities, and what model of support services will provide these functions?

From a data standpoint, several layers are utilised for performance oversight; the executive summary level, the population level and the patient detail level. When developing your data vision, it is advantageous to include dashboards or reports that start with a high-level summary that includes the ability to drill down to the population- and then the patient-level detail. From experience, one of the first things a provider will ask when you show them that they have poor or even moderate performance is 'what are the details, so I know what to fix?'

Executive level data

Executive summary-level data is by far the easiest to aggregate, format and present after the data sources have been mapped and validated. Use your network or programme's overall objectives and note opportunities to present as key performance indicators (KPIs) for summary-level reporting. Most healthcare payers and regulatory agencies require the same or similar measures or measure categories. Take time to understand the KPI measures, their scope, criteria and the clinical settings that are accountable for completing the measures. This knowledge will be helpful during the integration of multiple data sources into a data warehouse or registry. Understand the data format that provides senior leadership, clinicians and the public with the best ability to interpret performance outcomes and then create reporting capabilities around that. Finally, ask the question,

Can the data manipulation be accomplished on one platform, or will it take several?

An example of an opportunity found and tracked as resources were implemented is displayed. A Keystone ACO network opportunity was discovered in post-acute utilisation with an inpatient rehab facility (IRF) placement record at over 2.5 times greater than the national Medicare FFS utilisation rate per 1,000 in 2016. After implementing care redesign within the hospital discharge team in 2017 and then changing contracts to a risk programme that allowed for SNF 3-day waiver utilisation for ACO beneficiaries, Keystone ACO reduced IRF utilisation by 48 per cent over four years. This was accomplished while also reducing and maintaining an overall length of stay below all other MSSP ACOs average rate and maintaining a gradually decreasing trend for overall SNF utilisation during the same time frame. The average cost savings of approximately US$10,000 per episode with IRF to SNF stay conversion was estimated by comparing Keystone ACO's average IRF cost to the average SNF cost. The noted reductions were upward of US$20,000 per episode when patients were discharged home with home health services rather than an IRF. The redirection of services to the most appropriate, least costly setting was accomplished with maintained quality of care. The following graphs (Figures 2–4) provide the performance data for Keystone ACO post-acute utilisation in MSSP 2016 through 2020, indicating a positive return on investment for post-acute initiatives and SNF 3-day waiver participation. Over 600 SNF 3-day waivers were utilised by Keystone ACO in 2018 and 2019, making a significant impact on the overutilisation of IRF placement.

Provider-level data

After summary-level data design has been completed, provider- or practice-level reporting is the next level to conquer. Provider, practice and later patient-level data should be more granular and should dig into the sources that drive the KPIs. For example, if a KPI is hospital admissions per 1,000, providing reports for the primary care and specialty providers to include the patients seen by them or at their site of care will allow them to observe how their patients' outcomes trend compared with those of like providers and practices. Practice

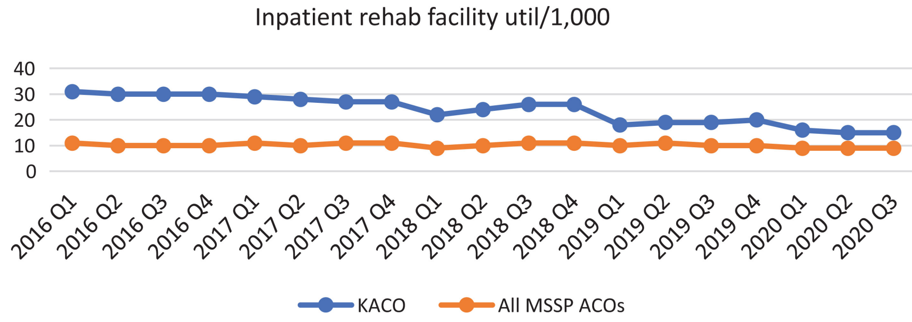

Figure 2: Keystone ACO Inpatient Rehab Facility utilisation trend.

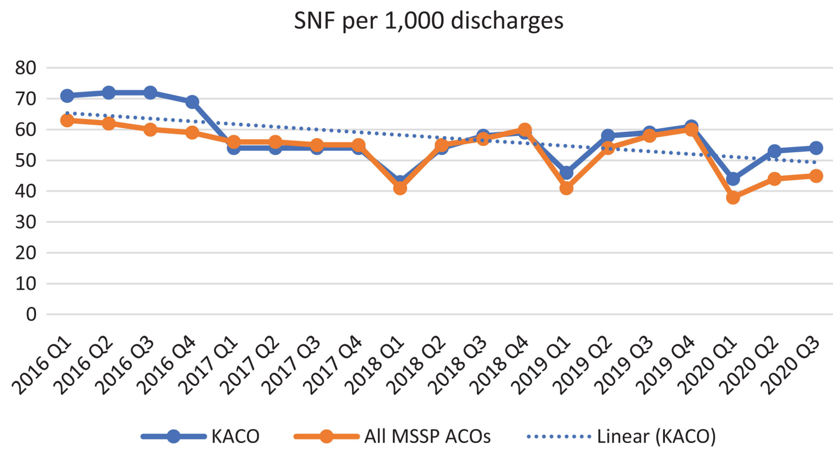

Figure 3: Keystone ACO Skilled Nursing Facility utilisation trend.

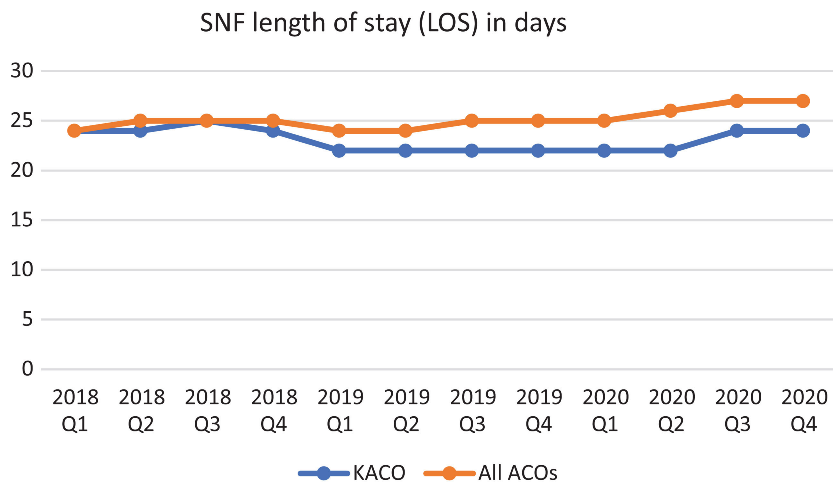

Figure 4: Keystone ACO Skilled Nursing Facility LOS trend.

reports may contain information on where the patients are admitted to or from, the diagnoses assigned to the admissions and the total disease burden relative to case mix index (CMI) or hierarchical condition category (HCC) scoring criteria. Cost parameters with and without risk adjustment factors are also essential to allow appropriate comparison with nationally or locally established benchmarks.

Beneficiary or patient-level data

Once opportunities are discovered at the network, practice and provider levels, patient-level data is the next layer of information used to drive positive change. Patient-level information drives change one person at a time. Projects will be constructed around like opportunities, but each individual must be identified and placed in the appropriate reporting categories to provide engagement opportunities. Because data elements are vast and can be constructed in unlimited ways, decisions about the end goal of the report will determine how to build the individual structure.

- Who are the ED and admission high utilisers or high-risk, high-cost individuals defined by your leadership or experts?
- Do they need CM services?
- Are there SDOH factors that need to be met, such as homelessness, food insecurity or medication unaffordability, requiring additional resource support or referral processing once identified?

The ability for clinicians, administrators and support staff to easily view, evaluate and manipulate data at this level is imperative to effectively driving sustained positive performance. It is patient-level data that the PTCs, CMs and engagement staff can build processes and tools around to further support patient and provider needs.

Figure 5 provides the high-level framework to start an overall IT needs evaluation.

CONCLUSION

As value-based care initiatives continue to grow at the federal, state and commercial payer levels, getting your foot in the door

Resource Considerations: In-house versus Vendor
• Data storage and processing, file transfers • Claims analysis • Report coding • Dashboards with drill-down capabilities • Number of payers, TINS, providers, sites and beneficiaries included in analysis needs • Population Health Platform that can aggregate multiple data sources include claims, registry and EMR data
Internal FTE and Skill Needs
• Number of new positions versus utilising portion of current positions • Job titles and duties • Current resource structure
Vendor Choice
• Full analytic package (including data ingestion, processing and staffing)   • or • Carve out needs (speciality reporting, data exchange and interfacing, etc.) • Development flexibility (how much input will you have in design?)
Budget
• Cost comparison (how much does one staffing option cost over the other?) • Percentage of budget to potential savings (size of ACO and revenue impacted by staffing or IT tool costs)

Figure 5: Framework to build a healthcare network's data support system

to explore the best options for network contracting will provide experience before more mandatory models are pushed forward. While not all-encompassing, the information provided lays out the framework and thought processes needed to create a functional network plan. The foundational needs depicted in regulation and contractual goals with systems, provider groups and facilities will provide the information to form the network governance structure. Evaluation of potential value-based care initiatives or joint venture opportunities will provide the framework for what is required to participate and create the network infrastructure to build on. And, finally, by utilising a defined project plan depicting new or repurposed staffing and tool requirements, the supporting budget can be developed with confidence. Always remember success takes hard work and innovation, which sometimes comes with setbacks. As discussed, value-based care programmes have been around since the 1970s as managed health plans started HMO networks and CMS started implementing value-based programmes in 2008 with the passing of the MIPPA. Yet most providers and/or practices do not have value-based care operational models completely figured out. With this information in mind, be aware of using missed opportunities or failed processes as learning opportunities to grow on. Not every intervention or innovation is perfect on the first try. If engaged leadership and committed providers drive strategic and positive change within networks, perhaps value-based care will soon be the foundation of healthcare delivery at the local, state and national levels.

References

1. Novikov, D., Cizmic, Z., Feng, J., Iorio, R., Meftah, M. (2018) 'The historical development of value-based care: How we got here', *The Journal of Bone and Joint Surgery*, Vol. 100, No. 22, p. e144. DOI: 10.2106/JBJS.18.00571 (accessed on 15th June, 2021).
2. Centers for Medicare and Medicaid Services. (2020) 'Value-based care programs: What are the value-based programs?', available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs (accessed 20th June, 2021).
3. The Centers for Medicare and Medicaid Services (CMS) Press Release. (2020) 'CMS issues new roadmap for states to accelerate adoption of value-based care to improve quality of care for Medicaid beneficiaries', 15th September, available at: https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-accelerate-adoption-value-based-care-improve-quality-care-medicaid (accessed 26th May, 2021).
4. Center for Medicare and Medicaid Services. (2021) 'Innovation models', available at: https://innovation.cms.gov/innovation-models#views=models (accessed 15th June, 2021).
5. Centers for Medicare and Medicaid Services. (n.d.) 'Shared savings program', available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram (accessed 26th May, 2021).
6. Centers for Medicare and Medicaid Services. (n.d.) 'Shared savings program: About the program', available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about (accessed 26th May, 2021).
7. Office of Inspector General, US Department of Health and Human Services. (n.d.) 'A roadmap for new physicians fraud and abuse laws', available at: https://oig.hhs.gov/compliance/physician-education/01laws.asp (accessed 15th June, 2021).
8. CMS Medicare Shared Savings Program. (2019) 'Shared savings and losses methodology, specifications', Section 2.1, available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V7.pdf (accessed 15th June, 2021).
9. Centers for Medicare and Medicaid Services. (2021) 'Skilled nursing facility 3-day rule waiver, guidance', available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/snf-waiver-guidance.pdf (accessed 26th May, 2021).
10. Raths, D. (2021) 'Geisinger redesigning chronic care management approach; Pennsylvania health system launches virtual care delivery platform in partnership with Noteworth', 25th May, available at: https://www.hcinnovationgroup.com/population-health-management/care-management/article/21224194/geisinger-redesigning-chronic-care-management-approach (accessed 20th June, 2021).
11. CMS Learning System for Accountable Care Organizations, Case Study. (2019) 'Keystone ACO's health navigator program to identify and close care gaps', available at: https://innovation.cms.gov/files/x/aco-casestudy-keystone.pdf (accessed 15th May, 2021).
12. HealthIT.GOV. (2015) 'Funding announcements: Advance interoperable health information technology

services to support health information exchange', available at: https://www.healthit.gov/sites/default/files/2017-09/advancedinteroperablehie-foa.pdf (accessed 15th May, 2021).
13. Centers for Medicare and Medicaid Services. (2021) 'Promoting interoperability: 2021 program requirement', available at: https://www.cms.gov/regulations-guidance/promoting-interoperability/2021-program-requirements (accessed 15th May, 2012).
14. Quality Payment Program. (2021) 'Promoting interoperability measures: Traditional MIPS requirements: 2021 promoting interoperability requirements', available at: https://qpp.cms.gov/mips/promoting-interoperability (accessed on 15th May, 2021).
15. Geisinger Health. (2021) 'Innovation hub', available at: https://www.geisinger.org/innovation-steele-institute/innovative-partners/intelligent-automation-hub (accessed 20th June, 2021).
16. Centers for Medicare and Medicaid Services. (2021) 'Meaningful measures 2.0: Moving from measure reduction to modernization', available at: https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization (accessed 15th May, 2021).
17. HL7 FHIR. (2021) 'Welcome to FHIR', available at: http://hl7.org/fhir/R4/ (accessed 20th June, 2021).